

ELIGIBILITY DOCUMENTATION

COMPLETING ENROLLMENT FORM

The enrollment form must be completed on every child with his or her initial enrollment. The form must indicate the normal days and hours in care, the meals the child normally receives, the name of the parent/guardian and his or her address and telephone number, and be signed by the parent/ guardian. Enrollment forms must be updated **ANNUALLY** with the signature of the parent/guardian and the date. This pertains to all prior year enrollment forms.

This form **does not** replace the CACFP Meal Benefit Income-Eligibility Form, which must be distributed annually (every year).

Head Start facilities need only complete Items 1, 2, 3, and 6.

Institutions participating **ONLY** in the CACFP At-Risk Meal Program, outside-school-hours care program, as adult day care institutions, or as emergency shelters are not required to complete enrollment forms.

NOTE: If a sponsoring organization (SO), copies of the enrollment form must be maintained at both the SO and the facilities.

EXAMPLE
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
ENROLLMENT FORM

CHILD'S INFORMATION

1. Child's Name: FLORENCE SCOTT Date of Birth: 10/3/YY

2. Normal Days in Attendance:

	X	X	X	X	X	
SUN	MON	TUE	WED	THU	FRI	SAT

3. Head Start Facilities Only: Indicate session and sign and date form.

A.M. P.M. All Day

4. Special Dietary Needs* Yes No

5. Normal Hours of Attendance: 7:00 to: 5:00
a.m./p.m. a.m./p.m.

6. Normal Meals Eaten:

Breakfast Lunch Supper

A.M. Snack P.M. Snack Late P.M. Snack

7. Signature of Parent/Guardian: FELECIA SCOTT Date: 10/3/4444

*Attach signed medical statement.

PARENT'S INFORMATION

Name of Parent/Guardian: FELECIA SCOTT

Address: 123 "A" STREET City: OKLAHOMA CITY Zip: OK

Home Telephone Number: 123-4567

RENEWAL UPDATES

If there are no changes to the above information, sign and date. If there are changes, a new enrollment form must be completed, signed, and dated.

Parent/Guardian Signature	Date
<u>FELECIA SCOTT</u>	<u>10/3/4444</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

EXCEPTIONS FOR SPECIAL DIETARY NEEDS

Documentation must be on file and available for individual participants who are unable, because of medical or other special dietary needs, to consume certain foods. Substitutions due to medical needs shall be supported by a statement from a recognized licensed physician, physician's assistant, or nurse practitioner and should include recommended alternate foods. If a medical statement is not available, meals lacking the required components/quantities cannot be claimed for reimbursement.

The facility must provide all required food components for the meals served in order to claim reimbursement. This includes any substitutions made to a meal served to a child with special dietary needs unless supported by the medical statement.

Facilities may consider ethnic and religious preferences when requested by a household. Food substitutions may be made, if requested by parents/guardians. Food items substituted must be a creditable item from the same food component if the meal is claimed for reimbursement. Variations on an experimental or continuing basis in the food components must have written approval from the United States Department of Agriculture (USDA).

MEDICAL STATEMENT

Part I (to be filled out by *institution* or *parent/guardian*)

Name of Student: John Doe, Jr. Age: 4

Name of Parent/Guardian: John Doe Telephone Number: 555-6789

Name of Institution: Toys N Noise

Part II (to be filled out by a *medical authority*)

Diagnosis (include description of the patient's medical or other special dietary needs that restrict the patient's diet):

Celiac Disease

List food(s) to be omitted from diet:

Anything that contains gluten

List food(s) that may be substituted (diet plan):

Any gluten-free products

Additional information:

This child has a disability as defined by the American Disability Act:

Yes

No

10/14/YYYY

Date

R. J. Hoffman, M.D.

Signature of Licensed Physician, Physician's Assistant, or Nurse Practitioner

555-1212

Telephone Number

EXAMPLE MILK SUBSTITUTION REQUEST

Child's Name: Jude Johnson Age: 4

My child cannot consume milk for the following reason(s):

Cultural

Signature of Parent/Guardian: Mrs. Johnson

Date: 10/3/YYYY

INSTITUTION APPROVAL:

Signature: Ima Fishul Date: 10/5/YYYY

Nondairy Beverages

In the case of children who cannot consume fluid milk due to medical or other special dietary needs other than a disability, nondairy beverages may be served in lieu of fluid milk. Nondairy beverages must be nutritionally equivalent to milk and meet the Nutrient Standards found in cow's milk. Nondairy beverage nutrient requirements per cup include each of the following:

- Calcium 276 mg
- Protein 8 g
- Vitamin A 500 IU
- Vitamin D 100 IU
- Magnesium 24 mg
- Potassium 222 mg
- Phosphorus 349 mg
- Riboflavin 0.44 mg
- Vitamin B-12 1.1 mg

Parents or guardians may now request in writing nondairy milk substitutions, as described above, without providing a medical statement. As an example, if a parent has a child who follows a vegan diet, the parent can submit a written request of the child's caretaker asking that a milk substitution be served in lieu of cow's milk. The written request must identify the medical or other special dietary need that restricts the diet of the child. A copy of a request form is on **page 205**. *Such substitutions are at the option and the expense of the facility.* The requirements related to milk or food substitutions for a participant who has a medical disability and who submits a medical statement signed by a licensed physician, physician's assistant, or nurse practitioner remain unchanged.

APPROVING CACFP FAMILY-SIZE AND INCOME APPLICATIONS

Every application must be approved at face value. Institutions **must not** complete any part of the application for a household nor can an institution require a household to complete an application.

A. The application **MUST** provide the following:

1. ***For Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF), and/or Food Distribution Program on Indian Reservations (FDPIR) households:***

a. The name of each child for whom the application is made.

b. A SNAP, TANF, or FDPIR case number.

(1) SNAP*: A valid SNAP number may begin with the letter **A, B, C, D, H, J, or T** followed by six to nine digits. All valid numbers **MUST** be Oklahoma-issued. Some numbers could also include a dash, followed by two additional numbers. **NOTE: Centers cannot go to the EBT machine and write down the number on the application. The application must be totally completed by the parent/guardian.**

(2) TANF*: A valid TANF number is recognized by a six- to nine-digit number beginning with the letter **C or H**. All valid numbers **MUST** be Oklahoma-issued. This number could be followed by a dash with two additional numbers.

(3) FDPIR*: An FDPIR number may be any combination of letters and/or numbers. It has no identifiable format. **NOTE:** A number starting with **KK** should not be considered an FDPIR number.

* If an application contains a single case number for SNAP, TANF, or FDPIR, all enrolled children listed on the application must be approved for free meal benefits. Any income information on an application containing a **SINGLE/CORRECT** SNAP, TANF, or FDPIR case number should be disregarded. (Reference USDA Memo SP-38-2009.)

* If there is any doubt of the validity of a case number submitted on an application, the institution should contact the appropriate SNAP, TANF, or FDPIR official and document the findings. (This is only for numbers that are not formatted as Oklahoma numbers.)

c. The signature of an adult household member.

2. ***Foster children are now categorically eligible, and the required information for foster children is:***

a. The name of the child and the indication that the child is a foster child.

b. The signature of an adult household member.

3. ***For Other Households (Income Households):***

- a. The names of all household members, including all children for whom the application is made.
- b. The amount of gross income received by each household member and the source of the income.
- c. The last four digits of the social security number of the adult household member who signs the application or an indication that the household member does not have one.
- d. The signature of an adult household member.

B. Computation of Current Income

1. Each household ***MUST*** provide the amount of gross income received. Income ***MUST*** be identified with the individual who received it and the source of the income (such as wages or welfare). It is the responsibility of the institution representative to compute the household's total current income and compare the total amount to the Income-Eligibility Guidelines. (See **page 215**.)
2. Households may report incomes for different periods; e.g., one monthly, one every two weeks, one twice a month, and one weekly. The institution representative ***MUST*** convert all reported incomes to ***ANNUAL*** income to determine the total household income.
3. To compute annual income:
 - a. If income is received ***every week***, multiply the total gross income by 52 to determine the annual income.
 - b. If income is received ***every two weeks***, multiply the total gross income by 26 to determine the annual income.
 - c. If income is received ***twice a month***, multiply the total gross income by 24 to determine the annual income.
 - d. If income is received ***once a month***, multiply the gross income by 12 to determine the annual income.

NOTE: In situations where income is reported weekly, every two weeks, monthly, or twice a month, and the software has no provision for dealing with dollars and cents, calculations should be done manually to arrive at the most accurate annual or monthly income. (Reference All State Directors' Memo 2001-CN-8.) All computerized software must include both the dollar amount and the CENT amount, unless the cents are computed manually.

