INSTRUCTIONS FOR
CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM
(CHILD CARE)

Follow these instructions, if your household gets SNAP, TANF or FDPIR:

Part 1: List all enrolled children and household members.
Part 2: List the eligibility number for any household members (including adults) receiving SNAP or TANF or FDPIR benefits. The SNAP or TANF number must be the 8 or 9 digit EDG# assigned by HHSC.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.

If you are applying on behalf of a FOSTER CHILD, follow these instructions:

If **all** children you are applying for are foster children, or if you are only applying for benefits for the foster child:

Part 1: List all foster children. Check the box indicating that the child is a foster child.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. A Social Security Number is **not** necessary.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.

If some of the children in the household are foster children.

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.
Part 2: If the household does not have an eligibility number, skip this part.
Part 3: **Applies only to parents/guardians of children in Tier II Day Care Homes.** Sponsors must provide the *List of Eligible Federal/State Funded Programs* (H1660), with this form to households with children enrolled in Tier II Day Care Homes. Parents/Guardians can enter the program name and number as applicable.
Part 4: Follow these instructions to report total household income from this month or last month.
Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.
Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.
Box 1: List the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and **other deductions. You should be able to find it on your stub or your boss can tell you.**
Box 2: List the amount each person got from the month from welfare, child support, alimony.
Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. *For ONLY the self-employed, report income after expenses in Box 1*. Box 4 is for your business, farm or rental property. Do not include income from SNAP, TANF, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box."

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of each person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. *For ONLY the self-employed, report income after expenses in Box 1*. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ ELIGIBILITY NUMBER: _____

Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and eligibility number: NAME: _____ ELIGIBILITY NUMBER: _____

Check here if no eligibility number ☐

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** **Note:** Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$200/bi-monthly
	$____/____	$____/____	$____/____	$____/____
	$____/____	$____/____	$____/____	$____/____
	$____/____	$____/____	$____/____	$____/____
	$____/____	$____/____	$____/____	$____/____
	$____/____	$____/____	$____/____	$____/____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the next page.)

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.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _*_*_*-_*_*-____ ☐ I do not have a Social Security Number

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

☐ **I do elect to allow my household information to be disclosed.**

☐ **I do not elect to allow my household information to be disclosed.**

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date:_____

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 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 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) eligibility 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.

Non-discrimination Statement:

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Texas Department of
Agriculture

Form H1625-A
June 2017

Income Eligibility Guidelines for Determining Free and Reduced-Price Benefits July 1, 2017 - June 30, 2018

Ingresos máximos para determinar la elegibilidad para el programa de nutrición 1 de julio de 2017 - 30 de junio de 2018

FAMILY SIZE	ANNUAL REDUCED	MONTHLY REDUCED	TWICE MONTHLY REDUCED	BI-WEEKLY REDUCED	WEEKLY REDUCED
1	$22,311	$1,860	$930	$859	$430
2	$30,044	$2,504	$1,252	$1,156	$578
3	$37,777	$3,149	$1,575	$1,453	$727
4	$45,510	$3,793	$1,897	$1,751	$876
5	$53,243	$4,437	$2,219	$2,048	$1,024
6	$60,976	$5,082	$2,541	$2,346	$1,173
7	$68,709	$5,726	$2,863	$2,643	$1,322
8	$76,442	$6,371	$3,186	$2,941	$1,471
For each additional family member add:	$7,733	$645	$323	$298	$149

Children from households whose incomes are at or below the levels shown above, or who receive Temporary Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP) benefits, are eligible for free or reduced-price meals.

Adult Day Care participants whose household incomes are at or below the levels shown above, or who receive Medicaid, Supplemental Security Income (SSI) or SNAP benefits, are eligible for free or reduced-price meals.

Los niños de hogares con ingresos iguales o menores a los niveles indicados anteriormente, o que reciben Asistencia Temporal para Familias Necesitadas (TANF), ayuda del Programa Suplementario de Asistencia Nutricional (SNAP), o del Programa de Distribución de Alimentos en Reservaciones Indígenas (FDPIR) califican para recibir comidas gratuitas o a precio reducido.

Las personas que participan en programas de Cuidado Diario para Adultos cuyos ingresos familiares son iguales o por debajo de los niveles indicados anteriormente, o que reciben Medicaid, Seguridad de Ingreso Suplementario (SSI), TANF, o beneficios de SNAP o FDPIR califican para recibir comidas gratuitas o a precio reducido.

