

## APPLICATION FOR FREE AND REDUCED PRICE MEALS

### **DIRECTIONS** FOR CHILD AND ADULT CARE FOOD PROGRAM CENTERS, MINISTRIES, SPONSORING ORGANIZATIONS AND FAMILY DAY CARE HOME PROVIDERS

#### **ORGANIZATIONS MUST USE THE FOLLOWING PROTOTYPE FORMS UNLESS APPROVAL HAS BEEN GIVEN FOR MODIFICATIONS:**

REQUIRED INFORMATION THAT *MUST* BE PROVIDED TO HOUSEHOLDS AND DAY CARE HOME PROVIDERS:

- LETTER TO HOUSEHOLDS: CHILD DAY CARE AND TIER II PROVIDERS AND ADULT DAY CARE
- LETTER TO TIER I AND FAMILY DAY CARE HOME PROVIDERS
- APPLICATION FOR FREE AND REDUCED PRICE MEALS: CHILD DAY CARE AND ADULT DAY CARE (WITH INSTRUCTIONS)
- BUILDING FOR THE FUTURE FLYER

NOTE: **LETTERS AND APPLICATION REVISED APRIL 2011.**

*Indiana requires that your application packet be available during a program review.*

The pages are designed to be printed on 8½" by 11" paper. Some pages may be printed front and back. The **[bold bracketed fields]** indicate where you need to insert your specific information of person to contact for assistance and where to submit the completed form(s).

Enter the name of the center contact person and phone number in the first row of the application. On the second row, enter the name of the center OR the name of the home provider.

PART 1: All members of the household (A household member is any child or adult living in the household.) must be listed--first, middle initial, and last name. Birth dates are required for all children. If the household member includes any foster children, the box must be marked to indicate the foster child. Foster children are categorically eligible for free meals and may be included in the number of household members for eligibility determination. In the last column, check the box for household members who have no income. Parent or guardian must sign and provide information in PART 5, however the last four digits of the Social Security number are not required.

PART 2: In this section, the household will indicate the name of the household member who receives food stamps or TANF benefits and enter the case number. All case numbers in Indiana will be ten digits long and begin with 10. If one household member has food stamp or TANF benefits, all children in the household are eligible for free meal benefits. Parent or guardian must sign and provide information in PART 5, however the last four digits of the Social Security number are not required.

PART 3: Enter the center contact's name and phone number as noted. The household will mark the form to indicate if a child is homeless, migrant, or a runaway. Center staff may contact the local school homeless liaison or migrant coordinator or Christina Endres (IDOE Special Programs and Data Collection) at 317-232-0548 for additional information. Parent or guardian

must sign and provide information in PART 5, however the last four digits of the Social Security number are not required.

PART 4: All household members with income must be listed. Gross income and how often received will be included. PART 5 must be completed and the last four digits of the Social Security number are required.

PART 5: Certification Statement must be signed and completed by an adult household member. Social Security information will be required as mentioned above in parts 2-4.

PART 6: Parents and guardians are NOT required to complete the ethnic and racial identities.

PART 7: Parents and guardians MUST side this section if they do not want information shared with Medicaid or Hoosier Healthwise.

The prototype letters also includes information regarding the exclusion of housing allowance for those in the Military Housing Privatization Initiative and pricing programs. Pricing information may be removed from the household letters without approval if the information is not pertinent to your facility.

#### **APPLICATION APPROVAL:**

Section A: Check the box to indicate if the application is based upon categorical eligibility (food stamps, TANF, or foster child) or household income. If household income, enter the household size and income. Compare this information to the current USDA income guidelines to categorize the participant's eligibility.

Section B: Based upon the information in Part A, classify the application as free, reduced price, or paid for centers OR tier I, tier II or tier II mixed for family day care homes.

Sponsors can temporarily approve an application for free meal benefits for 45-days if the household indicates zero income. In this case, complete the information in the section for temporary approval. This must be re-evaluated every 45 days. It is acceptable to ask for a brief note explaining how the household provides food, clothing, and shelter and when income is expected.

Section C: The application must be signed and dated by the person who is responsible for approving the application for free and reduced-price meals as shown in #63-64 on the Sponsor Information form in the CNPweb®. An application is not valid if it is not signed and dated. Each application expires one year from the date it was approved.