C. Application Approval or Denial

1. Households that submit an incomplete application cannot be approved. If any **REQUIRED** information is missing, the information **MUST** be obtained before an eligibility determination can be made. Institutions **must not** complete any part of the application for a household.
2. To get the required information, the institution representative may return the application to the household or contact the household either in person, by phone, or in writing. The institution representative must document the details of the contact and date and initial the entry. Applications missing the signature of an adult household member **MUST** be returned for signature.
3. Every reasonable effort should be made to obtain the missing information prior to determining the application is not eligible.
4. If there are any inconsistencies or questions concerning the required eligibility information provided, the household's application **MUST** be determined as not eligible unless the inconsistencies or questions are resolved. For instance, if it is unclear whether the household provided weekly or monthly income, this issue **MUST** be resolved before an eligibility determination can be made. The institutional representative may contact the household prior to determining the application is not eligible, document the details of the contact, and date and initial the entry.
5. ***Each CACFP FSIA must contain the approval signature of the institution representative and date the form was approved to be considered valid.***

NOTE: If the person who is approving the application has registered his/her signature with the State of Oklahoma, then a stamped signature is permissible.

Effective Date:

CACFP institutions have flexibility concerning the effective date of certification for program benefits. For the purposes of nonschool institutions, the date to be used to make this determination may be either the date the parent or guardian signed the income-eligibility form or the date on which the sponsor or independent center official signs the form to certify eligibility of the participant. However, if the date of parent signature is not within the month of certification or the immediately preceding month, the effective date must be the date of certification. Please note, the date of submission by the parent or guardian is not required to be recorded on the income-eligibility form. (Reference USDA Memo 01-2015)

D. Foreign Language Translations

Where a significant number or proportion of the population eligible to be served in the institution needs information in a language other than English, institutions **MUST** make reasonable efforts, considering the size and concentration of such population, to send appropriate non-English-language household letters or notices and application forms to such households. USDA provides copies of these applications, which include the following languages: Arabic, Cambodian, Chinese (Mandarin), Farsi, French, Greek, Haitian, Hindi, Hmong, Japanese, Korean, Kurdish, Loatian, Polish, Portuguese, Russian, Samoan, Serbo-Croatian, Somali, Spanish, Sudanese, Tagalog, Thai, Urdu, and Vietnamese. Log onto <http://www.fns.usda.gov/cnd/Care/Benefit_Forms/Translations.htm>

ELIGIBILITY DEFINITIONS

Determining Household Size

Adopted Child—An adopted child for whom a household has accepted responsibility is considered to be a member of that household. If the adoption is a **SUBSIDIZED** adoption (children who are difficult to place), the subsidy is included in the total household income.

Child Attending an Institution—A child who attends, but does not reside in, an institution is considered a member of the household in which he or she resides.

Child Away at School—A child who is temporarily away at school (e.g., attending boarding school or college) should be counted as a member of the household.

Child Living With One Parent, Relatives, or Friends—In cases where no specific welfare agency or court is legally responsible for the child or where the child is living with one parent, other relatives, or friends of the family, the child is considered to be a member of the household with whom he or she resides. Children of divorced or separated parents are generally part of the household that has custody.

Emancipated Child—A child living alone or as a separate economic unit is considered to be a household of one. In some cases, an emancipated child may be living with relatives or friends, none of whom is an adult. If the household is one economic unit, all income and household members **MUST** be included to determine eligibility. Age is not a factor in defining an emancipated child.

Family Members Living Apart—Family members living apart on a **TEMPORARY** basis are considered household members. Family members not living with the household for an **EXTENDED** period of time are not considered members of the household for purposes of determining eligibility, but any money made available by them or on their behalf for the household is included as income to the household.

Foreign Exchange Student—A foreign exchange student is considered to be a member of the household in which he or she resides; i.e., the household hosting the student.

Foster Child—A foster child is a child whose care and placement is the responsibility of an agency that administers a state plan under Part B or E of Title IV of the Social Security Act or a foster child who a court has placed with a caretaker household. These provisions only apply to children formally placed in foster care by a state child welfare agency or a court. They do not apply to informal arrangements such as caretaker arrangements or permanent guardianship placements that may exist outside of or as a result of state- or court-based systems. Whether placed by the state child welfare agency or a court, in order for a child to be considered categorically eligible for free meals, the state must retain legal custody of the child. The household keeping the foster child **DOES** include the foster child in its family size, and it does include as part of the household income any monies the foster child receives. However, the household does not report any monies the foster parents are receiving for the care of the foster child. **NOTE: Because some adopted children were first placed in families as foster children, parents may not be aware that once a child is adopted, he or she must be determined eligible based on the economic unit and all income available to that household, including any adoption assistance, is counted when making an eligibility determination.**

Household/Economic Unit—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 and who share housing and/or significant income and expenses of its members. Generally, individuals residing in the same house are an economic unit. However, more than one economic unit may reside together in the same house. Separate economic units in the same house are characterized by prorating expenses and maintaining economic independence from one another.

Institutionalized Child—An institutionalized child is a child who resides in a residential-type facility that the state has determined is not a boarding school. Such a child is considered a household of one.

Joint Custody—In cases where joint custody has been awarded and the child physically changes residence, determination should be based on the household where the child would receive the highest benefit.

Military Family Member—For the purpose of determining household size, deployed service members should be considered as family members living apart on a temporary basis. A school or an institution would instruct families to include the names and only that portion of the deployed service member’s income made available by the service member, or on his or her behalf, to the household where the children are staying should be counted as income for eligibility determination purposes.

Determining Household Income

Income is any money received on a recurring basis, including **GROSS** earned income, unless specifically excluded by legislation. Specifically, gross earned income means all money earned before deductions for employee’s income taxes, social security taxes, insurance premiums, bonds, savings programs, and/or other income deductions.

Income includes the following:

Adopted Child Subsidy—The subsidy a household receives for a child that has been adopted is counted as income.

Alimony and Child Support—Any money received by a household in the form of alimony or child support is considered as income to the receiving household. However, any money paid out for alimony or child support may not be deducted from that household’s reported gross income.

Child’s Income—The earnings of a child who is a full-time or regular part-time employee **MUST** be listed on the application as income. However, occasional earnings such as income from occasional baby-sitting or mowing lawns should not be listed on the application as income.

Current Gross Income—Households **MUST** report current income on a Family-Size and Income Application (FSIA).

Current income means income received by the household. If this income is higher or lower than usual and does not fairly or accurately represent the household’s actual circumstances, the household may project its annual rate of income.

Earnings From Work—Wages, salaries, tips, commissions, net income from self-owned businesses and farms, strike benefits, unemployment compensation, and worker’s compensation.

Foster Child’s Income—A foster child is a child who is living with a household but who remains the legal responsibility of the welfare agency or court. The household keeping the foster child **DOES** include the foster child in its family size, and it does include as part of the household income any monies the foster child receives. However, the household does not report any monies the foster parents are receiving for the care of the foster child. **NOTE: Because some adopted children were first placed in families as foster children, parents may not be aware that once a child is adopted, he or she must be determined eligible based on the economic unit and all income available to that household, including any adoption assistance, is counted when making an eligibility determination.**

Garnisheed Wages and Bankruptcy—Income is the gross income received by a household before deductions. In the case of garnisheed wages and income ordered to be used in a specified manner, the total gross income **MUST** be considered, regardless of whatever portions are garnisheed or used to pay creditors.

Income for the Self-Employed—Self-employed persons may use last year’s income as a basis to project their current year’s net income, unless their current net income provides a more accurate measure. Self-employed persons are credited with net income rather than gross income. Net income for self-employment is determined by subtracting business expenses from gross receipts:

- (a) Gross receipts include the total income from goods sold or services rendered by the business.
- (b) Deductible business expenses include the cost of goods purchased, rent, utilities, depreciation charges, wages and salaries paid, and business taxes (not personal, federal, state, or local income taxes).
- (c) Nondeductible business expenses include the value of salable merchandise used by the proprietors of retail businesses.
- (d) For a household with income from wages and self-employment, each amount **MUST** be listed separately. When there is a business loss, income from wages may not be reduced by the amount of the business loss. If income from self-employment is negative, it should be listed as zero income.

Institutionalized Child's Income—Payments from any source directly received by the institution on a child's behalf are not considered as income to the child. Only the income a child earns from full-time or regular part-time employment and/or personally receives while in residence at the institution is considered as income.

Lump Sum Payments—When lump sum payments are put into a savings account and the household regularly draws from that account for living expenses, the amount withdrawn is counted as income.

Military Benefits—Gross income, including base pay, regular housing allowance (BAH, VHA, BAQ), subsistence (BAS), clothing allowance, hazardous duty, hostile fire, flight pay, incentive, etc., must be included for military families. The only exceptions are as follows:

- (a) *U.S. Armed Forces Family Subsistence Supplemental Allowances (FSSA)*. (Reference All State Directors' Memo 2006-CN-10.)
- (b) *Privatized housing* refers to the Military Housing Privatization Initiative, a program operating at a number of military installations. This initiative puts the operation of military-owned housing under private contractors. Under this privatization initiative, a housing allowance appears on the leave and earnings statement of service members living in privatized housing. It is important to note that this income exclusion is only for service members living in housing covered under the Military Housing Privatization Initiative. It is not an allowable exclusion for households living off base in the general commercial/private real estate market. (Reference All State Directors' Memos 2004-CN-06, 2004-CN-01, 2003-CN-17, 2003-CN-16.)
- (c) During Operation Enduring Freedom, where a household member is deployed to any location, regardless of the specific military operation, only the income made available to the household is to be counted and the deployed household member is to be counted as part of the household.