Child + Adult Care Food Program
Food Program Enrollment Form

Per AFI 34-144 Para 7.1.1., our center participates in the Child & Adult Care Food Program (CACFP) under the guidance of the Texas Department of Agriculture. The CACFP helps to ensure that your children are served healthy meals and provides our center assistance with food costs that help us keep your child's tuition more affordable. IAW AFI 34-144 Para 7.1.4, the CDC uses cycle menus that have been approved by a dietitian or AFSVA/SVI. Only USDA creditable foods will be purchased and served.

Please complete each section, sign/date at the bottom, and return to with your enrollment package.

Child (1)

Child's Full Name/ *Nombre y Apellido del Nino*	Child's Date of Birth/ *Fecha de Nacimiento*	Enrollment Date / *Fecha de Matriculacion*

Times In Care/ *Las Horas en Cuidado*

START TIME: _____ AM
_____ PM

END TIME: _____ AM
_____ PM

Check the days your child normally attends/ *Los dias su nino asiste nomalment* (Check those that apply)

- □ MON
- □ TUE
- □ WED
- □THRU
- □ FRI
- □ SAT
- □ SUN

Check the meals your child normally receives while in care / *Las cominads su nino recibe normalmente mientras en el cuidado* (Check those that apply)

- □ BREAKFAST
- □ AM SNACK
- □ LUNCH
- □ PM SNACK
- □ SUPPER
- □ EV SNACK

For office use only. *Solo para el uso de la agencia.*
Withdrawl Date:

Child (2)

Child's Full Name/ *Nombre y Apellido del Nino*	Child's Date of Birth/ *Fecha de Nacimiento*	Enrollment Date / *Fecha de Matriculacion*

Times In Care/ *Las Horas en Cuidado*

START TIME: _____ AM
_____ PM

END TIME: _____ AM
_____ PM

Check the days your child normally attends/ *Los dias su nino asiste nomalment* (Check those that apply)

- □ MON
- □ TUE
- □ WED
- □THRU
- □ FRI
- □ SAT
- □ SUN

Check the meals your child normally receives while in care / *Las cominads su nino recibe normalmente mientras en el cuidado* (Check those that apply)

- □ BREAKFAST
- □ AM SNACK
- □ LUNCH
- □ PM SNACK
- □ SUPPER
- □ EV SNACK

For office use only. *Solo para el uso de la agencia.*
Withdrawl Date:

Date of Signature / La fecha de Firma	Signature-Parent or Guardian / La firma de Padre o Gurardian
Parent/ Guardian Phone No. /Numero de telefono	Parent/ Guardian Email Address / Direccion electronico

November 2011

Building for the Future

This child care center receives Federal cash assistance to serve healthy meals to your children. Good Nutrition today means a stronger tomorrow!

Meals served here must meet nutrition requirements established by USDA's **Child and Adult Care Food Program**

Questions? Concerns?
Call USDA at **1-800-795-3272**

or

Food and Nutrition at **1-800-TELL-TDA**
(835-5832)
or

Your child care center at

Laughlin CDC
830-298-5419

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866)632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6316 (Spanish). USDA is an equal opportunity provider and employer.

November 2011

Nos preparamos para el futuro

Este centro de cuidado de niños recibe asistencia económica federal para servir comidas nutritivas a sus hijos. La Buena nutrición hoy significa un mañana más saludable.

Las comidas que se sirven aquí tienen que cumplir con los requisitos de nutrición establecidos por el Programa de Alimentos para Adultos y Niños del Departamento de Agricultura de los Estados Unidos (USDA).

¿Tiene preguntas o inquietudes? Comuíquese con el USDA al 1-800-795-3272

o

Alimentación y Nutrición al 1-800-TELL-TDA (835-5832)

o

Centro de cuidado de niños de su hijo al

Laughlin CDC 830-298-5419

De acuerdo con la ley federal y las políticas del Departamento de Agricultura de los EE.UU. (USDA, sigla en inglés), se le prohibe a esta institución que discrimine por razón de raza, color, origen, sexo, edad, o discapacidad. Para presentar una queja sobre discriminación, escriba a USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410, o llame gratis al (866) 632-9992 (voz). Personas con discapacidad auditiva o del habla pueden contactar con USDA por medio del Servicio Federal de Relevo (Federal Relay Service) al (800) 845-6136 (español) o (800) 877-8339 (inglés). USDA es un proveedor y empleador que ofrece oportunidad igual para todos.