



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
 CHILD AND ADULT CARE FOOD PROGRAM
INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS

To apply for free or reduced-price meal eligibility benefits for your child(ren), please fill out this form and return it to the child care center.

PART 1 CHILDREN ENROLLED AT THE CHILD CARE CENTER

Complete information below for children enrolled at the center. If child(ren) are receiving Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamp) or Temporary Assistance (formerly AFDC, now funded by TANF), complete Parts 1, 3, and 4 only. Complete Parts 1, 2, 3, and 4 if you did not provide a SNAP case number or Temporary Assistance case number **for all of the children listed in Part 1.**

| NAME (first and last) | BIRTH DATE | FOSTER CHILD | SNAP CASE NUMBER | TEMPORARY ASSISTANCE CASE NUMBER |
|-----------------------|------------|--------------|------------------|----------------------------------|
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PART 2 HOUSEHOLD AND INCOME INFORMATION

List all members of the household including the children listed in Part 1. Indicate source and amount of current monthly gross income for all members of the household before deductions, such as taxes and social security. Where there are wage earners and self-employed adults, the income of the wage earner cannot be offset by the business losses of the self-employed adult. If last month's income does not accurately reflect your circumstances, you may provide a projection of your current annual income. Irregular self-employed income may be averaged over the prior 12 months. Foster children may be eligible regardless of household income. Contact the center for more information.

| INCOME BASED ON (CHECK ONE) | YEARLY <input type="checkbox"/> | MONTHLY <input type="checkbox"/> | 2 X A MONTH <input type="checkbox"/> | EVERY 2 WEEKS <input type="checkbox"/> | WEEKLY <input type="checkbox"/> |
|-----------------------------|---------------------------------|----------------------------------|---------------------------------------|--|---------------------------------|
| HOUSEHOLD MEMBERS | GROSS WAGES | WELFARE, CHILD SUPPORT, ALIMONY | PENSIONS, RETIREMENT, SOCIAL SECURITY | OTHER | |
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PART 3 RACIAL ETHNIC INFORMATION (You are not required to answer this section)

Are you of Hispanic or Latino origin? YES NO

What is your race? (Select one or more)

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|---|--------------------------------|--|--|--------------------------------|
| 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"/> |
|---|--------------------------------|--|--|--------------------------------|

PART 4 SIGNATURE

I hereby certify that all information provided is correct. I understand that this information is being given in connection with the receipt of federal funds, that institution officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

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|----------------------------------|------------------------|--------------|
| SIGNATURE OF ADULT FAMILY MEMBER | SOCIAL SECURITY NUMBER | DATE |
| PRINTED NAME OF ADULT | ADDRESS | PHONE NUMBER |

Section 9 of the National School Lunch Act requires that, unless your children's SNAP or Temporary Assistance case number is provided, you must include a social security number of the adult household member signing the application or indicate that the household member signing the application does not possess a social security number. Provision of a social security number is not mandatory, but if a social security number is not provided or an indication is not made that the signer has none, the application cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the accuracy of information stated on the application. These verification efforts may be carried out through program reviews and investigations, and may include contacting employers to determine income, contacting a SNAP or welfare office to determine current certification for receipt of SNAP or Temporary Assistance benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to provide the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

FOR CENTER USE ONLY

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|-----------------------|---------|--|--------------------------|--------------------------|
| TOTAL HOUSEHOLD SIZE: | INCOME: | INCOME BASED ON (CHECK ONE): | SNAP (Food Stamp) | TEMPORARY ASSISTANCE |
| | | YEAR <input type="checkbox"/> MONTH <input type="checkbox"/> 2 X A MONTH <input type="checkbox"/> EVERY 2 WEEKS <input type="checkbox"/> WEEKLY <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Eligibility Determination: Free Reduced Paid

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| SIGNATURE OF CENTER REPRESENTATIVE | DATE |
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