Additionally, USDA has provided clarification regarding household-size and income determination where both parents are deployed military and their children are staying with friends or relatives. Consistent with the above policy, the children would be counted as part of the household where they are staying; however, both parents would also be included in the household and only the funds provided to the household by the deployed military parents would be included in total household income. (Reference All State Directors' Memo 2003-CN-06.)

- (d) *Military Combat Pay*. This exclusion is authorized by the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act, 2010 (P.L. 111-80; October 21, 2009).

As set forth in the statute, Combat Pay is defined as an additional payment made under Chapter 5 of Title 37 of the United States Code, or as otherwise designated by the Secretary to be excluded, that is received by the household member who is deployed to a designated combat zone. Combat Pay is excluded if it is:

- Received in addition to the service member's basic pay.
- Received as a result of the service member's deployment to or service in an area that has been designated as a combat zone.

AND

- Not received by the service member prior to his or her deployment to or service in the designated combat zone.

A combat zone is any area that the President of the United States designates by Executive Order as an area in which the U.S. Armed Forces are engaging or have engaged in combat. As with other types of income commonly received by military personnel (such as the Basic Allowance for Housing or Basic Allowance for Subsistence payments), Combat Pay received by service members is normally reflected in the entitlements column of the military Leave and Earnings Statement (LES). Information regarding deployment to or service in a combat zone may also be available through military orders or public records on deployment of military units. Deployed service members are considered members of the household for purposes of determining income eligibility for the CNP. (Reference USDA Memo SP-06-2010.)

- (e) The Earned Income Tax Credit (EITC). (Reference All State Directors' Memo 2003-CN-13.)
- (f) Any payments made under the Agent Orange Compensation Exclusion Act.
- (g) Any payments made or any mandatory salary reduction related to the Veteran's Educational Assistance Act of 1964 (GI Bill).
- (h) Deployment Extension Incentive Pay (DEIP)

The exclusion of Combat Pay, as described in P.L. 111-80, is extended to DEIP. DEIP is given to active-duty service members who agree to extend their military service by completing deployment with their units without reenlisting. This exemption applies only until the service members return to their home station. Any additional DEIP payments provided to service members serving at their home station is considered income as they are no longer considered deployed. (Reference USDA Policy Memo SP-06-2011.)

Other Income—Net rental income; annuities; net royalties; disability benefits; interest; dividend income; cash withdrawn from savings; income from estates, trusts, and/or investments; regular contributions from persons not living in the household; and any other money that may be available to pay for the children's meals.

Pensions/Retirements/Social Security—Pensions, retirement income, social security, supplemental security income (SSI), and veterans' payments.

Seasonal/Temporary Workers—Seasonal workers such as migrants and others whose income fluctuates so that they usually earn more money in some months than in other months. In these situations, the household may project its annual rate of income and report this amount as its current income. If the prior year's income provides an accurate reflection of the household's current annual rate of income, the prior year may be used as a basis for the projected annual rate of income.

Welfare—Public assistance payments/welfare receipts (General Assistance, General Relief, etc.).

Income Exclusions

Income **NOT** to be reported or counted as income in the determination of a household's eligibility for free or reduced-price benefits includes:

Any cash income or value of benefits a household receives from any federal program that excludes such income by **legislative prohibition**, such as the value of food benefits provided under SNAP.

Student financial assistance provided for the costs of attendance at an educational institution, such as grants and scholarships, awarded to meet educational expenses and not available to pay for meals.

The foster parent does not include as part of the household income any monies the foster child receives **NOR** that the foster parent receives from the welfare agency for shelter and care.

LOANS, such as bank loans, since these funds are only temporarily available and **MUST** be repaid.

The value of **in-kind compensation** such as housing for clergy or any other noncash benefit.

Occasional earnings received on an irregular basis; e.g., nonrecurring, such as payment for occasional baby-sitting or mowing lawns.

Lump sum payments or large cash settlements are not counted as income since they are not received on a regular basis. These funds may be provided as compensation for a loss that **MUST** be replaced, such as payment from an insurance company for fire damage to a house.

Any subsidy that a household receives through the prescription drug discount card program is not considered income. (Reference All State Directors' Memo 2004-CN-04.)

Earned Income Tax Credit: The federal earned income tax credit may be a refund of taxes withheld, a credit against taxes withheld, or a cash payment in excess of what was withheld. (Reference All State Directors' Memo 2003-CN-13.)

Payments made under the National Flood Insurance Act of 1968 for flood mitigation activities. (Reference All State Directors' Memo 2006-CN-04.)

**ABC Day Care
111 Main Street
Somewhere, OK 99999
LETTER TO THE HOUSEHOLD**

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. (Name of Center) **ABC Day Care** offers healthy meals to all enrolled children as part of our participation in the United States Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached CACFP Family-Size and Income Application (FSIA). In addition, by filling out this application, we will be able to determine if your children qualify for free or reduced-price meals.

1. **Do I need to fill out an FSIA for each of my children in day care?** You may complete and submit one FSIA for all children enrolled in child care in your household *ONLY* if the children in child care are enrolled in the same center. We cannot approve an FSIA that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed FSIA to:** (Name of Center) **ABC Day Care** , (Address) **111 Main Street** , (Phone Number) **555-5555** .
2. **Who can get free meals without providing income information?** Children in households getting Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) can get free meals. Foster children and children enrolled in Head Start are also eligible for free meals. Children in households participating in Women Infants and Children (WIC) *MAY* be eligible for free meals.
3. **Who can get reduced-price meals?** Your children can get low-cost meals if your household income is within the reduced-price limits on the Income-Eligibility Guidelines, shown on this application. Children in households participating in WIC *MAY* be eligible for reduced-price meals.
4. **May I fill out an FSIA if someone in my household is not a United States (U.S.) citizen?** Yes. Your or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.
5. **Who should I include as members of my household?** You must include all people in your household (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children who live with you. You also must include foster children who live with you.
6. **How do I report income information and changes in employment status?** The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income-Eligibility Guidelines, the center will receive a higher level of reimbursement. Once properly approved for free or reduced-price benefits, whether through income or by providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for the current fiscal year. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.
7. **What if my income is not always the same?** List the amount that you normally get. For example, if you normally get \$1000 each month but you missed some work last month and only got \$900, put down that you get \$1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.
8. **What if I have foster children?** Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the FSIA but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children should contact (Name) **Somewhere DHS** , (Address) **1000 Center Avenue** , (Phone Number) **999-6666** .
9. **We are in the military; do we include our housing and supplemental allowance as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

This institution is an equal opportunity provider and employer.

If you have other questions or need help, call (Phone Number) **555-5555** .

Sincerely,

(Signature) **Ima Fishul**

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**CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
FAMILY-SIZE AND INCOME APPLICATION**

PART 1. ALL HOUSEHOLD MEMBERS				
a. Name(s) of Enrolled Child(ren) Brother Q Public, Sister Q Public, John Q Public, Baby Q Public				
b. Names of ALL Household Members (First, Middle Initial, Last)	Age of Enrolled Child(ren)	Birth Date of Enrolled Child(ren)	Check If a Foster Child (The Legal Responsibility of a Welfare Agency or Court)* *If all children indicated below are foster children, skip to Part 5 to sign this form.	Check if <i>NO</i> Income
Daddy Q Public			<input type="checkbox"/>	<input type="checkbox"/>
Mommy Q Public			<input type="checkbox"/>	<input checked="" type="checkbox"/>
Brother Q Public	4	6/30/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Sister Q Public	3	2/20/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
John Q Public	2	3/16/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Baby Q Public	3 mo	8/3/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
PART 2. BENEFITS				
If any member of your household receives <i>SNAP, TANF</i> or <i>FDPIR</i> benefits, provide the name and case number for the <i>ONE</i> person who receives benefits. <i>If no one receives these benefits, skip to Part 3.</i>				
NAME: _____ CASE NUMBER: _____				
PART 3. IF ANY CHILD YOU ARE APPLYING FOR IS HOMELESS, MIGRANT, OR A RUNAWAY, CHECK THE APPROPRIATE BOX AND CALL (YOUR SCHOOL, HOMELESS LIAISON, OR MIGRANT COORDINATOR AT PHONE NUMBER)				
<input type="checkbox"/> Homeless <input type="checkbox"/> Migrant <input checked="" type="checkbox"/> Runaway				
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			
	Earnings From Work Before Deductions	Welfare, Child Support, Alimony	Pensions, Retirement, Social Security, SSI, VA Benefits	All Other Income
(Example) Jane Smith	\$ 200 / weekly	\$ 100 / twice a month	\$ 100 / monthly	\$ _____ / _____
Daddy Q Public	\$ 3000 / mo	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

EXAMPLE
 VALID FREE
 INCOME
 CORRECTLY
 APPROVED

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 also must list the last four digits of his or her social security number or mark the I do not have a social security number box.*

I certify that all information on this form is true and that all income is reported. I understand that the center will get federal funds based on the information that 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: Daddy Q Public Print Name: Daddy Q Public
 Date: 10/3/YYYY
 Address: 123 Somewhere Phone Number: 123-4567
 City: Nowhere State: USA Zip Code: 11111
 Last four digits of social security number: *** - ** - 5 5 5 5 I do not have a social security number.

