

**INCOME ELIGIBILITY GUIDELINES
 For Child Care Centers
 (FOR INTERNAL/OFFICE USE ONLY)**

The eligibility scale is for determining participating children's eligibility category for federal meal reimbursement if they are not recipients of SNAP (Formerly food stamps) or K-TAP. Participants from households with total gross incomes at or below the following levels may be eligible for free or reduced-price reimbursement rates.

INCOME ELIGIBILITY SCALE

Income Guidelines for Free/Reduced Price Meals Effective July 1, 2015-June 30, 2016				
Household Size	Free Meals		Reduced Price Meals	
	<i>Monthly</i>	<i>Yearly</i>	<i>Monthly</i>	<i>Yearly</i>
1	\$1,276	\$15,301	\$1,815	\$21,775
2	\$1,726	\$20,709	\$2,456	\$29,471
3	\$2,177	\$26,117	\$3,098	\$37,167
4	\$2,628	\$31,525	\$3,739	\$44,863
5	\$3,078	\$36,933	\$4,380	\$52,559
6	\$3,529	\$42,341	\$5,022	\$60,255
7	\$3,980	\$47,749	\$5,663	\$67,951
8	\$4,430	\$53,157	\$6,304	\$75,647
For each additional family member add:	+\$451	+\$5,408	+\$642	+\$7,696

* The term “household” means a group of related or unrelated individuals who are not residents of an institution or boarding house but who are living as one economic unit, sharing housing and all significant income and expenses.

Note: Children that are recipients of the following programs are automatically eligible for the free reimbursement rate:

- SNAP (formerly known as Food Stamps)
- Kentucky Transitional Assistance Program (K-TAP)
- Foster Care Program
- Head Start or Even Start
- Kinship

CHILD ENROLLMENT FORM/INCOME APPLICATION

1. Participant Information: (To be completed by Parent/Guardian)

If a child is a SNAP/K-TAP recipient or a Kinship/Foster/Head Start participant, the child is automatically eligible to receive free Program meal benefits, subject to the requirements of 7 CFR 226.23.

If your participant receives assistance from the items below, they are automatically eligible for free meals. (Please complete and skip to section 3.)

Participant's Last Name	Participant's First Name	Date of Birth	Normal Typical Hours of Care	Normal/Typical Days of Care (Circle all that apply)	Meals Normally Eaten (Circle all that apply)	Snap or K-TAP #	Kinship	Foster
			-	M T W Th F Sa Su	B AM L PM S LN		<input type="checkbox"/>	<input type="checkbox"/>
			-	M T W Th F Sa Su	B AM L PM S LN		<input type="checkbox"/>	<input type="checkbox"/>
			-	M T W Th F Sa Su	B AM L PM S LN		<input type="checkbox"/>	<input type="checkbox"/>
			-	M T W Th F Sa Su	B AM L PM S LN		<input type="checkbox"/>	<input type="checkbox"/>
			-	M T W Th F Sa Su	B AM L PM S LN		<input type="checkbox"/>	<input type="checkbox"/>

***Parent/Guardian works multiple shifts and participants may be in care different days/hours** yes no

2. Income Application Household Members and Monthly Income:

NAMES OF HOUSEHOLD MEMBERS Including Children Not Listed Above Last, First	GROSS MONTHLY Income From Work (Before Deductions)	MONTHLY Income From Welfare Payments, Child Support, Alimony	MONTHLY Income From Pensions, Retirement, Social Security, Unemployment Compensation	Any Other MONTHLY Income Including Money Received from Kinship/Foster Child
1.	\$	\$	\$	\$
2.	\$	\$	\$	\$
3.	\$	\$	\$	\$
4.	\$	\$	\$	\$
5.	\$	\$	\$	\$

3. Signature and Social Security Number:

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

X _____
Signature of Adult Household Member

X _____ No Social Security Number X _____
Last four digits Social Security Number* Date

FOR SPONSOR USE ONLY. DO NOT WRITE BELOW THIS LINE.

Application approved for:	<input type="checkbox"/> Free Meals <input type="checkbox"/> Reduced Price Meals <input type="checkbox"/> Paid	<input type="checkbox"/> SNAP/KTAP <input type="checkbox"/> Foster/Kinship <input type="checkbox"/> Income Household	_____ Signature of Determining Official _____ Date
		Total Household Monthly Income _____	
		Household Size _____	

*7 CFR 226.15 (e)(2) “USDA is an equal opportunity provider and employer.”

“The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The last four digits of the Social Security Number are not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program.”

INFANT ADDENDUM TO ENROLLMENT

Dear Parent:

This child care center participates in the USDA Child & Adult Care Food Program (CACFP). This program provides reimbursement to the center for creditable components served to your baby while in our care. We want to work with you to provide the very best nutritional care for your baby. Under the CACFP regulations, the center may NOT charge you a separate fee for meals that are claimed for reimbursement.

We use the meal pattern (attached to this addendum) developed by the USDA for centers participating in the CACFP. The type and amount of foods served vary according to the age of the infant. However, the actual foods we provide will be based on what you tell us about your baby's own food needs.

Talk with your health care provider and let us know whether you want to use breast milk or a formula while your child is in the center's care. We also need to know when you will introduce solid foods to your infant. You may choose for us to provide the formula, or you may provide the formula for your infant.

(Name of Daycare Center)

currently provides the following formula(s): _____

Breast milk and formula that you provide should be labeled with your child's name, the contents of the bottle (breast milk or brand of formula), and the date the formula was prepared or the date of collection for breast milk.

Please fill out the form below and return it to help us plan the meals for your infant. If this information changes, you will need to complete a new form.

Sincerely,

Sponsor Representative

Phone Number

Date

MUST BE COMPLETED BY PARENT/GUARDIAN

Infant Name _____

Infant Birthdate ____/____/____

Check all that apply:

_____ **Parent** will breast-feed the infant at the day care center

_____ **Parent** will provide expressed breast milk

_____ **Parent** will provide iron fortified formula/breast milk and **Center** will provide additional baby food

_____ **Parent** will provide iron fortified formula/breast milk and additional baby food.

_____ **Center** will furnish all iron fortified infant formula

_____ **Center** will furnish all iron fortified infant formula and additional baby food

Parent/Guardian and/or Client Signature

Date

*7 CFR 226.20(b)(5)