Illinois Child Care Bureau

Day Care Provider Name ----------

CHILD AND ADULT CARE FOOD PROGRAM – HOUSEHOLD ELIGIBILITY APPLICATION FOR PARENT/GUARDIANS OF ENROLLED CHILDREN IN A DAY CARE HOME

1 LIST EVERYONE IN HOUSEHOLD (Children and Adults)

NAME (First, Middle and Last)	Check If No Income	Date of Birth	Ages of Children Enrolled in Day Care Home	2 FOSTER CHILD Check box for all foster children that are a legal responsibility of DCFS or the court.
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐

3 CATEGORICAL ELIGIBILITY FOR FEDERAL OR STATE PROGRAMS

Name of Child: _____

SNAP or TANF Number:

— — — — — — — — — — —

WIC Number _

OTHER CATEGORICAL ELIGIBILITY –

☐ Low Income Home Energy Assistance Program

☐ Other Extended Categorical

4 OPTIONAL—SHARING INFORMATION WITH *ALL KIDS INSURANCE PROGRAM*

May we share your information on this application with *All Kids Insurance Program*, the complete health insurance program for every child in Illinois? If yes, do not sign below.

No, I do not want my information from this application shared with *All Kids Insurance Program.* *Sign here:* _____

5 HOUSEHOLD MEMBERS WITH INCOME—List only the names of individuals living in the household, their gross income, and how often it is received. If a person has a second job, list that income in the last column. After completing, **go to Number 6.**

NAMES (List only individuals with income)	Earnings from Work (Gross before Deductions)		Income from Welfare, Child Support, Alimony		Income from Retirement, Pensions, SSI, Social Security		Income Received From Savings, Investments, Trust Accounts, and Other Resources	
	How Much?	How Often?	How Much?	How Often?	How Much?	How Often?	How Much?	How Often?
	$ /		$ /		$ /		$ /	
	$ /		$ /		$ /		$ /	
	$ /		$ /		$ /		$ /	
	$ /		$ /		$ /		$ /	
	$ /		$ /		$ /		$ /	

6 Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Number 5 above is completed the adult signing the form must also list the last four digits of his or her social security number or mark the box *I do not have a social security number.*

X X X - X X - _____ Social Security Number

☐ I **do not** have a social security number.

I certify all information on this application is true and all income is reported. I understand the day care provider will get federal funds based on the information I give. I understand the institution, Illinois State Board of Education, or Office of Inspector General, may verify this information on the application. Deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Date *Printed Name of Adult Household Member* *Signature of Adult Household Member* *Address of Adult Household Member*

***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 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 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 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 Child and Adult Care Food Program. 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.*

***NON-DISCRIMINATION STATEMENT**: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

SPONSOR REPRESENTATIVE USE ONLY—ELIGIBILITY DETERMINATION—Follow the instructions provided in the Household Income instructions.

Mark one of the boxes below to show how you are going to determine eligibility.

☐ **Categorically Eligible for Federal or State Program**

☐ **Income Household**

Use the conversion table to convert income to total

☐ Approved for Tier I Meal Rate ☐ Denied ☐

Signature of Representative: _____

CONVERSION TABLE	annual income. Total the number of household members from Section 5.	
To convert all income to annual income use the following conversion calculations: Weekly Income x 52 Every 2 Weeks x 26 Twice a Month x 24 Monthly x 12	Total Household Annual Income $_____ Total Household Size _____	_____ *Date* **Effective Date of Application:* _____ **Effective Date may be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month in which the child's eligibility is certified.*

INCOME ELIGIBILITY GUIDELINES

July 1, 2021 through June 30, 2022

Reduced-Price Meals
185% Federal Poverty Guideline

Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	23,828	1,986	993	917	459
2	32,227	2,686	1,343	1,240	620
3	40,626	3,386	1,693	1,563	782
4	49,025	4,086	2,043	1,886	943
5	57,424	4,786	2,393	2,209	1,105
6	65,823	5,486	2,743	2,532	1,266
7	74,222	6,186	3,093	2,855	1,428
8	82,621	6,886	3,443	3,178	1,589
Each Additional Family Member Add	8,399	700	350	324	162