Part 6: Participant's Ethnic and Racial Identities (Optional)

Mark one ethnic identity:
 Hispanic or Latino
 Not Hispanic or Latino

Mark one or more racial identities:
 Asian
 White
 American Indian or Alaska Native
 Native Hawaiian or other Pacific Islander
 Black or African American

PART 7: OTHER BENEFITS: You do not have to complete this part to participate in the CACFP.

Health Insurance Yes, I want health insurance for my children. Institution officials may give information from my FSIA to SoonerCare Health Benefit officials so that they can send me information about free or low-cost health insurance for my children.
 No, I *DO NOT* want information from my FSIA shared with SoonerCare Health Benefits officials.

I certify that I am the parent/guardian of the children for whom application is being made.

I understand that I will be releasing information that will show that I qualify for free or reduced-price meals for my children. I give up my rights to confidentiality for this purpose only.

Signature of Parent/Guardian: _____ Date: _____

The participant in the day care facility may qualify for free or reduced-price meals if your household income falls within the limits of this chart.

185% of Poverty Level	
Household Size	Yearly
1	21,775
2	29,471
3	37,167
4	44,863
5	52,559
6	60,255
7	67,951
8	75,647
Each additional person:	7,696

In accordance with federal civil rights law and United States Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, office, 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 [ASL]) 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
3. E-Mail: program.intake@usda.gov

This institution is an equal opportunity provider.

DO NOT 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: 36,000 Per: Week ____ Every 2 Weeks ____ Twice a Month ____ Month ____ Year X
 Household Size: 6
 Categorical Eligibility: ____ Date Withdrawn: ____ Eligibility: Free X Reduced ____ Denied ____
 Reason: Income qualified
 Determining Official's Signature: Ima Fishul Date: 10/4/YYYY

INSTRUCTIONS FOR COMPLETING THE CACFP FAMILY-SIZE AND INCOME APPLICATION (FSIA)

IF YOUR HOUSEHOLD RECEIVES BENEFITS FROM *SNAP*, *TANF*, OR *FDPIR*, FOLLOW THESE INSTRUCTIONS:

- Part 1:** a. List all enrolled children.
b. List all household members; including the enrolled children. For each enrolled child, include his/her age and birth date.
- Part 2:** List the case number for any household member (including adults) receiving *SNAP*, *TANF*, or *FDPIR* benefits.
- 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:** ***OTHER BENEFITS.*** You may be eligible for free or low-cost health insurance for your children. Look at Part 7 on the back of the FSIA. This part must be signed if you want health insurance. You are not required to complete this to get meal benefits.

IF YOU ARE APPLYING FOR 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:** a. List all enrolled foster children.
b. List all foster children with ages and birth dates of those enrolled. Check the box indicating 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. The last four digits of a social security number are *NOT* necessary.
- Part 6:** Answer this question if you choose.
- Part 7:** ***OTHER BENEFITS.*** You may be eligible for free or low-cost health insurance for your children. Look at Part 7 on the back of the FSIA. This part must be signed if you want health insurance. You are not required to complete this to get meal benefits.

- **If some of the children in the household are foster children:**

- Part 1:** a. List all enrolled foster children.
b. List all foster children with ages and birth dates of those enrolled. Check the box indicating the child is a foster child. For any person, including children, with no income, you must check the *No Income* box.
- Part 2:** If the household does not have a case number, skip this part.
- Part 3:** If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call (*your school, homeless liaison, or migrant coordinator*) _____. If not, 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, 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.
In 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 pay stub, or your boss can tell you.
In Box 2, list the amount each person got for the month from welfare, child support, alimony.
In Box 3, list retirement, Social Security, Supplemental Security Income (SSI), veteran’s benefits (VA benefits), and disability benefits.

In 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. Do not include income from SNAP, TANF, FDPIR, WIC, or federal education benefits. For **ONLY** the self-employed, under *Earnings From Work*, report income after expenses. This is for your business, farm, or rental property. If you are in the Military Privatized Housing Initiative or get Combat Pay, do not include these allowances as income.

Part 5: Adult household member must sign the form and list the last four digits of his/her social security number or mark the box if he/she does not have one.

Part 6: Answer this question if you choose.

Part 7: OTHER BENEFITS. You may be eligible for free or low-cost health insurance for your children. Look at Part 7 on the back of the FSIA. This part must be signed if you want health insurance. You are not required to complete this to get meal benefits.

ALL OTHER HOUSEHOLDS, INCLUDING WIC HOUSEHOLDS, FOLLOW THESE INSTRUCTIONS:

Part 1: a. List all enrolled children.

b. List all household members; for the enrolled children, list ages and birth dates. Check the box indicating the child is a foster child. For any person, 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, 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.

In 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 pay stub, or your boss can tell you.

In Box 2, list the amount each person got for the month from welfare, child support, alimony.

In Box 3, list retirement, Social Security, Supplemental Security Income (SSI), veteran’s benefits (VA benefits), and disability benefits.

In 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. Do not include income from SNAP, TANF, FDPIR, WIC, or federal education benefits. For **ONLY** the self-employed, under *Earnings From Work*, report income after expenses. This is for your business, farm, or rental property. If you are in the Military Privatized Housing Initiative or get Combat Pay, do not include these allowances as income.

Part 5: Adult household member must sign the form and list the last four digits of his/her social security number or mark the box if he/she does not have one.

Part 6: Answer this question if you choose.

Part 7: OTHER BENEFITS. You may be eligible for free or low-cost health insurance for your children. Look at Part 7 on the back of the FSIA. This part must be signed if you want health insurance. You are not required to complete this to get meal benefits.

PRIVACY ACT STATEMENT: This explains how we will use the information you give us.

NONDISCRIMINATION STATEMENT: This explains what to do if you believe you have been treated unfairly.

**CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
FAMILY-SIZE AND INCOME APPLICATION**

PART 1. ALL HOUSEHOLD MEMBERS

a. Name(s) of Enrolled Child(ren) Peter Phillips				
b. Names of ALL Household Members (First, Middle Initial, Last)	Age of Enrolled Child(ren)	Birth Date of Enrolled Child(ren)	Check If a Foster Child (The Legal Responsibility of a Welfare Agency or Court)* *If all children indicated below are foster children, skip to Part 5 to sign this form.	Check if NO Income
Peter Phillips	3	9/1/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Penelope Phillips			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

**EXAMPLE
VALID SNAP
(CORRECTLY
APPROVED)**

PART 2. BENEFITS

If any member of your household receives SNAP, TANF, or AFDC benefits, provide the name and case number for the ONE person who receives benefits. *If no one receives these benefits, skip to Part 3.*

NAME: **Penelope Phillips** CASE NUMBER: **A113116002**

PART 3. IF ANY CHILD YOU ARE APPLYING FOR IS HOMELESS, MIGRANT, OR A RUNAWAY, CHECK THE APPROPRIATE BOX AND CALL (YOUR SCHOOL, HOMELESS LIAISON, OR MIGRANT COORDINATOR AT PHONE NUMBER)

Homeless Migrant Runaway

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			
	Earnings From Work Before Deductions	Welfare, Child Support, Alimony	Pensions, Retirement, Social Security, SSI, VA Benefits	All Other Income
<i>(Example) Jane Smith</i>	\$ <u>200</u> / <u>weekly</u>	\$ <u>150</u> <u>twice a month</u>	\$ <u>100</u> / <u>monthly</u>	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

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 also must list the last four digits of his or her social security number or mark the I do not have a social security number box.*

I certify that all information on this form is true and that all income is reported. I understand that the center will get federal funds based on the information that 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: Penelope Phillips Print Name: Penelope Phillips
 Date: 10/3/YYYY
 Address: _____ Phone Number: _____
 City: _____ State: _____ Zip Code: _____
 Last four digits of social security number: *** - ** - ____ I do not have a social security number.

Part 6: Participant's Ethnic and Racial Identities (Optional)

Mark one ethnic identity:
 Hispanic or Latino
 Not Hispanic or Latino

Mark one or more racial identities:
 Asian
 White
 American Indian or Alaska Native
 Native Hawaiian or other Pacific Islander
 Black or African American

PART 7: OTHER BENEFITS: You do not have to complete this part to participate in the CACFP.

