Letter for Non-Pricing Institutions
Child and Adult Care Food Program

Dear Parent or Guardian:

Please fill out the attached form and return it as soon as possible. The form will be kept in our files and treated as confidential. The information you give will help us get money for the meals served to children in our program through the U. S. Department of Agriculture's Child and Adult Care Food Program.

If you receive SNAP (Food Stamps) or TANF funding, fill out top of Part 3 of the form with your case number.

If you have a foster child in our program (he/she must be a legal ward of the State), check the applicable box in Part 1. If you are homeless, check (☑) the box in part 2.

If you do not have a SNAP (Food Stamps) number, TANF case number, or are not a foster child, you **must** fill out Part 3 of the form. Include the income(s) of all people living in your household, related or not (such as grandparents, other relatives, or friends). You must include yourself and all children who live with you. An adult household member *[parent/legal guardian]* must sign and date the form and provide the last four (4) digits of their Social Security number.

The income you report must be last month's total household income, before any taxes or anything else is taken out, for each household member. List the amount you normally get. For example, if you normally get $1,000 each month, but you missed some work last month and only got $900, put down that you get $1,000 per month.

Forms must be signed and dated in Part 3 (IEF without enrollment) and in Part 4 (IEF with enrollment).

Thank you for taking the time to fill out this form. This center participates in the Child and Adult Care food Program through the Sponsor Agency Children & Families First. If you need any help, please contact the center or you may Children & Families First Food Program at 302 479-1683.

INCOME ELIGIBILITY GUIDELINES FOR REDUCED PRICE MEALS

Effective Date July 1, 2023 – June 30, 2024

FAMILY SIZE	YEARLY	MONTHLY	WEEKLY
1	$26,973	$2,248	$519
2	$36,482	$3,041	$702
3	$45,991	$3,833	$855
4	$55,500	$4,625	$1,068
5	$65,009	$5,418	$1,251
6	$74,518	$6,210	$1,434
7	$84,027	$7,003	$1,616
8	$93,536	$7,795	$1,799
For each additional household member, add:	$9,509	$793	$183

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 Rights
   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.

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

CHILD INCOME ELIGIBILITY FORM CENTER/PROVIDER NAME: _____

PART 1 *(Complete one application per household. Please use a pen, not a pencil.)*

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in **Foster care** and children who meet the definition of **Homeless**, **Migrant** or **Runaway** are eligible for free meals. Read **How to Apply for Free and Reduced Price School Meals** for more information.

Child's First Name	MI	Child's Last Name	Date of Birth	Ethnicity Hispanic or Latino? Yes	No	Race (check one or more) American Indian or Alaskan Native	Asian	Black Or African American	Native Hawaiian or Other Pacific Islander	White	Foster Child	Homeless, Migrant; Runaway
				☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐

PART 2 - ENROLLMENT

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 **AM Snack** **Lunch** **PM Snack** **Supper** **Evening Snack**

PART 3 – HOUSEHOLD INCOME

Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP or TANF?
Check one: ☐ Yes / ☐ No

If you answered NO – Complete Part 3. **If you answered YES** – Write a case number below, then go to Part 4
Case Number: (Write only one case number in this space)

A. Child Income
Sometimes children in the household earn income. Please include the TOTAL income earned by all Child Household Members listed in PART 1 here.

Child Income	How Often? Weekly	Bi-Weekly	2x Month	Monthly
$	☐	☐	☐	☐

B. All Adult Household Members (including yourself)
List all Household Members not listed in Part 1 (including yourself) **even if they do not receive income**. For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any source, write "0". If you enter "0" or leave any fields blank, you are certifying (promising) that there is not income to report.

Name of Adult Household Members (First/Last)	Earnings from Work (Before Deductions)	How Often? Weekly	Bi-Weekly	2x Month	Monthly	Public Assistance/ Child Support/ Alimony	How Often? Weekly	Bi-Weekly	2x Month	Monthly	Pensions/SSI/ Retirement/ All Other Income	How Often? Weekly	Bi-Weekly	2x Month	Monthly
1	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
2	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
3	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
4	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
5	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

PART 4 – CONTACT INFORMATION and ADULT SIGNATURE

An adult household member must **sign and date** this form before it can be approved.
"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Total Household Members (Children and Adults)		**Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household** * * * - * * - ____ ____ ____ ____	Check if No SSN ☐

Street Address (if available)	City	State	Zip	Daytime Phone and Email (optional)
Printed Name of adult completing the form	Signature of adult completing the form			Today's Date

SPONSOR USE ONLY:

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

DELAWARE DEPARTMENT OF EDUCATION CHILD AND ADULT CARE FOOD PROGRAM (CACFP) ENROLLMENT FORM

Day Care Provider/Child Care Center

Name: ____

Provider/Center's Name

Address: ______________________________ **Telephone:** ____________________

Address

City: ___________________________ **State:** ________________ **Zip:** _____________

Participant(s) Information

______________________________________ ______________________ **M/F**

Name of CACFP Participant **Date of Birth** (Circle)

Hispanic/Latino	Not Hispanic/Latino	White	Black	American Indian/Alaskan Native	Native Hawaiian/Pacific Islander	Asian
(Choose one ethnicity)		*(Choose one or more regardless of ethnicity)*				

______________________________________ ______________________ **M/F**

Name of CACFP Participant **Date of Birth** (Circle)

Hispanic/Latino	Not Hispanic/Latino	White	Black	American Indian/Alaskan Native	Native Hawaiian/Pacific Islander	Asian
(Choose one ethnicity)		*(Choose one or more regardless of ethnicity)*				

______________________________________ ______________________ **M/F**

Name of CACFP Participant **Date of Birth** (Circle)

Hispanic/Latino	Not Hispanic/Latino	White	Black	American Indian/Alaskan Native	Native Hawaiian/Pacific Islander	Asian
(Choose one ethnicity)		*(Choose one or more regardless of ethnicity)*				

Start Date: ____________________________ **Shift work: Yes No**

Arrival Time: _________ **AM/PM** (Circle) **Departure time:** ___________ **AM/PM** (Circle)

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

Meals eaten at Provider Home/Day Care Center: (Circle all that apply.)
Breakfast AM Snack Lunch PM Snack Supper Evening Snack

Parent/Guardian:

Name ____ **Telephone:** ____________________

Address: ____
City State Zip Code

Signature: ____________________________ ________________________
Parent/Guardian/Participant Date

Sponsor Use Only

_____ _____

Determining Official **Date**

Participant/s Exit Date: _____

USDA Nondiscrimination 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.