| Tennessee Department of Human Services (TDHS) | | Form HS-1949C Revised May 2011 |
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Child and Adult Care Food Program (CACFP)

# INCOME ELIGIBILITY APPLICATION FOR CHILD CARE HOME PROVIDER

**PART 1** – NAME

_____
Last First MI

**PART 2A** - IF YOU ARE CURRENTLY RECEIVING FAMILIES FIRST (FF) CASH ASSISTANCE , OR YOU (OR A MEMBER OF YOUR HOUSEHOLD) ARE RECEIVING SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) BENEFITS, COMPLETE THIS PART AND SIGN THE STATEMENT IN PART 4 - DO NOT COMPLETE PART 2C.) ACCENT Case Number for SNAP or FF Cash Assistance: _____

**PART 2B** - IF YOU COMPLETED 2A ABOVE, IDENTIFY BELOW THE CHILDREN 12 YEARS OF AGE AND UNDER WHO ARE LIVING IN YOUR HOME (ATTACH ADDITIONAL SHEETS AS NECESSARY):

1. _____ Name Birth Date
2. _____ Name Birth Date
3. _____ Name Birth Date

**PART 2C** – ALL OTHER HOUSEHOLDS (If no information is entered in Part 2A above, complete this part, and sign the statement in Part 4. Attach additional sheets as necessary)

| Names of All Household Members | Earnings from Work (Before Deductions) | Child Support, Alimony or Other Income | Payments Received from Pensions, Retirement, & Social Security |
|---|---|---|---|
| 1. | $ _____ per year | $ _____ per year | $ _____ per year |
| 2. | $ _____ per year | $ _____ per year | $ _____ per year |
| 3. | $ _____ per year | $ _____ per year | $ _____ per year |
| 4. | $ _____ per year | $ _____ per year | $ _____ per year |

**Total Number of Household Members:** ___ **Total Yearly Income for Household from All Sources:** $ _____ Yearly income is calculated as follows: Multiply Weekly income by 52, Bi-weekly income (received every two weeks) by 26, Semi-monthly income (received twice a month) by 24, and Monthly income by 12. Do not round up any numbers during the conversion.

**PART 2D** – FOSTER CHILD (Complete this part and sign the statement in Part 4.) If any household member is a foster child, check here: ____. A foster child is the legal responsibility of a state children services agency or court, and is categorically eligible for free meals.

**PART 3** – Medicaid and State Children's Health Insurance Programs – Please check if you do **not** want the information in this application to be shared with the Medicaid and State Children's Health Insurance Programs: ___ DO NOT WANT APPLICATION INFORMATION TO BE SHARED WITH THE MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAMS.

**PART 4** – SIGNATURE (An adult household member must sign the application.) PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct. 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 the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

| Signature of Provider: | Social Security Number (only last four digits): | Home Telephone: |
|---|---|---|
| | | |

**PART 5** – ETHNIC/RACIAL IDENTITY (**You are not required to answer this question.**): **For Ethnicity**, please check one of the following: ___ Hispanic or Latino ___ Not Hispanic or Latino. **For Race**, please check one or more of the following: ___ American Indian or Alaskan Native ___ Asian ___ Black or African American ___ Native Hawaiian or Other Pacific Islander ___ White. Please see the definitions of Ethnicity and Race on the back of this application.

**FOR SPONSORING AGENCY USE ONLY:** Classification (Circle): Tier 1 **or** Tier 2
Basis for Classification (Circle) Categorically Eligible **or** Income Eligible

Determining Official Signature: _____ Date: _____

## INCOME ELIGIBILITY APPLICATION INSTRUCTIONS

**PART 1 - PROVIDER INFORMATION:** All HOUSEHOLDS COMPLETE THIS PART.

(1) Print your full name and address.

**PART 2A - HOUSEHOLDS RECEIVING SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM OR FAMILIES FIRST CASH ASSISTANCE:** COMPLETE THIS PART AND PART 4.

(1) List your current Supplemental Nutrition Assistance Program or Families First Cash Assistance Case Number.

(2) If any portion of this Part is completed, do not complete Part 2C.

