

INSTRUCTIONS FOR COMPLETING THE CACFP
APPLICATION FOR FREE AND REDUCED-PRICE MEALS (Child Care)

Follow these instructions, if your **household gets SNAP OR TANF**:

Part 1: List all household members and birth dates for children.

Part 2: List the case number for any household member (including adults) receiving Food Stamps or TANF.

Part 3: Skip this part.

Part 4: Skip this part.

Part 5: Sign the form and enter the contact information. The last four digits of a Social Security Number are not necessary.

Part 6: Sign this part if you do not want your application information shared with Medicaid or Hoosier Healthwise.

Part 7: Answer this question if you choose.

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

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

Part 1: List all foster children. Check the box indicating that the child is a foster child.

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Skip this part.

Part 5: Sign the form and complete the contact information. A Social Security Number is not necessary.

Part 6: Sign this part if you do not want your application information shared with Medicaid or Hoosier Healthwise.

Part 7: Answer this question if you choose.

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

Part 1: List all household members. For any person, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.

Part 2: If the household does not have 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 [sponsor contact and phone number]. If not, skip this part.

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

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

Section 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 stub or your boss can tell you.

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

In Box 3 - list retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), 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. For ONLY the self-employed, under *Earnings From Work*, report income after expenses. This is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

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

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Part 6: Sign this part if you do not want your application information shared with Medicaid or Hoosier Healthwise.

Part 7: Answer this question if you choose.

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

Part 1: List all household members. 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:

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

Section 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 stub or your boss can tell you.

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

In Box 3 - list retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), 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. For ONLY the self-employed, under *Earnings From Work*, report income after expenses. This is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: An adult household member must sign the form, complete the information, and list the last four digits of his or her Social Security Number, or mark the box if he or she doesn't have one.

Part 6: Sign this part if you do not want your application information shared with Medicaid or Hoosier Healthwise.

Part 7: Answer this question if you choose.

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

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

This institution is an equal opportunity provider.



Dr. Jennifer McCormick
Superintendent of Public Instruction

DEPARTMENT OF EDUCATION

Working Together for Student Success

The United States Department of Agriculture has issued the following
INCOME ELIGIBILITY GUIDELINES effective **July 1, 2019- June 30, 2020**

Household Size	Reduced-Price Meals – 185%					Free Meals – 130%				
	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	23,107	1,926	963	889	445	16,237	1,354	677	625	313
2	31,284	2,607	1,304	1,204	602	21,983	1,832	916	846	423
3	39,461	3,289	1,645	1,518	759	27,729	2,311	1,156	1,067	534
4	47,638	3,970	1,985	1,833	917	33,475	2,790	1,395	1,288	644
5	55,815	4,652	2,326	2,147	1,074	39,221	3,269	1,635	1,509	755
6	63,992	5,333	2,667	2,462	1,231	44,967	3,748	1,874	1,730	865
7	72,169	6,015	3,008	2,776	1,388	50,713	4,227	2,114	1,951	976
8	80,346	6,696	3,348	3,091	1,546	56,459	4,705	2,353	2,172	1,086
For each add'l family member, add	8,177	682	341	315	158	5,746	479	240	221	111

THE TOTAL HOUSEHOLD INCOME STATED ON THE ENROLLED CHILDREN'S INCOME APPLICATION MUST BE COMPARED TO THE ABOVE GUIDELINES PRIOR TO THE SUBMISSION OF THE JULY CLAIM FOR REIMBURSEMENT FOR THE CURRENT FISCAL YEAR.

Following is the definition of income:

In accordance with the Department's policy as provided in the Food and Nutrition Service publication Eligibility Manual for School Meals, "income," as the term is used in this Notice, means income before any deductions such as income taxes, Social Security taxes, insurance premiums, charitable contributions and bonds. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from nonfarm self-employment; (3) net income from farm self-employment; (4) Social Security; (5)

dividends or interest on savings or bonds or income from estates or trusts; (6) net rental income; (7) public assistance or welfare payments; (8) unemployment compensation; (9) government civilian employee or military retirement, or pensions or veterans payments; (10) private pensions or annuities; (11) alimony or child support payments; (12) regular contributions from persons not living in the household; (13) net royalties; and (14) other cash income. Other cash income would include cash amounts received or withdrawn from any source including savings, investments, trust accounts and other resources that would be available to pay the price of a child's meal.

