

2011/2012 CONFIDENTIAL INCOME STATEMENT – Child Care Centers/Family Day Care Providers

INSTRUCTIONS:

- If your household received SNAP, TANF or FDPIR, complete parts 1-3, and 5; part 6 is optional.
- If you do not receive these benefits and your income is below the guidelines (back) complete parts 1, 2, 4 and 5; part 6 is optional.
- If you are applying for a FOSTER CHILD only, complete parts 1, 2 and 5; (part 6 is optional).

1 HOUSEHOLD INFORMATION

| | |
|--|--|
| Print name of person completing this application (Last name, First name) _____ Name Print _____ Mailing Address – Apt # _____ City State Zip _____ | Home Phone or Cell Phone (Circle One) _____ Work Phone _____ → Number living in this household _____ (Write names of all household members on part 2 and/or part 4 of this form) |
|--|--|

2 CHILD INFORMATION – (Names of Children Enrolled in Child Care)

| Child's Name (Legal Last name, First name) | Birth Date | Age | Check if Foster Child (placed by welfare agency or court) If all are in foster care, complete this and go to part 5. |
|--|------------|-------|---|
| 1. _____ | _____ | _____ | <input type="checkbox"/> |
| 2. _____ | _____ | _____ | <input type="checkbox"/> |
| 3. _____ | _____ | _____ | <input type="checkbox"/> |
| 4. _____ | _____ | _____ | <input type="checkbox"/> |
| 5. _____ | _____ | _____ | <input type="checkbox"/> |

3 PUBLIC BENEFITS Indicate which **benefits** your household currently receives, and list case number, if any:

Name: _____ Case Number: _____

SNAP (Supplemental Nutrition Assistance Program) (*Oregon Trail Card number not acceptable*)

TANF (Temporary Assistance to Needy Families) (*Employment Related Day Care does not qualify*)

Does this household receive FDPIR (Food Distribution on Indian Reservations) **Yes** (Go Part 5 and complete)

4 HOUSEHOLD MEMBERS & GROSS MONTHLY INCOME – if not monthly, see back for conversions

| Column 1 List all household members, including children not attending school, and income. Do not include children listed in part 2, unless they receive regular income. (<i>Last name, first name</i>) | Column 2 MONTHLY INCOME (Total earnings & wages before deductions) | Column 3 MONTHLY CHILD SUPPORT, WELFARE, ALIMONY RECEIVED | Column 4 MONTHLY PENSIONS, SOCIAL SEC., RETIREMENT, SSI, VA | Column 5 OTHER MONTHLY INCOME -Including unemployment and workers comp. | Column 6 Check if No Income |
|--|--|--|--|--|--------------------------------|
| 1. _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> |
| 2. _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> |
| 3. _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> |
| 4. _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> |

5 SIGNATURE, DATE and Last four numbers of SOCIAL SECURITY NUMBER (Adult must sign)

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.

| | | | |
|-------------------------------------|-------------------------|---|--|
| Signature of Adult Household Member | Date Signed | Social Security Number (See privacy statement on back) | <input type="checkbox"/> I do not have a Social Security Number. |
| X _____ | _____ Month/day/year | XXX-XX - ____ | |

6 RACIAL OR ETHNIC GROUP (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 & Alaskan Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Other |
|---|--|

SPONSOR USE ONLY - DO NOT WRITE BELOW THIS LINE

Total Income: _____ Number in Household: _____

Eligibility : Free Reduced Above Scale Tier 1 Tier 2 Temporary From: _____ To: _____
(maximum 45 days)

Eligibility based on : SNAP/TANF FDPIR Household Income Foster Child

Notes: _____

Determining Official's Signature : _____ Date _____ 2nd Check (initial)

DETERMINING MONTHLY INCOME FOR EARNINGS & WAGES

Monthly income for all household members must be reported in Section 4 of this application. Income means any money regularly received from work, child support, alimony, pensions, retirements, social security or any other source. Exclude student/school loans. Money received from a business or farm owned by you should be reported as "net income". *Net Income is defined as the total income left after business and farm operating expenses are subtracted from gross receipts.*

Homeless, migrant and runaway youth are categorically eligible for free meals.

Household members who are not paid monthly should change earnings into monthly income by doing the following:

Household members who are paid every week: Multiply total earnings and wages for one pay period, before deductions, by 52. Then divide by 12. The resulting amount is the total monthly income.

Household members who are paid every 2 weeks: Multiply total earnings and wages for one pay period, before deductions, by 26. Then divide by 12. The resulting amount is the total monthly income.

Household members who are paid twice a month: Multiply total earnings and wages for one pay period, before deductions, by 24 then divide by 12. The resulting amount is the total monthly income.

Household members who are seasonal workers or work less than 12 months: Project annual rate of income to accurately represent actual circumstances then divide by 12. The resulting amount is the projected monthly income.

FEDERAL INCOME GUIDELINES

Your children may qualify at least for reduced price meals if your household income falls within the limits of this chart.

| Household Size | <i>Reduced Price Meals</i> | | | | |
|---------------------------------------|----------------------------|---------|-----------------|-----------------|--------|
| | Annual | Monthly | Twice Per Month | Every Two Weeks | Weekly |
| -1- | 20,147 | 1,679 | 840 | 775 | 388 |
| -2- | 27,214 | 2,268 | 1,134 | 1,047 | 524 |
| -3- | 34,281 | 2,857 | 1,429 | 1,319 | 660 |
| -4- | 41,348 | 3,446 | 1,723 | 1,591 | 796 |
| -5- | 48,415 | 4,035 | 2,018 | 1,863 | 932 |
| -6- | 55,482 | 4,624 | 2,312 | 2,134 | 1,067 |
| -7- | 62,549 | 5,213 | 2,607 | 2,406 | 1,203 |
| -8- | 69,616 | 5,802 | 2,901 | 2,678 | 1,339 |
| For each additional family member add | 7,067 | 589 | 295 | 272 | 136 |

PRIVACY STATEMENT - SOCIAL SECURITY NUMBERS and OTHER INFORMATION

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 your child for free or reduced price meals. You must include the last 4 digits of the social security number of the adult household member who signs the application. The last 4 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 for Needy Families (TANF) Program case number or Food Distribution Program on Indian Reservations (FDPIR) identifier for your child 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 your child is eligible for free or reduced price meals and for administration and enforcement of the lunch and breakfast programs. We **may** share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs; auditors for program reviews; and law enforcement officials to help them look into violations of program rules. We may share the information on this form with Medicaid or the State Children's Health Insurance Program (SCHIP), unless you tell us not to. The information, if disclosed, will only be used to identify eligible children and seek to enroll them in Medicaid or SCHIP.

NON-DISCRIMINATION STATEMENT

This explains what to do if you believe you have been treated unfairly. "In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discrimination on the basis of race, color, national origin, sex, age, or disability." To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call, toll free (866) 632-9992 (Voice). Individual who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay at (800) 877-8339 or (866) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."