

VIRGINIA CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS and FAMILY DAY HOMES

Child Development	rcenter																	
1	All House	2	3															
NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children] First, Middle Initial, Last Check Ages of Skip to Part 6 if all are foster												SNAP, TANF or FDPIR CASE # Skip to Part 6 if you list a SNAP,						
	Tirst, Wildele	initial, Last			if NO children			children.		103101	TANF or FDPIR case number MUST BE SEVEN (7) DIGI							
1.																		
2.																		
3.																		
4.																		
5.																		
6.																		
4 Homeless, Migrant, or Runaway																		
Homeless Migrant Runaway If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your School Homeless Liaison, Migrant Coordinator.																		
Total Household Gross Income (before deductions). You must tell us how much and how often.																		
GROSS INCOME AND HOW OFTEN IT IS RECEIVED (Example: \$100/month, \$100/twice a month, \$100/every other week, \$100/week)															()			
(LIST ALL HOUSEHOLD MEMBERS WITH INCOME)			Earnings Fr	Earnings From Work			Welfare, Child Support, Alimony			nt, Social	Worker's Comp, Unemployment, SSI, etc. (All other income)							
	VVIIIII	(COIVIE)	Amount	How often?	Amo	unt	How often?	Amo	ount H	low often?		moı	nt		How	often	?	
i.			\$		\$			\$			\$							
ii.			\$		\$			\$			\$							
iii.			\$		\$			\$			\$							
iv.			\$		\$			\$			\$							
V.			\$		\$			\$			\$		_		_	_	_	
6 Signature and Social Security Number (Adult must sign)																		
An adult household member must sign the application. If Part 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits of his or her social security number or mark the <i>I</i> do not have a social security number box. I do not have a social security number.															al			
I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.																		
	Da			Name of Adult I	Household I	Member			Signature	of Adult Hou	ısehold	Mei	nber	_	_	_	_	
7	Contact I	nformation (Optional)															
	ork Telenhon	e Numher (Include	Area Code)	Home Telenho	ne Numher	· (Include	Area Code)		ome Addres	s (Numher 9	Street (itv	State	7in i	^ode)		
Work Telephone Number (Include Area Code) Home Telephone Number (Include Area Code) Home Address (Number, Street, City, State, Zip Code) 8 Optional - Sharing Information with Virginia's Health Insurance Program for Children (FAMIS)																		
May we share your information on this application with the FAMIS, the complete health insurance program for every child in Virginia? If yes, do not sign below.															_			
No, I do not want my information from this																		
PRIVACY ACT STATEMENT: 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 your child for															or			
free or reduced-price meals. You must include the last four digits of your social security number of the adult household member who signs the application. The social security number is 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 or other FDPIR identifier for your child 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 your child is eligible for free or reduced-price meals, and for administration and enforcement of the Child and Adult Care Food Program. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.																		
NON-DISCRIMINATION STATEMENT: The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing, or have speech disabilities and wish to file either an EEO or program complaint please contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (in Spanish). USDA is an equal opportunity provider and employer.														00				
CHILD CARE REPRESENTATIVE USE ONLY – ELIGIBILITY DETERMINATION – COMPLETE SECTIONS A and B BEL																		
SEC	TION A	Annual Income	Conversion: We	ekly X 52 Ev	ery 2 Wee	ks X 26	Twice a Mo	nth X 24	Once a Mo	onth X 12	Convei freque							
TOTA	AL INCOME	\$	Per: [] Week □ E	very 2 Wee	ks 🗆	Twice a Month	☐ Mor	nth 🗆 \	/ear	NUI		R IN	: -				
		☐ FREE based or		☐ REDUCED based on:				□ DENIED reason:										
☐ foster child ☐ migrant ☐ SNAP or TANF☐ homeless ☐ runaway ☐ household income						☐ household income				☐ income too high ☐ incomplete application☐ non-qualifying SNAP/TANF								
SECTION B Signature of Determining Official:													_					