Health Insurance Yes, I want health insurance for my children. Insitution officials may give information from my FSIA to SoonerCare Health Benefit officials so that they can send me information about free or low-cost health insurance for my children.
 No, I *DO NOT* want information from my FSIA shared with SoonerCare Health Benefits officials.

I certify that I am the parent/guardian of the children for whom application is being made.

I understand that I will be releasing information that will show that I qualify for free or reduced-price meals for my children. I give up my rights to confidentiality for this purpose only.

Signature of Parent/Guardian: _____ Date: _____

The participant in the day care facility may qualify for free or reduced-price meals if your household income falls within the limits of this chart.

185% of Poverty Level	
Household Size	Yearly
1	21,775
2	29,471
3	37,167
4	44,863
5	52,559
6	60,255
7	67,951
8	75,647
Each additional person:	7,696

In accordance with federal civil rights law and United States Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, office, 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 [ASL]) 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
3. E-Mail: program.intake@usda.gov

This institution is an equal opportunity provider.

DO NOT 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: X Date Withdrawn: _____ Eligibility: Free X Reduced _____ Denied _____
 Reason: SNAP recipient
 Determining Official's Signature: Ima Fishul Date: 10/5/YYYY

**CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
FAMILY-SIZE AND INCOME APPLICATION**

PART 1. ALL HOUSEHOLD MEMBERS				
a. Name(s) of Enrolled Child(ren) Mariah Olson				
b. Names of ALL Household Members (First, Middle Initial, Last)	Age of Enrolled Child(ren)	Birth Date of Enrolled Child(ren)	Check If a Foster Child (The Legal Responsibility of a Welfare Agency or Court)* *If all children indicated below are foster children, skip to Part 5 to sign this form.	Check if NO Income
Mariah Olson	3	7/31/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Owen Olson			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
PART 2. BENEFITS				
If any member of your household receives SNAP, TANF, or TPIR benefits, provide name and case number for the ONE person who receives benefits. <i>If no one receives these benefits, skip to Part 3.</i>				
NAME: <u>Owen Olson</u> CASE NUMBER: <u>555-66-7891</u>				
PART 3. IF ANY CHILD YOU ARE APPLYING FOR IS HOMELESS, MIGRANT, OR A RUNAWAY, CHECK THE APPROPRIATE BOX AND CALL (YOUR SCHOOL, HOMELESS LIAISON, OR MIGRANT COORDINATOR AT PHONE NUMBER)				
<input type="checkbox"/> Homeless <input type="checkbox"/> Migrant <input type="checkbox"/> Runaway				
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			
	Earnings From Work Before Deductions	Welfare, Child Support, Alimony	Pensions, Retirement, Social Security, SSI, VA Benefits	All Other Income
(Example) Jane Smith	\$ 200 / weekly	\$ 150 twice a month	\$ 100 / monthly	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

EXAMPLE
 TPIR NUMBER
 (CORRECTLY
 APPROVED)

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 also must list the last four digits of his or her social security number or mark the I do not have a social security number box.*

I certify that all information on this form is true and that all income is reported. I understand that the center will get federal funds based on the information that 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: Owen Olson Print Name: Owen Olson

Date: 10/3/YYYY

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of social security number: *** - ** - ____ I do not have a social security number.

Part 6: Participant's Ethnic and Racial Identities (Optional)

Mark one ethnic identity: Hispanic or Latino Not Hispanic or Latino

Mark one or more racial identities: Asian White American Indian or Alaska Native Native Hawaiian or other Pacific Islander Black or African American

PART 7: OTHER BENEFITS: You do not have to complete this part to participate in the CACFP.

Health Insurance Yes, I want health insurance for my children. Institution officials may give information from my FSIA to SoonerCare Health Benefit officials so that they can send me information about free or low-cost health insurance for my children.

No, I *DO NOT* want information from my FSIA shared with SoonerCare Health Benefits officials.

I certify that I am the parent/guardian of the children for whom application is being made.

I understand that I will be releasing information that will show that I qualify for free or reduced-price meals for my children. I give up my rights to confidentiality for this purpose only.

Signature of Parent/Guardian: _____ Date: _____

The participant in the day care facility may qualify for free or reduced-price meals if your household income falls within the limits of this chart.

185% of Poverty Level	
Household Size	Yearly
1	21,775
2	29,471
3	37,167
4	44,863
5	52,559
6	60,255
7	67,951
8	75,647
Each additional person:	7,696

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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
3. E-Mail: program.intake@usda.gov

This institution is an equal opportunity provider.

DO NOT 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: X Date Withdrawn: _____ Eligibility: Free X Reduced _____ Denied _____

Reason: FDPPIR recipient

Determining Official's Signature: Ima Fishul Date: 10/5/YYYY

**CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
FAMILY-SIZE AND INCOME APPLICATION**

PART 1. ALL HOUSEHOLD MEMBERS				
a. Name(s) of Enrolled Child(ren) Addie Butler, Thatcher Butler, Harrison Butler				
b. Names of ALL Household Members (First, Middle Initial, Last)	Age of Enrolled Child(ren)	Birth Date of Enrolled Child(ren)	Check If a Foster Child (The Legal Responsibility of a Welfare Agency or Court)* *If all children indicated below are foster children, skip to Part 5 to sign this form.	Check if NO Income
Addie Butler	3	2/20/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Thatcher Butler	3	2/20/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Harrison Butler	9 mo	1/6/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Sheila Butler			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

PART 2. BENEFITS

If any member of your household receives SNAP, TANF, or FDISR benefits, provide the name and case number for the ONE person who receives benefits. *If no one receives these benefits, skip to Part 3.*

NAME: **Addie Butler** CASE NUMBER: **M-157230 002**

PART 3. IF ANY CHILD YOU ARE APPLYING FOR IS HOMELESS, MIGRANT, OR A RUNAWAY, CHECK THE APPROPRIATE BOX AND CALL YOUR SCHOOL, HOMELESS LIAISON OR MIGRANT COORDINATOR AT PHONE NUMBER

Homeless Migrant Runaway

PART 4. TOTAL HOUSEHOLD GROSS INCOME. You must tell us how much and how often.

A. NAME OF PERSON RECEIVING GROSS INCOME AND HOW OFTEN IT WAS RECEIVED

(List only household members with income)	Earnings From Work Before Deductions	Welfare, Child Support, Alimony	Pensions, Retirement, Social Security, SSI, VA Benefits	All Other Income
(Example) Jane Smith	\$ 200 / weekly	_____ / twice a month	\$ 100 / monthly	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

INVALID SNAPSHOT NUMBER CORRECTLY DETERMINED NOT ELIGIBLE

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 also must list the last four digits of his or her social security number or mark the I do not have a social security number box.*

I certify that all information on this form is true and that all income is reported. I understand that the center will get federal funds based on the information that 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: Sheila Butler Print Name: Sheila Butler

Date: 9/30/YYYY

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of social security number: *** - ** - ____ I do not have a social security number.

Part 6: Participant's Ethnic and Racial Identities (Optional)

Mark one ethnic identity:

- Hispanic or Latino
 Not Hispanic or Latino

Mark one or more racial identities:

- Asian American Indian or Alaska Native Black or African American
 White Native Hawaiian or other Pacific Islander

PART 7: OTHER BENEFITS: You do not have to complete this part to participate in the CACFP.

- Health Insurance** Yes, I want health insurance for my children. Institution officials may give information from my FSIA to SoonerCare Health Benefit officials so that they can send me information about free or low-cost health insurance for my children.
 No, I *DO NOT* want information from my FSIA shared with SoonerCare Health Benefits officials.

I certify that I am the parent/guardian of the children for whom application is being made.

I understand that I will be releasing information that will show that I qualify for free or reduced-price meals for my children. I give up my rights to confidentiality for this purpose only.

Signature of Parent/Guardian: _____ Date: _____

The participant in the day care facility may qualify for free or reduced-price meals if your household income falls within the limits of this chart.

185% of Poverty Level	
Household Size	Yearly
1	21,775
2	29,471
3	37,167
4	44,863
5	52,559
6	60,255
7	67,951
8	75,647
Each additional person:	7,696

In accordance with federal civil rights law and United States Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, office, 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 [ASL]) 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.

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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
3. E-Mail: program.intake@usda.gov

This institution is an equal opportunity provider.

