



**INCOME ELIGIBILITY & ENROLLMENT FORM FOR CHILD CARE CENTERS**  
**JULY 1, 2021 THROUGH JUNE 30, 2022**

**Part 1. CHILD ENROLLMENT:** Complete the information below for all children in care. If the child is an infant, foster child (legal responsibility of a foster care agency or the court), Head Start eligible or a school-age child, please check the box.

Last Name, First Name	Date of Birth	Enroll Date	Times of Care (Usual)		Usual Days of Care							Meals Served During Care					Infant	School Age	Head Start	Foster Child			
			Arrival Time	Leave Time	M	T	W	T	F	S	S	B	A M	L	P M	D					E V		
																			<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"/>	<input type="checkbox"/>	<input type="checkbox"/>

**OPTIONAL:** Please check the ethnicity and race of the child(ren) you are enrolling.

- Ethnicity (select one or more):  Hispanic or Latino  Not Hispanic or Latino
- Race (select one or more):  American Indian or Alaskan Native  Asian  Black or African American  
 Native Hawaiian or other Pacific Islander  White or Caucasian

**Part 2. Household Receiving Benefits:** Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR): **Complete Parts 1, 2 and 4.**

Check Applicable Program & Provide Case Number(s):  SNAP Case #: \_\_\_\_\_  TANF Case #: \_\_\_\_\_  FDPIR Case #: \_\_\_\_\_

**Part 3A. HOUSEHOLDS EXCEEDING THE INCOME GUIDELINES:** Complete Parts 1, 3A and 4.

If your family income exceeds the income guidelines (listed on attached letter), check this box

**Part 3B. ALL OTHER HOUSEHOLDS** - If you do not have a SNAP, TANF or FDPIR **MASTERCASE** number: Complete Parts 1, 3B and 4.

List the Names of All Household Members not listed in Part 1 and Foster Children	Earnings from Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		All Other Income		Check if ZERO income
	How much?	How often?	How much?	How often?	How much?	How often?	How much?	How often?	
1									<input type="checkbox"/>
2									<input type="checkbox"/>
3									<input type="checkbox"/>
4									<input type="checkbox"/>

Social Security Number of Household Member who signs form:

Last four digits of Social Security Number: XXX-XX - \_\_\_\_\_ If you do not have a Social Security Number, check this box

**Part 4. SIGNATURE AND CONTACT INFORMATION:**

I certify (promise) that all information on this form is true and that all income is reported. I understand that the facility will receive 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 their meal benefits, and I may be prosecuted.

Print Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

E-Mail Address/Telephone \_\_\_\_\_

**FOR SPONSOR USE ONLY**

\_\_\_\_ SNAP/TANF/FDPIR HOUSEHOLD  
\_\_\_\_ ANNUAL INCOME: \_\_\_\_\_ HOUSEHOLD SIZE: \_\_\_\_\_

**HOUSEHOLD CATEGORY:**  Free  
 Reduced  
 Paid  
 Incomplete

**Foster Child - Free Category**  
List name of foster child(ren)  
\_\_\_\_\_

Center Official Signature \_\_\_\_\_ Date of Signature \_\_\_\_\_

Effective Date \_\_\_\_\_ Expiration Date \_\_\_\_\_