“Income,” as the term is used in this Notice, does not include any income or benefits received under any Federal programs that are excluded from consideration as income by any statutory prohibition. Furthermore, the value of meals or milk to children shall not be considered as income to their households for other benefit programs in accordance with the prohibitions in section 12(e) of the Richard B. Russell National School Lunch Act and section 11(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1760(e) and 1780(b)).

If you have questions about the Income Eligibility Guidelines, please contact **Carol Markle** (cmarkle@doe.in.gov or 317-232-0873) or **Rachel Reynolds** (rreynolds@doe.in.gov or 317-232-0851).

This institution is an equal opportunity provider.

SPONSOR NAME:		PHONE NUMBER:		
CACFP APPLICATION FOR FREE AND REDUCED-PRICE MEALS (CHILD CARE)				
CENTER:		FDC PROVIDER:		
PART 1. ALL HOUSEHOLD MEMBERS		BIRTH DATES OF CHILDREN	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 4 TO SIGN THIS FORM.	
NAMES OF ALL HOUSEHOLD (FIRST, MIDDLE INITIAL, LAST)				CHECK IF NO INCOME
		<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 RECEIVED [FOOD STAMPS] OR [STATE TANF CASH ASSISTANCE], PROVIDE THE NAME AND CASE NUMBER FOR THE 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 [INSERT CENTER CONTACT AND PHONE NUMBER] HOMELESS <input type="checkbox"/> MIGRANT <input type="checkbox"/> RUNAWAY <input type="checkbox"/>				
PART 4. TOTAL HOUSEHOLD GROSS INCOME —You must tell us how much and how often CHECK IF NO INCOME <input type="checkbox"/>				
A. NAME (LIST ONLY HOUSEHOLD MEMBERS WITH INCOME) <i>(EXAMPLE)</i> JANE SMITH	B. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED			
	1. EARNINGS FROM WORK BEFORE DEDUCTIONS	2. WELFARE, CHILD SUPPORT, ALIMONY	3. PENSIONS, RETIREMENT, SOCIAL SECURITY, SSI, VA BENEFITS	4. ALL OTHER INCOME
	\$200/WEEKLY	\$150/TWICE A MONTH	\$100/MONTHLY	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
PART 5. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN) AN ADULT HOUSEHOLD MEMBER MUST SIGN THIS FORM. IF PART 4 IS COMPLETED, THE ADULT SIGNING THE FORM MUST ALSO LIST THE LAST FOUR DIGITS OF HIS OR HER SOCIAL SECURITY NUMBER OR MARK THE "I DO NOT HAVE A SOCIAL SECURITY NUMBER" BOX. (SEE PRIVACY ACT STATEMENT ON THE BACK OF THIS PAGE.) <i>I CERTIFY THAT ALL INFORMATION ON THIS FORM IS TRUE AND THAT ALL INCOME IS REPORTED. I UNDERSTAND THAT THE CENTER OR DAY CARE HOME WILL GET FEDERAL FUNDS BASED ON THE INFORMATION I GIVE. I UNDERSTAND THAT CACFP OFFICIALS MAY VERIFY THE INFORMATION. I UNDERSTAND THAT IF I PURPOSELY GIVE FALSE INFORMATION, THE PARTICIPANT RECEIVING MEALS MAY LOSE THE MEAL BENEFITS, AND I MAY BE PROSECUTED.</i> SIGN HERE: _____ PRINT NAME: _____ DATE: _____ ADDRESS: _____ PHONE NUMBER: _____ CITY: _____ STATE: _____ ZIP CODE: _____ LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: XXX - XX - ____ - ____ <input type="checkbox"/> I DO NOT HAVE A SOCIAL SECURITY NUMBER ____ Initial here if you consent to allow [Provider's Name] to collect your form and provide it to the Sponsor. [Provider's Name] will not review your form.				
PART 6: Other Benefits: THE LAS ALLOWS US TO TELL MEDICAID AND HOOSIER HEALTHWISE THAT YOUR CHILDREN ARE ELIGIBLE FOR FREE OR REDUCED PRICE MEALS. WE MAY SHARE YOUR APPLICATION INFORMATION WITH MEDICAID OR HOOSIER HEALTHWISE UNLESS YOU DO NOT WANT US TO. IF YOU DO NOT WANT US TO SHARE THIS INFORMATION, PLEASE SIGN HERE: _____ SIGNATURE OF PARENT OR GUARDIAN				
FOR INFORMATION ABOUT HOOSIER HEALTHWISE HEALTH INSURANCE CALL 1-800-889-9949				