DO NOT 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 X

Reason: Invalid SNAP number

Determining Official's Signature: Ima Fishul Date: 10/3/YYYY

**CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
FAMILY-SIZE AND INCOME APPLICATION**

PART 1. ALL HOUSEHOLD MEMBERS				
a. Name(s) of Enrolled Child(ren) Cathy Thomas, Gary Thomas				
b. Names of ALL Household Members (First, Middle Initial, Last)	Age of Enrolled Child(ren)	Birth Date of Enrolled Child(ren)	Check If a Foster Child (The Legal Responsibility of a Welfare Agency or Court)* *If all children indicated below are foster children, skip to Part 5 to sign this form.	Check if NO Income
Cathy Thomas	4	2/8/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Gary Thomas	3	3/1/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Rachel Thomas			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

PART 2. BENEFITS

If any member of your household receives SNAP, TANF, or FPIIR benefits, provide the name and case number for the ONE person who receives benefits. *If no one receives these benefits, skip to Part 3.*

NAME: Gary Thomas CASE NUMBER: 6005 8902 2715 2239

PART 3. IF ANY CHILD YOU ARE APPLYING FOR IS HOMELESS, MIGRANT, OR A RUNAWAY, CHECK THE APPROPRIATE BOX AND CALL YOUR SCHOOL, HOMELESS LIAISON, OR MIGRANT COORDINATOR AT PHONE NUMBER

Homeless Migrant Runaway

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			
	Earnings from Work Before Deductions	Welfare, Child Support, Annuity	Pension, Retirement, Social Security, SSA Benefits	All Other Income
(Example) Jane Smith	\$ 20 / weekly	\$ 15 / twice a month	\$ 100 / monthly	\$ /
	\$ /	\$ /	\$ /	\$ /
	\$ /	\$ /	\$ /	\$ /
	\$ /	\$ /	\$ /	\$ /
	\$ /	\$ /	\$ /	\$ /
	\$ /	\$ /	\$ /	\$ /

**EXAMPLE
INVALID
NUMBER
CORRECTLY AS
DETERMINED AS
NOT ELIGIBLE**

**CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
FAMILY-SIZE AND INCOME APPLICATION**

PART 1. ALL HOUSEHOLD MEMBERS				
a. Name(s) of Enrolled Child(ren) Jodi Jensen, Amber Cashion				
b. Names of ALL Household Members (First, Middle Initial, Last)	Age of Enrolled Child(ren)	Birth Date of Enrolled Child(ren)	Check If a Foster Child (The Legal Responsibility of a Welfare Agency or Court)* *If all children indicated below are foster children, skip to Part 5 to sign this form.	Check if NO Income
Charles Jensen			<input type="checkbox"/>	<input type="checkbox"/>
Jamie Cashion			<input type="checkbox"/>	<input type="checkbox"/>
Michael Jensen			<input type="checkbox"/>	<input type="checkbox"/>
Jodi Jensen	5	7/1/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Amber Cashion	3	1/16/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

PART 2. BENEFITS

If any member of your household receives *SNAP, TANF, or FOPIN* benefits, provide the name and case number for the *ONE* person who receives benefits. *If no one receives these benefits, skip to Part 3.*

NAME: Jodi Jensen CASE NUMBER: S-423245

PART 3. IF ANY CHILD YOU ARE APPLYING FOR IS HOMELESS, MIGRANT, OR A RUNAWAY, CHECK THE APPROPRIATE BOX AND CALL YOUR SCHOOL HOMELESS LIAISON, OR MIGRANT COORDINATOR AT PHONE NUMBER

Homeless Migrant Runaway

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	C. Earnings From Work Before Deductions	D. Welfare, Child Support, Alimony	E. Pensions, Retirement, Social Security, SS, VA Benefits	F. All Other Income
(Example) Jane Smith	\$ 200 / week	\$ 100 / twice a month	\$ 10 / monthly	\$ _____ / _____	\$ _____ / _____
Charles Jensen	\$ 1500 / monthly	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
Jamie Cashion	\$ 1000 / monthly	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
Michael Jensen	\$ 400 / monthly	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

INVALID TANF NUMBER CORRECTLY BASED ON INCOME

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 also must list the last four digits of his or her social security number or mark the I do not have a social security number box.*

I certify that all information on this form is true and that all income is reported. I understand that the center will get federal funds based on the information that 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: Charles Jensen Print Name: Charles Jensen
 Date: 9/28/YYYY
 Address: _____ Phone Number: _____
 City: _____ State: _____ Zip Code: _____
 Last four digits of social security number: *** - ** - 4 4 4 4 I do not have a social security number.

Part 6: Participant's Ethnic and Racial Identities (Optional)

Mark one ethnic identity:
 Hispanic or Latino
 Not Hispanic or Latino

Mark one or more racial identities:
 Asian
 White
 American Indian or Alaska Native
 Native Hawaiian or other Pacific Islander
 Black or African American

PART 7: OTHER BENEFITS: You do not have to complete this part to participate in the CACFP.

Health Insurance Yes, I want health insurance for my children. Institution officials may give information from my FSIA to SoonerCare Health Benefit officials so that they can send me information about free or low-cost health insurance for my children.
 No, I *DO NOT* want information from my FSIA shared with SoonerCare Health Benefits officials.

I certify that I am the parent/guardian of the children for whom application is being made.
 I understand that I will be releasing information that will show that I qualify for free or reduced-price meals for my children. I give up my rights to confidentiality for this purpose only.

Signature of Parent/Guardian: Charles Jensen Date: 9/28/YYYY

The participant in the day care facility may qualify for free or reduced-price meals if your household income falls within the limits of this chart.

185% of Poverty Level	
Household Size	Yearly
1	21,775
2	29,471
3	37,167
4	44,863
5	52,559
6	60,255
7	67,951
8	75,647
Each additional person:	7,696

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1400 Independence Avenue, SW
Washington, D.C. 20250-9410
2. Fax: 202-690-7442
3. E-Mail: program.intake@usda.gov

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Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12
 Total Income: \$2900 Per: Week _____ Every 2 Weeks _____ Twice a Month _____ Month X Year _____
 Household Size: 5
 Categorical Eligibility: _____ Date Withdrawn: _____ Eligibility: Free X Reduced _____ Denied _____
 Reason: _____
 Determining Official's Signature: Ima Fishul Date: 10/3/YYYY

**CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
FAMILY-SIZE AND INCOME APPLICATION**

PART 1. ALL HOUSEHOLD MEMBERS				
a. Name(s) of Enrolled Child(ren) Frank Scott, Florence Scott				
b. Names of ALL Household Members (First, Middle Initial, Last)	Age of Enrolled Child(ren)	Birth Date of Enrolled Child(ren)	Check If a Foster Child (The Legal Responsibility of a Welfare Agency or Court)*	Check if NO Income
			*If all children indicated below are foster children, skip to Part 5 to sign this form.	
Frank Scott	6 wk	8/16/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Florence Scott	5	10/3/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Felecia Scott			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
PART 2. BENEFITS				
If any member of your household receives SNAP, TANF, or WPIR benefits, provide the name and case number for the ONE person who receives benefits. <i>If no one receives these benefits, skip to Part 3.</i>				
NAME: _____ CASE NUMBER: _____				
PART 3. IF ANY CHILD YOU ARE APPLYING FOR IS HOMELESS, MIGRANT, OR A RUNAWAY, CHECK THE APPROPRIATE BOX AND CALL (YOUR SCHOOL, HOMELESS LIAISON, OR MIGRANT COORDINATOR AT PHONE NUMBER)				
<input type="checkbox"/> Homeless <input type="checkbox"/> Migrant <input type="checkbox"/> Runaway				
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			
	Earnings From Work Before Deductions	Welfare, Child Support, Alimony	Pensions, Retirement, Social Security, SSI, VA Benefits	All Other Income
(Example) Jane Smith	\$ 200 / weekly	\$ 150 twice a month	\$ 100 / monthly	\$ _____ / _____
Felecia Scott	\$ 1800 / monthly	\$ 400 / monthly	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

EXAMPLE PRICE
 REDUCED INCOME
 CORRECTLY APPROVED

**CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
FAMILY-SIZE AND INCOME APPLICATION**

PART 1. ALL HOUSEHOLD MEMBERS				
a. Name(s) of Enrolled Child(ren) Barbara Simonsky, Brenda Childs				
b. Names of ALL Household Members (First, Middle Initial, Last)	Age of Enrolled Child(ren)	Birth Date of Enrolled Child(ren)	Check If a Foster Child (The Legal Responsibility of a Welfare Agency or Court)*	Check if NO Income
			*If all children indicated below are foster children, skip to Part 5 to sign this form.	
Barbara Simonsky	5	9/18/YY	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Brenda Childs	2	6/1/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Tiffany Childs			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
PART 2. BENEFITS				
If any member of your household receives <i>SNAP, TANF</i> , or <i>OPIN</i> benefits, provide the name and case number for the <i>ONE</i> person who receives benefits. <i>If no one receives these benefits, skip to Part 3.</i>				
NAME: _____ CASE NUMBER: _____				
PART 3. IF ANY CHILD YOU ARE APPLYING FOR IS HOMELESS, MIGRANT, OR RUNAWAY, CHECK THE APPROPRIATE BOX AND CALL (YOUR SCHOOL, HOMELESS LIAISON, OR MIGRANT COORDINATOR AT PHONE NUMBER)				
<input type="checkbox"/> Homeless <input type="checkbox"/> Migrant <input type="checkbox"/> Runaway				
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			
	Earnings From Work Before Deductions	Welfare, Child Support, Alimony	Pensions, Retirement, Social Security, SSI, VA Benefits	All Other Income
(Example) Jane Smith	\$ 200 / weekly	\$ 150 twice a month	\$ 100 / monthly	\$ _____ / _____
Tiffany Childs	\$ 2800 / mo	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

EXAMPLE FOSTER CHILD AND OTHER CHILDREN (CORRECTLY APPROVED)

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 also must list the last four digits of his or her social security number or mark the I do not have a social security number box.*

I certify that all information on this form is true and that all income is reported. I understand that the center will get federal funds based on the information that 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: Tiffany Childs Print Name: Tiffany Childs
 Date: 9/30/YYYY
 Address: _____ Phone Number: 521-8888
 City: _____ State: _____ Zip Code: _____
 Last four digits of social security number: *** - ** - 9 9 9 9 I do not have a social security number.

