

Child and Adult Care Food Program (CACFP) Day Care Home (DCH) Provider Income Eligibility Form 2022-2023

Provider Name: _____

Additional instructions for completing this form are on the back of this sheet. If you have questions, please contact the Sponsor for help.

1. List the Full Name (first and last name) of Participant attending the center.	Check box if	List the Full Name (first and last name) of Participant attending the center.	Check box if	List the Full Name (first and last name) of Participant attending the center.	Check box if
Name: _____	<input type="checkbox"/> Foster <input type="checkbox"/> Homeless <input type="checkbox"/> Migrant <input type="checkbox"/> Runaway <input type="checkbox"/> Head Start	Name: _____	<input type="checkbox"/> Foster <input type="checkbox"/> Homeless <input type="checkbox"/> Migrant <input type="checkbox"/> Runaway <input type="checkbox"/> Head Start	Name: _____	<input type="checkbox"/> Foster <input type="checkbox"/> Homeless <input type="checkbox"/> Migrant <input type="checkbox"/> Runaway <input type="checkbox"/> Head Start

2. If any member of the household receives 3SquaresVT or Reach Up, provide the name of the individual receiving the benefit and the case number associated with the benefit. **If completed, skip to Number 5.**

Name: _____ Case Number: _____

3. List the Full Name(s) (first and last name) of Household Members . This includes all people living in the household.	Check if no income	4. Enter gross income (before deductions) of each household member for the last month under how often it is received (Weekly, monthly, every two weeks, twice a month, or annually).														
		Gross Earnings from Work – Before Deductions					Child Support, Alimony or Welfare					Social Security, Pensions, Retirement or Other Income				
		Week	Every Two Weeks	Twice per Month	Month	Annual	Week	Every Two Weeks	Twice per Month	Month	Annual	Week	Every Two Weeks	Twice per Month	Month	Annual
	<input type="checkbox"/>															
	<input type="checkbox"/>															
	<input type="checkbox"/>															
	<input type="checkbox"/>															
	<input type="checkbox"/>															
	<input type="checkbox"/>															

5. Please provide a signature and the last four digits of the signer's social security number.

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of Federal funds. Officials may verify the information on the application and deliberate misrepresentation of information may be subject to prosecution under applicable State or Federal laws.

Signature of Parent or Legal Guardian: _____	Street Address _____	City _____
Social Security Number: XXX – XX – _____	State _____	Zip code _____
<input type="checkbox"/> I do not have a Social Security Number	Home/Cell Phone _____	Date Signed _____

Other Benefits: For information on free or low-cost health insurance contact Green Mountain Care at 1-800-250-8427 or www.GreenMountainCare.org. For information on 3SquaresVT to help with food costs, call 1-800-479-6151 or visit www.vermontfoodhelp.com.

THE SPACE BELOW IS FOR CENTER USE ONLY

Household Size: _____ Total Income Reported _____ Per Time Period Annually Monthly Twice per Month Every Two Weeks Weekly

Annual Income Conversion – Weekly x 52 • Every 2 weeks x 26 • Twice a Month x 24 • Monthly x 12	Eligibility Determination (Below): Check the box and circle the qualifying reason.	
Be sure to use the Current Income Eligibility Guidelines for CACFP to approve this form. To be valid, this form must be signed and dated by the individual approving the form.	<input type="checkbox"/> Tier 1 Income 3SquaresVT or Reach Up Foster, Homeless, Migrant, Runaway, Head Start	<input type="checkbox"/> Tier 2 Over Income Incomplete Application
Signature of Approver _____ Date _____		

Vermont Agency of Education

Instructions:

Number 1: Print the **Full Name(s) (first and last name)** of Participant(s) attending the provider’s care. If the participant(s) is **Homeless, Migrant, or Runaway** check the appropriate box and contact the local school’s Homeless Liaison or Migrant Coordinator. If the participant participates in **Head Start** check the appropriate box.

Number 2: If the participant(s) lives in a household that receives **3SquaresVT** or **Reach Up**, please list the name of the individual receiving the benefit and the case number here.

Number 3: Print the **Full Name(s) (first and last name)** of each person living in the household, related or not (such as grandparents, other relatives, or friends).

Number 4: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly. For earnings, be sure to list gross income – not take-home pay. *Gross income* is the amount earned before taxes and other deductions. This should be on your pay stub, or your boss can tell you. For *child support, alimony, or welfare* list the amount each person got for the month. *Pensions, retirement, Social Security, Supplemental Security Income (SSI), Veterans Benefits (VA benefits), and disability benefits* must be listed for each person who received these benefits. Under *Any other Income* list Worker’s Compensation, unemployment or strike benefits, regular contributions from people who do not live in your household, and any other income. Do not include income from 3SquaresVT, WIC, Federal Education benefits and foster payments received by the family from the placing agency. For **ONLY** the self-employed, under *Earnings from Work*, report income after expenses. This is for your business, farm, or rental property. If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.

Number 5: Adult household member must sign the form and list the last four digits of the Social Security number.

Income Eligibility Guidelines

The chart below shows reduced-priced guidelines. Households earning more than the income(s) listed per time period below are Over Income.

Please refer to the Current Income Eligibility Guidelines to view free guidelines.

Household Size	Yearly	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	25,142	2,096	1,048	967	484
2	33,874	2,823	1,412	1,303	652
3	42,606	3,551	1,776	1,639	820
4	51,338	4,279	2,140	1,975	988
5	60,070	5,006	2,503	2,311	1,156
6	68,802	5,734	2,867	2,647	1,324
7	77,534	6,462	3,231	2,983	1,492
8	86,266	7,189	3,595	3,318	1,659
For each additional household member add	8,732	728	364	336	168

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 four digits of the social security number of the adult household member who signs the application. The last four 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 (3SquaresVT), Temporary Assistance for Needy Families (Reach-Up) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other 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.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA’s TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf> from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant’s name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: 1. **mail:** U.S. Department of Agriculture Office of the Assistant Secretary for Civil Right 1400 Independence Avenue, SW Washington, D.C. 20250-9410; or 2. **fax:** (833) 256-1665 or (202) 690-7442; or 3. **email:** program.intake@usda.gov

This institution is an equal opportunity provider.