

**OHIO CHILD AND ADULT FOOD CARE FOOD PROGRAM: FAMILY CHILD CARE COMPONENT  
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICED MEALS - FY2012**

Income eligibility information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure and their decision will not affect their children's eligibility for free and reduced-price meals. **Forms must be updated annually and are valid for only 12 months.**

**PART 1 – CHECK** Application Type:

- 1. Provider requesting Tier I status by application (May only qualify through Food Assistance, Ohio Works First (OWF) or Income. PROOF OF INCOME IS REQUIRED to qualify as a Tier I provider by this application.
- 2. Provider is requesting meals for own/residential children **enrolled** for childcare. (May only qualify through Food Assistance, OWF or Income.)
- 3. Provider or Parent requesting meals for foster child. In certain cases, foster children are eligible for free and reduced-price meals regardless of household income.
- 4. Parent requesting child meals with family child care provider: (May qualify through Food Assistance, OWF, WIC, Healthy Start or Income.)

**Write the name of your child care provider here:** \_\_\_\_\_

**PART 2 – CHILD INFORMATION:** Print information below for all children whose meals will be claimed on the CACFP.

**BENEFIT INFORMATION:** Enter the benefit program from PART 1 that automatically qualifies a child for Tier I meals. Enter the NAME and CASE or ID Number.

PRINT INFORMATION FOR ALL CHILDREN ENROLLED IN CARE			CHECK IF A FOSTER CHILD (the legal responsibility of a welfare agency or court).	LIST EACH CHILD'S FOOD ASSISTANCE OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 10 OR 12 DIGITS. DO NOT USE SWIPE CARD NUMBER.
* NAME OF ENROLLED CHILD(REN)	* AGE	* BIRTH DATE		Circle type of benefit: FOOD ASSISTANCE or OWF
1.			<input type="checkbox"/>	CASE NUMBER: _____
2.			<input type="checkbox"/>	CASE NUMBER: _____
3.			<input type="checkbox"/>	CASE NUMBER: _____
4.			<input type="checkbox"/>	CASE NUMBER: _____

**PART 3 – TOTAL HOUSEHOLD SIZE AND TOTAL HOUSEHOLD GROSS INCOME:** List names of all household members. List all gross income: list how much and how often. If Part 2 is completed, skip to Part 4.

a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	b. CHECK IF NO/ZERO INCOME	c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED: Weekly, Every 2 Weeks, Twice a Month, Monthly, Yearly			
		1. Earnings from work before deductions	2. Welfare payments, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA	4. All Other Income
1.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
2.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
3.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
4.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
5.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

**PART 4 – SIGNATURE AND SOCIAL SECURITY NUMBER:** Adult household member must sign form. If Part 3 is completed, the adult signing the form must also list last 4 digits of his or her Social Security Number or check the "I do not have a Social Security Number" box.

I certify that all information on this form is true and correct and that all income is reported. I understand that the center will get Federal Funds based on the information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

* _____ SIGNATURE OF ADULT HOUSEHOLD MEMBER	* _____ DATE	If Part 3 is completed, insert last 4 digits of Social Security Number <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (check if applicable) <input type="checkbox"/> I do not have a Social Security Number
Print Name: _____	Daytime Phone Number: _____	Work Phone Number: _____
Street / Apt: _____	City / State / Zip: _____	County: _____

**PART 5: RACIAL/ETHNIC IDENTITY (Optional):** Please check appropriate boxes to identify the race or ethnicity of enrolled child (ren) :

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other

Please mark one ethnic identity: Hispanic or Latino  Not Hispanic or Latino

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.

State Distribution: Week of 6/27/2011

-----SPONSOR MUST COMPLETE THIS SECTION-----

Zero Income Temporary Free Approval Until: _____	Provider Tier I	Residential Child	Child Tier I	Total Household Income \$ _____	Signature of Official _____	Date _____
Approved	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Must be reviewed again in 45 days.	Denied	<input type="checkbox"/>	<input type="checkbox"/>	Total Household Size _____		

EXPIRATION DATE OF FORM \_\_\_\_\_

## FREE & LOW – COST HEALTH CARE

Families with children eligible for school meals may be eligible for free & low - cost health coverage through Healthy Start & Healthy Families. If you are interested in information from Healthy Start & Healthy Families call 1-800-324-8680 or contact the web site at: [www.state.oh.us/odjfs/ohp/bcps/hshf/index.stm](http://www.state.oh.us/odjfs/ohp/bcps/hshf/index.stm) Note: If you have an Ohio Medicaid Card, you are already getting this coverage.

### HOW TO COMPLETE THE OHIO CACFP FAMILY CHILD CARE INCOME ELIGIBILITY APPLICATION

1. PART 1 – Mark the box that applies in PART 1. If marking box 4, enter the home care provider's name in the space.
2. PART 2 – Enter the names of all children who will be claimed for meal reimbursement. If you are receiving benefits from programs such as Food Assistance or Ohio Works First (OWF) enter the case number. PARENTS checking # 4 in Part 1 and qualifying through other categorically eligible benefit programs (WIC, Healthy Start), enter the name for the benefit program and the case or identification number. The Family Child Care Sponsoring Organization may request additional documentation to verify participation.
3. PART 3 - Complete this part only if benefit name and case number in PART 2 are blank. Enter the names of all household members. A household is defined as a group of related or unrelated individuals who are living as one economic unit that share housing and/or significant income and expenses of its members. Income is any money received on a recurring basis, including gross earned income. Enter the gross income (amount before taxes are taken out) for the past month for each person with income. Monthly Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a Month x 24. Proof of income is required for Providers qualifying for Tier I by application (attach the documents that support the income entries).
4. PART 5 – A household member (provider, when using income to determine Tier eligibility, parent or guardian) must sign and date the form. If PART 3 is completed, the last 4 digits of your social security number must be entered. If the adult does not have a social security number, check the box that indicates they do not have one. If a valid Food Assistance or OWF case number or other eligible state identified benefit program and case or identification number is listed in Part 2, a social security number is not required. Enter the address and phone number information. **REMEMBER TO SIGN AND DATE THE FORM.**
5. PART 6 – Complete the racial/ethnic, check the appropriate box. Parents/guardians are not required to complete this section.

### REDUCED INCOME ELIGIBILITY GUIDELINES – 185%

Guidelines to be effective from July 1, 2011 through June 30, 2012

Households with incomes less than or equal to the reduced price values below are eligible for free or reduced-price meal benefits.

<u>HOUSEHOLD SIZE</u>	<u>YEAR</u>	<u>MONTH</u>	<u>TWICE PER MONTH</u>	<u>EVERY TWO WEEKS</u>	<u>WEEK</u>
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