Part 6: Participant's Ethnic and Racial Identities (Optional)

Mark one ethnic identity:
 Hispanic or Latino
 Not Hispanic or Latino

Mark one or more racial identities:
 Asian
 White
 American Indian or Alaska Native
 Native Hawaiian or other Pacific Islander
 Black or African American

PART 7: OTHER BENEFITS: You do not have to complete this part to participate in the CACFP.

Health Insurance Yes, I want health insurance for my children. Insitution officials may give information from my FSIA to SoonerCare Health Benefit officials so that they can send me information about free or low-cost health insurance for my children.
 No, I *DO NOT* want information from my FSIA shared with SoonerCare Health Benefits officials.

I certify that I am the parent/guardian of the children for whom application is being made.

I understand that I will be releasing information that will show that I qualify for free or reduced-price meals for my children. I give up my rights to confidentiality for this purpose only.

Signature of Parent/Guardian: _____ Date: _____

The participant in the day care facility may qualify for free or reduced-price meals if your household income falls within the limits of this chart.

185% of Poverty Level	
Household Size	Yearly
1	21,775
2	29,471
3	37,167
4	44,863
5	52,559
6	60,255
7	67,951
8	75,647
Each additional person:	7,696

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Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
2. Fax: 202-690-7442
3. E-Mail: program.intake@usda.gov

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DO NOT 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: \$2800 Per: Week _____ Every 2 Weeks _____ Twice a Month _____ Month X Year _____

Household Size: 3
 Categorical Eligibility: X Date Withdrawn: _____ Eligibility: Free X Reduced X Denied _____

Reason: Barbara is a foster child—Brenda approved on income

Determining Official's Signature: Ima Fishul Date: 10/3/YYYY

**CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
FAMILY-SIZE AND INCOME APPLICATION**

PART 1. ALL HOUSEHOLD MEMBERS

a. Name(s) of Enrolled Child(ren) **Johnny McClain, Joanie McClain, David McClain, Chase McClain**

b. Names of ALL Household Members (First, Middle Initial, Last)	Age of Enrolled Child(ren)	Birth Date of Enrolled Child(ren)	Check If a Foster Child (The Legal Responsibility of a Welfare Agency or Court)* *If all children indicated below are foster children, skip to Part 5 to sign this form.	Check if NO Income
Mike McClain			<input type="checkbox"/>	<input type="checkbox"/>
Gertrude McClain			<input type="checkbox"/>	<input type="checkbox"/>
Johnny McClain	5	4/24/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Joanie McClain		3/16/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
David McClain	3	5/22/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Chase McClain		3/7/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

PART 2. BENEFITS

If any member of your household receives SNAP, TANF, or FDIPIR benefits, provide the name and case number for the ONE person who receives benefits. *If no one receives these benefits, skip to Part 3.*

NAME: _____ CASE NUMBER: _____

PART 3. IF ANY CHILD YOU ARE APPLYING FOR IS HOMELESS, MIGRANT, OR A RUNAWAY, CHECK THE APPROPRIATE BOX AND CALL YOUR SCHOOL HOMELESS LIAISON, OR MIGRANT COORDINATOR AT PHONE NUMBER

Homeless Migrant Runaway

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			
	Earnings From Work Before Deductions	Welfare, Child Support, Alimony	Pension, Retirement, Social Security, SSI, VA benefits	All Other Income
<i>(Example) Jane Smith</i>	\$ 200 / weekly	\$ 150 twice a month	\$ 100 / monthly	\$ _____ / _____
Mike McClain	\$ 1840.25 / monthly	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
Gertrude McClain	\$ 1100.00 / monthly	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

**EXAMPLE
INCOMPLETE APPLICATION - NO LAST FOUR DIGITS OF THE SOCIAL SECURITY NUMBER**

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 also must list the last four digits of his or her social security number or mark the I do not have a social security number box.*

I certify that all information on this form is true and that all income is reported. I understand that the center will get federal funds based on the information that 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: Mike McClain Print Name: _____
 Date: 9/28/YYYY
 Address: _____ Phone Number: _____
 City: _____ State: _____ Zip Code: _____
 Last four digits of social security number: *** - ** - ____ I do not have a social security number.

Part 6: Participant's Ethnic and Racial Identities (Optional)

Mark one ethnic identity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	Mark one or more racial identities: <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Black or African American
---	--

PART 7: OTHER BENEFITS: You do not have to complete this part to participate in the CACFP.

Health Insurance Yes, I want health insurance for my children. Institution officials may give information from my FSIA to SoonerCare Health Benefit officials so that they can send me information about free or low-cost health insurance for my children.
 No, I *DO NOT* want information from my FSIA shared with SoonerCare Health Benefits officials.

I certify that I am the parent/guardian of the children for whom application is being made.
 I understand that I will be releasing information that will show that I qualify for free or reduced-price meals for my children. I give up my rights to confidentiality for this purpose only.

Signature of Parent/Guardian: Mike McClain Date: 9/28/YYYY

The participant in the day care facility may qualify for free or reduced-price meals if your household income falls within the limits of this chart.

185% of Poverty Level	
Household Size	Yearly
1	21,775
2	29,471
3	37,167
4	44,863
5	52,559
6	60,255
7	67,951
8	75,647
Each additional person:	7,696

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Washington, D.C. 20250-9410
2. Fax: 202-690-7442
3. E-Mail: program.intake@usda.gov

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Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12
 Total Income: **\$2,940.25** Per: Week ____ Every 2 Weeks ____ Twice a Month ____ Month **X** Year ____
 Household Size: 6
 Categorical Eligibility: ____ Date Withdrawn: ____ Eligibility: Free ____ Reduced ____ Denied **X**
 Reason: Incomplete—No SSN—May change to free if last 4 digits of SSN is obtained
 Determining Official's Signature: Ima Fishul Date: 10/3/YYYY

**CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
FAMILY-SIZE AND INCOME APPLICATION**

PART 1. ALL HOUSEHOLD MEMBERS				
a. Name(s) of Enrolled Child(ren) Julie Douglas, Debbie Douglas, Steffy Douglas				
b. Names of ALL Household Members (First, Middle Initial, Last)	Age of Enrolled Child(ren)	Birth Date of Enrolled Child(ren)	Check If a Foster Child (The Legal Responsibility of a Welfare Agency or Court)* *If all children indicated below are foster children, skip to Part 5 to sign this form.	Check if NO Income
Julie Douglas	2	6/20/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Debbie Douglas	3	7/6/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Steffy Douglas	1	4/17/YY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Dee Dee Douglas			<input type="checkbox"/>	<input checked="" type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
PART 2. BENEFITS				
If any member of your household receives SNAP, TANF, or FDC benefits, provide the name and case number for the ONE person who receives benefits. <i>If no one receives these benefits, skip to Part 4.</i>				
NAME: _____ CASE NUMBER: _____				
PART 3. IF ANY CHILD YOU ARE APPLYING FOR IS HOMELESS, MIGRANT, OR A RUNAWAY, CHECK THE APPROPRIATE BOX AND CALL (YOUR SCHOOL, HOMELESS LIAISON, OR MIGRANT COORDINATOR AT PHONE NUMBER)				
<input type="checkbox"/> Homeless <input type="checkbox"/> Migrant <input type="checkbox"/> Runaway				
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			
	Earnings From Work Before Deductions	Welfare, Child Support, Alimony	Pensions, Retirement, Social Security, SSI, VA Benefits	All Other Income
(Example) Jane Smith	\$ 200 / weekly	\$ 150 twice a month	\$ 100 / monthly	\$ _____ / _____
Dee Dee Douglas	\$ 0 / _____	\$ 0 / _____	\$ 0 / _____	\$ 0 / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

EXAMPLE
 ZERO
 APPLICATION
 (CORRECTLY
 APPROVED)

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 also must list the last four digits of his or her social security number or mark the I do not have a social security number box.*

I certify that all information on this form is true and that all income is reported. I understand that the center will get federal funds based on the information that 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: Dee Dee Douglas Print Name: _____
 Date: 10/3/YYYY
 Address: _____ Phone Number: _____
 City: _____ State: _____ Zip Code: _____
 Last four digits of social security number: *** - ** - 4 2 2 2 I do not have a social security number.

