Dropped Date: __________ Re-Entered Date: __________ Transferred Date: ____________

CACFP 106 (Rev. 06-17)
FY 2018 FRPM Application

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

MEAL BENEFIT INCOME ELIGIBILITY FORM

FREE AND REDUCED PRICE MEAL (FRPM) APPLICATION FORM (October 1, 2017 – September 30, 2018)

INSTITUTION NAME: ________________________________ FACILITY NAME: ____________________

PART1. CHILD OR ADULT ENROLLED TO RECEIVE DAY CARE **(USE A SEPARATE APPLICATION FOR EACH PARTICIPANT)**

Print Name of Participant:	(First, Middle Initial, Last)		Age	DOB (mm/dd/yy)
Foster Child?	Yes _____	No: _____	If participant is in Foster Care, Eligibility is **FREE**. Enter Foster Child's **Personal Income Earned** in Part 2, Section 4 **(If applicable)**	
Enter CID # for Child or Adult Care, if applicable :				
Enter FITAP or FDPIR # for Child or Adult Care, if applicable:				
Enter SSI/Medicaid # for Adult Day Care Only				

PART 2. Total Household Gross Income

If you listed a CID/FITAP/FDPIR/SSI/Medicaid case # above, Eligibility is FREE (Skip PART 2.)

A. Name (List **everyone** in household, including child listed above)	**B. Gross income and how often it was received** Examples: $100 / monthly $100 / twice a month $100 / every two weeks $100 / weekly				**C. Check if NO income**
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement	4. All Other Income	
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑

PART 3: USDA Supplemental Annual Enrollment Information: (This section must be completed annually by an adult household member for all children enrolled at Child Care Centers participating in the USDA Child and Adult Care Food Program.)

Expected Days of participation: _____ **Monday** _____ **Tuesday** _____ **Wednesday** _____ **Thursday** _____ **Friday**

Expected Hours of participation: From____ To ____ or Before School: From _____To_____ Afterschool: From _____To_____

Expected Meal participation: ______ **Breakfast** _______ **Lunch** ______ **Snack**

PART 4. Adult Signature, Social Security Number, and Contact Information

An adult household member must sign this form. If **Part 3** is completed, the adult signing the form must also list his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on page 2.)

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 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.

Sign Here: ______________________________ Print Name: ____________________ Date: __________

Address: ____ Phone Number: ______________

Social Security Number: XXX -XX - __ __ __ __ ❑ I do not have a Social Security Number

Part 5. Participant's ethnic and racial identities (optional)

Mark one ethnic identity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino **Mark one or more racial identities:** ❑ Asian ❑ White ❑ Black or African American ❑ American Indian or Alaskan Native ❑ Native Hawaiian or Other Pacific Islander

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: ❑ Month, ❑ Twice a month, ❑ Every two weeks, ❑ Week, ❑ Year Household size: __________

Eligibility Determination: _______Free ❑ CID(Food Stamp)/FITAP/FDPIR/SSI/Medicaid Eligible ______Reduced _______Above/ Paid

Extended Categorical Eligibility Validation Attached ____YES ____NO

Determining Official's Signature: ____ Date: ______________