If you have questions about the Application for Free and Reduced Price Meals, contact:

<b>CAROL MARKLE</b> <a href="mailto:cmarkle@doe.in.gov">cmarkle@doe.in.gov</a> 800-537-1142, EXT 20873 317-232-0873	<b>MAGGIE ABPLANALP</b> <b>(<a href="mailto:Maggie@doe.in.gov">Maggie@doe.in.gov</a>)</b> 800-537-1142, EXT 20851 317-232-0851
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## CACFP APPLICATION FOR FREE AND REDUCED PRICE MEALS (CHILD CARE)

<b>SPONSOR NAME:</b> THE DAY NURSERY ASSOCIATION OF INDIANAPOLIS, INC.	<b>PHONE NUMBER:</b> 317-636-5727 EXT 249
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<b>CENTER:</b>	<b>FDC PROVIDER:</b>
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<b>PART 1. ALL HOUSEHOLD MEMBERS</b>	BIRTH DATES OF CHILDREN	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 4 TO SIGN THIS FORM.	CHECK IF NO INCOME
NAMES OF ALL HOUSEHOLD (FIRST, MIDDLE INITIAL, LAST)			
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

**PART 2. BENEFITS:** IF ANY MEMBER OF YOUR HOUSEHOLD RECEIVED FOOD STAMPS] OR [STATE TANF CASH ASSISTANCE], PROVIDE THE NAME AND CASE NUMBER FOR THE PERSON WHO RECEIVES BENEFITS. **IF NO ONE RECEIVES THESE BENEFITS, SKIP TO PART 3.**

NAME: \_\_\_\_\_ CASE NUMBER: \_\_\_\_\_

**PART 3.** IF ANY CHILD YOU ARE APPLYING FOR IS HOMELESS, MIGRANT, OR A RUNAWAY CHECK THE APPROPRIATE BOX AND CALL [INSERT CENTER CONTACT AND PHONE NUMBER]      HOMELESS       MIGRANT       RUNAWAY

**PART 4. TOTAL HOUSEHOLD GROSS INCOME—YOU MUST TELL US HOW MUCH AND HOW OFTEN**

A. NAME (LIST ONLY HOUSEHOLD MEMBERS WITH INCOME) <i>(EXAMPLE)</i> JANE SMITH	B. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED			
	1. EARNINGS FROM WORK BEFORE DEDUCTIONS	2. WELFARE, CHILD SUPPORT, ALIMONY	3. PENSIONS, RETIREMENT, SOCIAL SECURITY, SSI, VA BENEFITS	4. ALL OTHER INCOME
	\$200/WEEKLY _____	\$150/TWICE A MONTH _____	\$100/MONTHLY _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

**PART 5. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN)**

AN ADULT HOUSEHOLD MEMBER MUST SIGN THIS FORM. **IF PART 4 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.)

*I CERTIFY THAT ALL INFORMATION ON THIS FORM IS TRUE AND THAT ALL INCOME IS REPORTED. I UNDERSTAND THAT THE CENTER OR DAY CARE HOME 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: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: XXX - XX - \_\_\_\_\_  I DO NOT HAVE A SOCIAL SECURITY NUMBER

## CACFP APPLICATION FOR FREE AND REDUCED PRICE MEALS (CHILD CARE)

A CHILD ENROLLED IN THE DAY CARE FACILITY MAY QUALIFY FOR FREE OR REDUCED PRICE MEALS IF THE HOUSEHOLD INCOME FALLS AT OR BELOW THE LIMITS ON THIS CHART:

JULY 1, 2011 TO JUNE 30, 2012			
HOUSEHOLD SIZE	MONTHLY INCOME	HOUSEHOLD SIZE	MONTHLY INCOME
1	1,679	5	4,035
2	2,268	6	4,624
3	2,857	7	5,213
4	3,446	8	5,802
FOR EACH ADDITIONAL FAMILY MEMBER, ADD \$589			

PART 6. PARTICIPANT'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)	
MARK ONE ETHNIC IDENTITY: <input type="checkbox"/> HISPANIC OR LATINO  <input type="checkbox"/> NOT HISPANIC OR LATINO	MARK ONE OR MORE RACIAL IDENTITIES: <input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER <input type="checkbox"/> BLACK OR AFRICAN AMERICAN

**PART 7: OTHER BENEFITS:** THE LAW ALLOWS US TO TELL MEDICAID AND HOOSIER HEALTHWISE THAT YOUR CHILDREN ARE ELIGIBLE FOR FREE OR REDUCED-PRICE MEALS. WE MAY SHARE YOUR APPLICATION INFORMATION WITH MEDICAID OR HOOSIER HEALTHWISE UNLESS YOU DO NOT WANT US TO. IF YOU DO NOT WANT US TO SHARE THIS INFORMATION, SIGN HERE:

FOR INFORMATION ABOUT HOOSIER HEALTHWISE HEALTH INSURANCE  
CALL 1-800-889-9949

\_\_\_\_\_  
SIGNATURE OF PARENT OR LEGAL GUARDIAN

**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 THE PARTICIPANT 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 FOR THE PARTICIPANT OR OTHER (FDPIR) IDENTIFIER 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 THE PARTICIPANT IS ELIGIBLE FOR FREE OR REDUCED PRICE MEALS, AND FOR ADMINISTRATION AND ENFORCEMENT OF THE PROGRAM.