Part 6: Participant's Ethnic and Racial Identities (Optional)

Mark one ethnic identity:
 Hispanic or Latino
 Not Hispanic or Latino

Mark one or more racial identities:
 Asian
 White
 American Indian or Alaska Native
 Native Hawaiian or other Pacific Islander
 Black or African American

PART 7: OTHER BENEFITS: You do not have to complete this part to participate in the CACFP.

Health Insurance Yes, I want health insurance for my children. Insitution officials may give information from my FSIA to SoonerCare Health Benefit officials so that they can send me information about free or low-cost health insurance for my children.
 No, I *DO NOT* want information from my FSIA shared with SoonerCare Health Benefits officials.

I certify that I am the parent/guardian of the children for whom application is being made.

I understand that I will be releasing information that will show that I qualify for free or reduced-price meals for my children. I give up my rights to confidentiality for this purpose only.

Signature of Parent/Guardian: Dee Dee Douglas Date: 10/3/YYYY

The participant in the day care facility may qualify for free or reduced-price meals if your household income falls within the limits of this chart.

185% of Poverty Level	
Household Size	Yearly
1	21,775
2	29,471
3	37,167
4	44,863
5	52,559
6	60,255
7	67,951
8	75,647
Each additional person:	7,696

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 last four digits of 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 to Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) case number 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 Programs.

The United States Department of Agriculture (USDA) 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 protected genetic information in employment or in any program or activity conducted or funded by USDA. (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 USDA by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, DC 20250-9410, by fax 202-690-7442, or e-mail at <program.intake@usda.gov>.

Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339 or 800-845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

DO NOT 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: 0 Per: Week _____ Every 2 Weeks _____ Twice a Month _____ Month _____ Year _____
 Household Size: 4
 Categorical Eligibility: _____ Date Withdrawn: _____ Eligibility: Free X Reduced _____ Denied _____
 Reason: Family has no income
 Determining Official's Signature: Ima Fishul Date: 10/3/YYYY

AUTOMATIC ELIGIBILITY OF HEAD START CHILDREN

The Healthy Meals for Americans Act allows children who are **ENROLLED** in a federally funded Head Start Program to be automatically eligible for free meal benefits in the CACFP. (Reference CACFP 11-2013.)

In order to facilitate implementation of this provision, the following applies:

1. **DOCUMENTATION FOR HEAD START ENROLLEES:** The CACFP institution representative must obtain documentation of the Head Start participants in order to confirm automatic eligibility for free meals. (Refer to the Head Start Federally Funded Enrollment Information form. The documentation may be a list of the names of the Head Start participants. The documentation must also include the signature of a Head Start employee authorized to provide the certification on behalf of the Head Start office, as appropriate, and the date.*
2. **ANNUAL UPDATE:** At the beginning of each year, the institution representative must establish whether each child continues to be enrolled in Head Start.
3. **RECORD RETENTION:** The Head Start list of participants must be maintained on file and readily available for review by USDA, the State Agency, or other appropriate agencies for a minimum of three years from the end of the fiscal year to which the information applies or as otherwise specified in program regulations.

Note that while the automatic eligibility for free meals can be documented through the Head Start records, all other monthly records for the CACFP must be properly maintained.

* All Head Start children **MUST** have a completed enrollment form.

HEAD START FEDERALLY FUNDED ENROLLMENT FORM INSTRUCTIONS

1. Record fiscal year.
2. Record name of institution.
3. Record name of facility.
4. Once the above items have been completed, submit the form to the Head Start agency.
5. The Head Start agency should complete the form of the participants. This form must be signed and dated by the person authorized to provide certification and returned to the institution.
6. The children listed will then be recorded on the free roster.

CACFP ROSTER FOR REGULAR MEALS ONLY

The CACFP Roster for Regular Meals Only is used to determine monthly counts of *free*, *reduced-price*, and *not eligible* participation.

Suggested methods for use (if you use another method, indicate key):

- Use a separate roster for each category (*free*, *reduced-price*, and *not eligible*).
- List eligible children on the appropriate roster.
- Check under the **EF** column when the annual enrollment is obtained.
- Indicate the date the FSIA is approved.
- Record monthly an **X** for each child who was in attendance and received at least one reimbursable meal (participated) during that month.
- Use X_D to indicate that a child participated that month but was also dropped from enrollment during the month.
- Use X_{RE} to indicate that the child reenrolled and participated during that month.
- Use X_E to indicate that a child enrolled for the first time and participated during that month.
- Totals for each category are reported monthly on Item 3 on the claim for reimbursement.
- Use **I** to indicate an infant who does not participate in CACFP meals and has a signed Infant Meals Waiver on file.
- Use **NP** to indicate a child who does not participate in CACFP meals.

It is recommended that the rosters be maintained in a loose-leaf binder. Children's CACFP Meal Benefit Income-Eligibility Forms should be placed behind the roster on which they are listed.

NOTE: *Any child eating at least one regular meal during the month MUST be included on the roster.*

EXAMPLE
FREE CACFP ROSTER FOR REGULAR MEALS ONLY

Center: Toys N Noise Fiscal Year: yyyy

NAME	EF*	DATE AP-PROVED	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	DATE DROPPED
1. <i>Phillips, Peter</i>	X	10/3/yy	X												
2. <i>Simonsky, Barbara</i>	X	10/3/yy	X												
3. <i>Douglas, Steffy</i>	X	10/3/yy	X												
4. <i>Douglas, Julie</i>	X	10/3/yy	X												
5. <i>Douglas, Debbie</i>	X	10/3/yy	X												
6. <i>Smith, Kathy</i>	X	10/3/yy	NP												
7. <i>Robbins, Cindy</i>	X	10/3/yy	NP												
8. <i>Hawks, Tommy</i>	X	10/3/yy	NP												
9. <i>Public, Brother Q</i>	X	10/3/yy	NP												
10. <i>Public, Sister Q</i>	X	10/3/yy	NP												
11. <i>Public, John Q</i>	X	10/3/yy	NP												
12. <i>Public, Baby Q</i>	X	10/3/yy	NP												
13. <i>Olson, Mariah</i>	X	10/5/yy	X												
14.															
15.															
16.															
17.															
18.															
19.															
20.															
21.															
22.															
23.															
24.															
25.															
26.															
27.															
28.															
29.															
30.															
TOTAL			6												

*EF = Enrollment Form obtained

EXAMPLE
REDUCED CACFP ROSTER FOR REGULAR MEALS ONLY

Center: Toys N Noise Fiscal Year: yyyy

NAME	EF*	DATE AP-PROVED	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	DATE DROPPED
1. Jensen, Jodi	X	10/3/yyy	X												
2. Cashion, Amber	X	10/3/yyy	X												
3. Sanders, Sue	X	10/3/yyy	I	I	I	I									
4. Sanders, Todd	X	10/3/yyy	X												
5. Childs, Brenda	X	10/3/yyy	NP												
6. Scott, Florence	X	10/27/yyy	X												
7. Scott, Frank	X	10/27/yyy	X												
8.															
9.															
10.															
11.															
12.															
13.															
14.															
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24.															
25.															
26.															
27.															
28.															
29.															
30.															
TOTAL				5											

NOTE: SUE SANDERS IS IDENTIFIED AS AN INFANT WHO DOES NOT PARTICIPATE. SEE INFANT MEAL WAIVER FORM ON PAGE 175.

*EF = Enrollment Form obtained

EXAMPLE
NOT ELIGIBLE CACFP ROSTER FOR REGULAR MEALS ONLY

Center: Toys N Noise Fiscal Year: YYYY

NAME	EF*	DATE AP-PROVED	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	DATE DROPPED
1. <i>Butler, Addie</i>	X	10/3/YYY	X												
2. <i>Butler, Thatcher</i>	X	10/3/YYY	X												
3. <i>Butler, Harrison</i>	X	10/3/YYY	X												
4. <i>Thomas, Cathy</i>	X	10/3/YYY	X												
5. <i>Thomas, Gary</i>	X	10/3/YYY	X												
6. <i>McClain, Johnny</i>	X	10/3/YYY	X												
7. <i>McClain, Joanie</i>	X	10/3/YYY	X												
8. <i>McClain, David</i>	X	10/3/YYY	X												
9. <i>McClain, Chase</i>	X	10/3/YYY	X												
10.															
11.															
12.															
13.															
14.															
15.															
16.															
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23.															
24.															
25.															
26.															
27.															
28.															
29.															
30.															
TOTAL			9												

*EF = Enrollment Form obtained

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