**PART 2B - IDENTIFICATION OF CHILDREN 12 YEARS OF AGE AND UNDER WHO ARE LIVING IN YOUR HOME:** COMPLETE THIS PART IF ANY PORTION OF PART 2A IS COMPLETED.

(1) List the names and birth dates of all children who reside in your home and have not reached their thirteenth birthday.

**PART 2C - ALL OTHER HOUSEHOLDS:** COMPLETE THIS PART AND PART 4.

(1) Write the names of everyone in your household. Households with foster and non-foster children may choose to include the foster child(ren) as household members, as well as any personal income earned by the foster child(ren), on the same household application that includes the non- foster child(ren).

(2) Write the amount of the income received on a yearly basis for each household member. The income may be for the current month, the amount projected for the first month the application is made for, or for the month prior to application. This income is the amount before taxes or any deductions are made. Also, indicate the source of the income. Refer to examples below for income to report.

**INCOME TO REPORT**

| Earnings from Work | Retirement/Social Security | Other Income Sources | Child Support/Alimony |
|---|---|---|---|
| Wages/salaries/tips | Pensions | Disability benefits | Alimony/child support benefits/payments |
| Strike benefits | Supplemental Security Income | Cash withdrawn from savings | |
| Unemployment benefits | Retirement income | Interest/dividends | |
| Worker's Compensation | Veteran's payments | Income from estates/trusts/investments | |
| Net income from self-employment | Social Security Income | Regular contributions from persons not living in the household | |
| | | Net royalties/annuities/net rental income | |

**PART 2D - HOUSEHOLDS WITH A FOSTER CHILD:** COMPLETE THIS PART AND PART 4 – **A foster child is the legal responsibility of a state children services agency or court, and is categorically eligible for free meals.** A foster parent or other official representing the child must sign the statement in PART 4.

**PART 3 – MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAMS** – Federal law allows the sharing of the information on this application with Medicaid and State Children's Health Insurance Programs. At this time, no procedures are in place to share this information. Since the procedures to share this information with the Medicaid and State Children's Health Insurance Programs may be established in the future, please indicate if you do not want this information to be shared. The Medicaid and State Children's Health Insurance Programs can only use the information to identify children who may be eligible for free or low cost health insurance and to enroll them in either Medicaid or the State Children's Health Insurance Program. They are not allowed to use the information for any other purpose. If this information is not shared, it will not affect the eligibility of your child(ren) for Tier 1 meals. If you do not want to share the information with the Medicaid and State Children's Health Insurance Programs, please indicate this decision by entering a check.

**PART 4 – SIGNATURE AND SOCIAL SECURITY NUMBER:** All households complete this part.

(1) All income eligibility statements must have the signature of an adult household member.

(2) The adult household member who signs the statement must include the last four digits of his/her Social Security Number. If he/she does not have a Social Security Number, write "none". If you listed an ACCENT case number for Supplemental Nutrition Assistance Program or Families First cash assistance, or a case number for Families First Child Care Assistance, the last four digits of the Social Security Number are not needed.

(3) The income eligibility application is valid for one calendar year from the date of the signature of the Determining Official. You will be contacted by the staff of the child care institution serving your child(ren) to update the information contained in this application before the close of the eligibility period. The staff of the child care institution is required to verify and certify the eligibility of your household every 12 months. Section 9 of the National School Lunch Act requires that, unless the participant's Supplemental Nutrition Assistance Program or Families First case number is provided, you must include the last four digits of the Social Security Number of the household member signing the statement or an indication that the household member signing the statement does not possess a Social Security Number. Provision of the last four digits of a Social Security Number is not mandatory, but if this Social Security information is not provided or an indication is not made that the adult household member signing the statement does not have a Social Security Number, the statement cannot be approved.

**PART 5 - RACIAL/ETHNIC IDENTITY:** You are **not required** to answer this question to receive meal benefits. However, this information will help ensure that everyone is treated fairly. **Definition of Ethnicity:** *Hispanic or Latino* means *a* person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. **Definition of Race:** *American Indian or Alaskan Native* means a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. *Asian* means a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. *Black or African American means a* person having origins in any of the black racial groups of Africa. *Native Hawaiian or Other Pacific Islander means a* person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. W*hite* means a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

**No person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the CACFP on the grounds of race, color, sex, age, disability, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law.**