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

### PART 1. ALL HOUSEHOLD MEMBERS

**a. Name(s) of Enrolled Child(ren)**

| 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 |
|---|---|---|---|---|
| | | | ☐ | ☐ |
| | | | ☐ | ☐ |
| | | | ☐ | ☐ |
| | | | ☐ | ☐ |
| | | | ☐ | ☐ |
| | | | ☐ | ☐ |
| | | | ☐ | ☐ |
| | | | ☐ | ☐ |

### PART 2. BENEFITS

If any member of your household receives *SNAP*, *TANF*, or *FDPIR* 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 IS 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** | |
| | $ | $ | $ | $ |
| | $ | $ | $ | $ |
| | $ | $ | $ | $ |
| | $ | $ | $ | $ |
| | $ | $ | $ | $ |
| | $ | $ | $ | $ |
| | $ | $ | $ | $ |
| | $ | $ | $ | $ |
| | $ | $ | $ | $ |

## 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, this participant receiving meals may lose the meal benefits and I may be prosecuted.*

**Sign Here:** _____ Print Name: _____
Date: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____

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

## PART 6: PARTICIPANT'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

| *Mark one ethnic identity:* | *Mark one or more racial identities:* | | |
|---|---|---|---|
| ☐ Hispanic or Latino<br>☐ Not Hispanic or Latino | ☐ Asian<br>☐ White | ☐ American Indian or Alaskan Native<br>☐ 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 Sooner Care Health Benefit officials so that they may send me information about free or low-cost health insurance for my children.

☐ No, I ***DO NOT*** want information from my FSIA shared with Sooner Care 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 confidentialty 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 | 22,311 |
| 2 | 30,044 |
| 3 | 37,777 |
| 4 | 45,510 |
| 5 | 53,243 |
| 6 | 60,976 |
| 7 | 68,709 |
| 8 | 76,442 |
| Each Additional Person: | 7,733 |

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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: | | Date Withdrawn: | Eligibility: Free | Eligibility: Reduced | Eligibility: Denied |
| Reason: | | | | | |
| Determining Official's Signature: | | | | Date: | |