**NON-DISCRIMINATION STATEMENT:** THIS EXPLAINS WHAT TO DO IF YOU BELIEVE YOU HAVE BEEN TREATED UNFAIRLY. "IN ACCORDANCE WITH FEDERAL LAW AND U.S. DEPARTMENT OF AGRICULTURE POLICY, THIS INSTITUTION IS PROHIBITED FROM DISCRIMINATING ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, SEX, AGE, OR DISABILITY. TO FILE A COMPLAINT OF DISCRIMINATION, WRITE USDA, DIRECTOR, OFFICE OF ADJUDICATION, 1400 INDEPENDENCE AVENUE, SW, WASHINGTON, D.C. 20250-9410 OR CALL TOLL FREE (866) 632-9992 (VOICE). INDIVIDUALS WHO ARE HEARING IMPAIRED OR HAVE SPEECH DISABILITIES MAY CONTACT USDA THROUGH THE FEDERAL RELAY SERVICE AT (800) 877-8339; OR (800) 845-6136 (SPANISH). USDA AND THE STATE OF INDIANA ARE EQUAL OPPORTUNITY PROVIDERS AND EMPLOYERS."

CHILD CARE REPRESENTATIVE USE ONLY	
ANNUAL INCOME CONVERSION: <u>WEEKLY X 52</u> – <u>EVERY 2 WEEKS X 26</u> – <u>TWICE A MONTH X 24</u> – <u>MONTHLY X 12</u>	
<b>SECTION A</b> MARK ONE OF THE BOXES BELOW TO SHOW HOW YOU ARE GOING TO DETERMINE ELIGIBILITY.  <input type="checkbox"/> <b>FOOD STAMP OR TANF HOUSEHOLD</b> —THE FOOD STAMP OR TANF NUMBER MEETS THE CRITERIA FOR AN ACCEPTABLE CASE NUMBER. COMPLETE SECTION B & C <b>OR</b>  <input type="checkbox"/> <b>FOSTER CHILD</b> —COMPARE THE FOSTER CHILD'S PERSONAL INCOME TO THE GUIDELINES. COMPLETE SECTION B & C <b>OR</b>  <input type="checkbox"/> <b>HOUSEHOLD INCOME</b> —COMPLETE THE INFORMATION BELOW AND COMPLETE SECTION B & C  TOTAL HOUSEHOLD SIZE: _____  TOTAL HOUSEHOLD INCOME \$ _____ / _____ <i>EXAMPLE: \$100/WEEK</i>  COMPARE TOTAL HOUSEHOLD INCOME TO CURRENT USDA INCOME ELIGIBILITY GUIDELINES. WHEN THE HOUSEHOLD INCOMES ARE LISTED FOR DIFFERENT PAY PERIODS, YOU MUST CONVERT ALL INCOME TO MONTHLY OR ANNUAL INCOME. USE THE CONVERSION LISTED ABOVE.	<b>SECTION B</b> BASED ON THE INFORMATION PROVIDED, THIS APPLICATION WILL BE: <input type="checkbox"/> APPROVED FREE <input type="checkbox"/> APPROVED TIER I <input type="checkbox"/> APPROVED REDUCED <input type="checkbox"/> APPROVED TIER II <input type="checkbox"/> PAID <input type="checkbox"/> APPROVED TIER II MIXED  <input type="checkbox"/> <b>TEMPORARY APPROVAL</b> <input type="checkbox"/> NA THIS APPLICATION REPORTED ZERO INCOME OR A TEMPORARY REDUCTION IN HOUSEHOLD INCOME. <input type="checkbox"/> APPROVED FREE <input type="checkbox"/> APPROVED REDUCED TEMPORARY APPROVAL IS GOOD FOR 45 DAYS AND EXPIRES ON _____ (DATE). RE-EVALUATE AFTER THAT DATE.  <b>SECTION C</b>  _____ SIGNATURE OF SPONSOR REPRESENTATIVE  _____ DATE OF APPROVAL  <b>THIS FORM EXPIRES ONE YEAR FROM THE DATE IT WAS APPROVED=</b>