Delaware Department of Education
Child Nutrition Programs Office
Child and Adult Care Food Program (CACFP)

Highlight Codes
Yellow ~ Parent Circle One Blue ~ Parent Fill-in
Green Admin Completion

INCOME ELIGIBILITY FORM

PART 1 *(This part must be completed for all participants. Enter the participant(s) name and information.)*

Participant's Name: _____ **DOB:** _____
Last First Middle Initial

Hispanic/Latino **Not Hispanic/Latino** *(Choose one ethnicity-Required for statistical reporting)*

White **Black** **American Indian/ Alaskan Native** **Native Hawaiian/ Pacific Islander** **Asian**
(Choose one or more regardless of ethnicity – Required for Statistical reporting)

Participant's Name: _____ **DOB:** _____
Last First Middle Initial

Hispanic/Latino **Not Hispanic/Latino** *(Choose one ethnicity-Required for statistical reporting)*

White **Black** **American Indian/ Alaskan Native** **Native Hawaiian/ Pacific Islander** **Asian**
(Choose one or more regardless of ethnicity – Required for Statistical reporting)

Start Date: _____ **Arrival Time:** _____ **AM/PM** **Departure Time:** _____ **AM/PM** **Shift Work:** **Yes/No**

***Normal* days of week Participant(s) is/are in care** *(circle all that apply):* **Mon** **Tues** **Wed** **Thurs** **Fri** **Sat** **Sun**

Meals eaten at Providers/Center: *(Circle all that apply. CACFP provides reimbursement for up to 2 approved meals and one snack per day/participant)*:
Breakfast X **AM Snack** **Lunch X** **PM Snack X** **Supper** **Evening Snack**

PART 2 - HOUSEHOLD AND INCOME INFORMATION

PART 2A – HOUSEHOLDS NOW GETTING SNAP OR TANF: *Complete this Part; skip to Part 3 to sign and date this form.*
SNAP Case Number (i.e., Food Stamp): **TANF Case Number:**

PART 2B – FOSTER CHILD - Check box if a foster child: ☐* (The legal responsibility of a welfare agency or court.) Include personal income earned by the foster child only. Foster payments received by the family from the placing agency are not considered income and do not need to be reported. Write the child's income: _____ ☐ Month/☐ Year. ***A copy of the State or local agency document indicating a child's foster status is required to be on file at the child care institution.** *Complete this part; skip to Part 3 to sign and date this form.*

PART 2C – HOMELESS - Check Box if homeless: ☐ *Complete this part; skip to Part 3 to sign and date this form.*

PART 2D – HOUSEHOLD INCOME – *If you do not need to complete Part 2A, 2B, or 2C, complete this Part and Part 3 to sign and date this form.*

HOUSEHOLD MEMBERS NAMES List Names of All Household Members (Attach Any Additional Members)	CURRENT INCOME (Please indicate by income as weekly, bi-weekly, 2x's a month, monthly or yearly) Earnings from Work (Before Deductions) Job 1	Welfare, Child Support, Alimony	Payments from Pensions, Retirement, Social Security	Earnings from Job 2 or any Other Income
(Example) - Jane Smith	$ 200/weekly	$ 150/twice a month	$ 100/monthly	$
1	$	$	$	$
2	$	$	$	$
3	$	$	$	$
4	$	$	$	$
5	$	$	$	$
6	$	$	$	$

PART 3 – SIGNATURE and LAST FOUR OF SOCIAL SECURITY NUMBER

An adult household member must sign and date this form before it can be approved. If Part 2D is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.) **PENALTIES FOR MISREPRESENTATION:** I certify that all of the above information is true and correct, that the SNAP or TANF Number is correct, and that all income is reported. I understand that this information is being given for the receipt of Federal funds; that institution officials may verify the information on the statement, and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Printed Name of Adult _____ **Signature of Adult** _____ **Date** _____

Home Address: _____ **Zip** _____

Home Phone: (_____ **Work Phone:** (_____

Last four digits of Social Security Number: * * * - * * - ☐ I do not have a Social Security Number

SPONSOR USE ONLY:

Categorical Eligibility (If Yes, Check One): ☐ SNAP (Food Stamp) Household
☐ TANF Household ☐ Head-Start ☐ ECAP ☐ Foster Child(ren) ☐ Homeless Participant(s)

DATE WITHDRAWN: _____

Total Family Income: $ _____ **Family Size:** _____ (Include all Participants)

Yearly Income Conversion: ***Weekly x 52; Every Two Weeks x 26; Twice a Month x 24; Monthly x 12***

ELIGIBILITY - Based on the information provided this application will be:
☐ Approved FREE ☐ Approved REDUCED ☐ **Denied – The meals will be claimed in the PAID category.**
Determining Official Signature: _____ **Review/Effective Date:** _____