

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

SPONSOR NAME:	PHONE NUMBER:
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CENTER:	FDC PROVIDER:
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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.	CHECK IF NO INCOME
NAMES OF ALL HOUSEHOLD (FIRST, MIDDLE INITIAL, LAST)			
		<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 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 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			
	1. EARNINGS FROM WORK BEFORE DEDUCTIONS	2. WELFARE, CHILD SUPPORT, ALIMONY	3. PENSIONS, RETIREMENT, SOCIAL SECURITY, SSI, VA BENEFITS	4. ALL OTHER INCOME
(EXAMPLE) JANE SMITH	\$200/WEEKLY _____	\$150/TWICE A MONTH _____	\$100/MONTHLY _____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____

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 CERTIFY THAT ALL INFORMATION ON THIS FORM IS TRUE AND THAT ALL INCOME IS REPORTED. I UNDERSTAND THAT THE CENTER OR DAY CARE HOME WILL GET FEDERAL FUNDS BASED ON THE INFORMATION I GIVE. I UNDERSTAND THAT CACFP OFFICIALS MAY VERIFY THE INFORMATION. I UNDERSTAND THAT IF I PURPOSELY GIVE FALSE INFORMATION, THE PARTICIPANT RECEIVING MEALS MAY LOSE THE MEAL BENEFITS, AND I MAY BE PROSECUTED.

SIGN HERE: _____ PRINT NAME: _____

DATE: _____

ADDRESS: _____ PHONE NUMBER: _____

CITY: _____ STATE: _____ ZIP CODE: _____

LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: XXX - XX - ____ - ____ 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.