CACFP APPLICATION FOR FREE AND REDUCED-PRICE MEALS (CHILD CARE)

A CHILD ENROLLED IN THE DAY CARE FACILITY MAY QUALIFY FOR FREE OR REDUCED PRICE MEALS IF THE HOUSEHOLD INCOME FALLS AT OR BELOW THE LIMITS ON THIS CHART:

JULY 1, 2019 TO JUNE 30, 2020			
HOUSEHOLD SIZE	MONTHLY INCOME	HOUSEHOLD SIZE	MONTHLY INCOME
1	1,926	5	4,652
2	2,607	6	5,333
3	3,289	7	6,015
4	3,970	8	6,696

FOR EACH ADDITIONAL FAMILY MEMBER, ADD **\$682**

PART 7. 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"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER <input type="checkbox"/> BLACK OR AFRICAN AMERICAN
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PRIVACY ACT STATEMENT: THE RICHARD B. RUSSELL NATIONAL SCHOOL LUNCH ACT REQUIRES THE INFORMATION ON THIS APPLICATION. YOU DO NOT HAVE TO GIVE THE INFORMATION, BUT IF YOU DO NOT, WE CANNOT APPROVE THE PARTICIPANT FOR FREE OR REDUCED PRICE MEALS. YOU MUST INCLUDE THE LAST FOUR DIGITS OF THE SOCIAL SECURITY NUMBER OF THE ADULT HOUSEHOLD MEMBER WHO SIGNS THE APPLICATION. THE SOCIAL SECURITY NUMBER IS NOT REQUIRED WHEN YOU APPLY ON BEHALF OF A FOSTER CHILD OR YOU LIST A SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP), TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) PROGRAM OR FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS (FDPIR) CASE NUMBER FOR THE PARTICIPANT OR OTHER (FDPIR) IDENTIFIER OR WHEN YOU INDICATE THAT THE ADULT HOUSEHOLD MEMBER SIGNING THE APPLICATION DOES NOT HAVE A SOCIAL SECURITY NUMBER. WE WILL USE YOUR INFORMATION TO DETERMINE IF THE PARTICIPANT IS ELIGIBLE FOR FREE OR REDUCED PRICE MEALS, AND FOR ADMINISTRATION AND ENFORCEMENT OF THE PROGRAM.

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

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

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

- (1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

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CHILD CARE REPRESENTATIVE USE ONLY

ANNUAL INCOME CONVERSION: WEEKLY X 52 – EVERY 2 WEEKS X 26 – TWICE A MONTH X 24 – MONTHLY X 12

SECTION A MARK ONE OF THE BOXES BELOW TO SHOW HOW YOU ARE GOING TO DETERMINE ELIGIBILITY. <input type="checkbox"/> FOOD STAMP OR TANF HOUSEHOLD —THE FOOD STAMP OR TANF NUMBER MEETS THE CRITERIA FOR AN ACCEPTABLE CASE NUMBER. COMPLETE SECTION B & C OR <input type="checkbox"/> FOSTER CHILD —COMPARE THE FOSTER CHILD'S PERSONAL INCOME TO THE GUIDELINES. COMPLETE SECTION B & C OR <input type="checkbox"/> HOUSEHOLD INCOME —COMPLETE THE INFORMATION BELOW AND COMPLETE SECTION B & C TOTAL HOUSEHOLD SIZE: _____ TOTAL HOUSEHOLD INCOME \$ _____ / _____ EXAMPLE: \$100/WEEK COMPARE TOTAL HOUSEHOLD INCOME TO CURRENT USDA INCOME ELIGIBILITY GUIDELINES. WHEN THE HOUSEHOLD INCOMES ARE LISTED FOR DIFFERENT PAY PERIODS, YOU MUST CONVERT ALL INCOME TO MONTHLY OR ANNUAL INCOME. USE THE CONVERSION LISTED ABOVE.	SECTION B BASED ON THE INFORMATION PROVIDED, THIS APPLICATION WILL BE: <input type="checkbox"/> APPROVED FREE <input type="checkbox"/> APPROVED TIER I <input type="checkbox"/> APPROVED REDUCED <input type="checkbox"/> APPROVED TIER II <input type="checkbox"/> PAID USE THIS SPACE FOR INCOME CALCULATION. SECTION C _____ SIGNATURE OF SPONSOR REPRESENTATIVE _____ DATE OF APPROVAL THIS FORM EXPIRES ONE YEAR FROM THE DATE IT WAS APPROVED
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