OHIO CHILD AND ADULT FOOD CARE FOOD PROGRAM: FAMILY DAY CARE HOMES COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICED MEALS
Fiscal Year 2016-2017

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 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, OWF or WIC 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, OWF or WIC
1.			☐	CASE NUMBER: _ _ _ _ _ _ _ _ _ _ _ _
2.			☐	CASE NUMBER: _ _ _ _ _ _ _ _ _ _ _ _
3.			☐	CASE NUMBER: _ _ _ _ _ _ _ _ _ _ _ _
4.			☐	CASE NUMBER: _ _ _ _ _ _ _ _ _ _ _ _

PART 3 – TOTAL HOUSEHOLD SIZE AND TOTAL HOUSEHOLD GROSS INCOME: List names of all household members. List all gross income; include 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 RECEIVED: Weekly, every two weeks, twice monthly, monthly, annually			
		1. Earnings from work before deductions	2. Welfare payments, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA	4. All Other Income
1.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
2.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
3.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
4.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
5.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____

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 four digits of his or her Social Security Number or check the box marked, "I do not have a Social Security Number."

I certify that all information on this form is true and correct and that all income is reported. I understand that the center will receive 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 four digits of Social Security Number** ☐☐☐☐ **(check if applicable) 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)

	American Indian or Alaska Native		Asian		Black or African American
	Native Hawaiian or Other Pacific Islander		White		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: 07/15/2016**

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

	Provider Tier I	Residential Child	Child Tier I
Approved	☐	☐	☐
Denied	☐	☐	☐

Total Household Income
$_____

Total Household Size
_____

_____
Signature of Official **Date**

Note: If using parent signature date to determine effective/expiration date of all forms, then option must be selected on CRRS management plan.

_____ **Effective Date** (From the first month of date Categorized by sponsor/center)

_____ **Expiration Date** **(Valid until last day of month of which form was dated and categorized by sponsor/center one year earlier)**

FREE AND LOW COST HEALTH CARE

Families with children eligible for school meals may be eligible for free low cost health coverage. For more information, please contact Healthy Start & Healthy Families at 1-800-324-8680 or www.state.oh.us/odjfs/ohp/bcps/hshf/index.stm Note: If you have an Ohio Medicaid Card, you already receive this coverage.

HOW TO COMPLETE THE OHIO CACFP FAMILY DAY 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, Ohio Works First (OWF) or Women, Infants and Children (WIC), enter the case number. PARENTS checking #4 in Part 1 and qualifying through other categorically eligible benefit programs 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 two 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 four 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, Ohio Works First (OWF) or Women, Infants and Children (WIC) case number is listed in Part 2, a social security number is not required. Enter the address and phone number information. REMINDER: Please 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, 2016 through June 30, 2017
Households with incomes less than or equal to the reduced price values below are eligible for free or reduced-price meal benefits.

HOUSEHOLD SIZE	ANNUAL	MONTH	TWICE PER MONTH	EVERY TWO WEEKS	WEEK
1	21,978	1,832	916	846	423
2	29,637	2,470	1,235	1,140	570
3	37,296	3,108	1,554	1,435	718
4	44,955	3,747	1,847	1,730	865
5	52,614	4,385	2,193	2,024	1,012
6	60,273	5,023	2,512	2,319	1,160
7	67,951	5,663	2,832	2,614	1,307
8	75,647	6,304	3,152	2,910	1,455
For each additional family member, add	7,696	642	321	296	148