

## MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE CHILD AND ADULT CARE FOOD PROGRAM

## **INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS**

To apply for free or reduced-price meal eligibility benefits for your child(ren), please fill out this form and return it to the child care center.

PART 1 CHILDREN ENROLLED AT THE CHILD CARE CENTER										
Complete information below for children enrolled at the center. If child(ren) are receiving Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamp) or Temporary Assistance (formerly AFDC, now funded by TANF), complete Parts 1, 3, and 4 only. Complete Parts 1, 2, 3, and 4 if you did not provide a SNAP case number or Temporary Assistance case number for all of the children listed in Part 1.										
NAME (first and last)		FOSTER CHILD						ORARY ASSISTANCE CASE NUMBER		
PART 2 HOUSEHOLD AND INC	OME INFORM	MATION								
List all members of the household not including the children listed in Part 1. Indicate source and amount of current monthly gross income for all members of the household before deductions, such as taxes and social security. Where there are wage earners and self-employed adults, the income of the wage earner cannot be offset by the business losses of the self-employed adult. If last month's income does not accurately reflect your circumstances, you may provide a projection of your current annual income. Irregular self-employed income may be averaged over the prior 12 months. Foster children may be eligible regardless of household income. Contact the center for more information.										
INCOME BASED ON (CHECK ON	IE)	YEARLY MONTHLY		2 X A MONTH EVI		VERY 2 WEEKS WEEK		LY		
HOUSEHOLD MEMBER	S	GROSS W	/AGES		FARE, CHILD PRT, ALIMONY	PENSIC RETIREMENT SECUR	, SOCIAL	OTHER		
PART 3 RACIAL ETHNIC INFORMATION (You are not required to answer this section)										
Are you of Hispanic or Latino origin? Yes No  AMERICAN INDIAN ACIAN BLACK OR NATIVE HAWAIIAN OR OTHER  MUTE										
or AL			ALASKA NATIVE ASI		AFRICAN AMERIC.		FIC ISLANDER			
PART 4 SIGNATURE										
I hereby certify that all information provided is correct. I understand that this information is being given in connection with the receipt of federal funds, that institution officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.										
SIGNATURE OF ADULT FAMILY MEMBER								DATE		
PRINTED NAME OF ADULT		ADDRESS	ADDRESS					PHONE NUMBER		
Section 9 of the National School Lunch Act requires that, unless your children's SNAP or Temporary Assistance case number is provided, you must include the last four digits of a social security number of the adult household member signing the application or indicate that the household member signing the application does not possess a social security number. Provision of the last four digits of a social security number is not mandatory, but if the last four digits of a social security number are not provided or an indication is not made that the signer has none, the application cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the accuracy of information stated on the application. These verification efforts may be carried out through program reviews and investigations, and may include contacting employers to determine income, contacting a SNAP or welfare office to determine current certification for receipt of SNAP or Temporary Assistance benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to provide the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.										
TOTAL HOUSEHOLD LINCOME.			R CENTE	R USE O	NLY					
TOTAL HOUSEHOLD   INCOME: SIZE:	INCOM YEAR	IE BASED ON (0 MONTH	CHECK ONE): 2 X A MON	NTH EV	ERY 2 WEEKS	WEEKLY SN	AP (Food Stan	TEMPORARY ASSISTANCE		
Eligibility Determination:		_						<b>_</b>		
Eligibility Determination:							DATE			
<b>&gt;</b>										

MO 580-1314 (2-11) CACFP-205