

**VIRGINIA CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (IEF) FOR CHILD CARE CENTERS and FAMILY DAY CARE HOMES**

1 All Household Members			2		3															
NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children]			FOSTER CHILD		SNAP, TANF or FDIPIR CASE #															
First, Middle Initial, Last			Check if NO income	Ages of children in care	Skip to Part 6 if all are foster children.					Skip to Part 6 if you list a SNAP, TANF or FDIPIR case number.										
					<b>SNAP AND TANF MUST BE NINE (9) DIGITS</b>															
1			<input type="checkbox"/>			<input type="checkbox"/>														
2			<input type="checkbox"/>			<input type="checkbox"/>														
3			<input type="checkbox"/>			<input type="checkbox"/>														
4			<input type="checkbox"/>			<input type="checkbox"/>														
5			<input type="checkbox"/>			<input type="checkbox"/>														
6			<input type="checkbox"/>			<input type="checkbox"/>														

**4 Homeless, Migrant, or Runaway**

Homeless     Migrant     Runaway    If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your School Homeless Liaison or Migrant Coordinator.

**5 Total Household Gross Income (before deductions). You must tell us how much and how often.**

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT IS RECEIVED (Example: \$100/month, \$100/twice a month, \$100/every other week, \$100/week)							
	Earnings From Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp, Unemployment, SSI, etc.	
	Amount	How often	Amount	How often	Amount	How often	Amount	How often?
i.	\$		\$		\$		\$	
ii.	\$		\$		\$		\$	
iii.	\$		\$		\$		\$	
iv.	\$		\$		\$		\$	
v.	\$		\$		\$		\$	

**6 Signature and Social Security Number (Adult must sign)**

An adult household member must sign the application. If Part 5 is completed or if zero income is listed, 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.

X X X - X X -    Social Security Number

I do not have a social security number.

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.

Date: \_\_\_\_\_ Printed Name of Adult Household Member: \_\_\_\_\_ Signature of Adult Household Member: \_\_\_\_\_

**7 Contact Information (Optional)**

Work Telephone Number (Include Area Code) ( ) \_\_\_\_\_ Home Telephone Number (Include Area Code) \_\_\_\_\_ Home Address (Number, Street, City, State, Zip Code) \_\_\_\_\_

**8 Optional - Sharing Information with Virginia's Health Insurance Program for Children (FAMIS)**

May we share your information on this application with the FAMIS, the complete health insurance program for every child in Virginia? If yes, do not sign below.

No, I do not want my information from this application shared with the FAMIS.    Date: \_\_\_\_\_    Sign here: \_\_\_\_\_

**CHILD CARE REPRESENTATIVE USE ONLY – ELIGIBILITY DETERMINATION – COMPLETE SECTIONS A and B BELOW**

**SECTION A Annual Income Conversion: Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12** Convert income only if different frequencies of pay are reported.

TOTAL INCOME Per \$ \_\_\_\_\_  Week     Every 2 Weeks     Twice a Month     Month     Year    **NUMBER IN HOUSEHOLD: \_\_\_\_\_**

<input type="checkbox"/> <b>FREE</b> based on:	<input type="checkbox"/> <b>REDUCED</b> based on:	<input type="checkbox"/> <b>DENIED</b> reason:
<input type="checkbox"/> foster child <input type="checkbox"/> migrant <input type="checkbox"/> SNAP, TANF, FDIPIR	<input type="checkbox"/> household income <input type="checkbox"/> income too high	<input type="checkbox"/> incomplete application <input type="checkbox"/> non-qualifying SNAP/TANF
<input type="checkbox"/> homeless <input type="checkbox"/> runaway <input type="checkbox"/> household income		

**SECTION B Signature of Determining Official: \_\_\_\_\_ Date: \_\_\_\_\_**

**Nondiscrimination Statement:** 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.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, 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](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](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.