

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled at a family day care home. Your child care provider offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form.

**1. Am I required to complete a Meal Benefit Income Eligibility Form in order for my child(ren) to receive CACFP Benefits?** No, but if you choose to do so, your provider may receive a higher reimbursement for the meals served to your child. If you do complete the form, you have the option of returning it directly to your Provider or to the Provider's Sponsor, **Yours for Children, Inc.** If you would like to provide your form directly to the sponsor, return the completed form to **Yours for Children, Inc., 303-313 Washington St., Auburn MA 01501.**

Initial here if you consent to allowing your child care provider to collect your form and provide it to the Sponsor. Your child care provider will not review your form.

**2. Do I need to fill out a Meal Benefit Form for each of my children in day care?** You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household **only** if the children in child care are enrolled in the same home. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information.

**3. Who qualifies for the higher reimbursement without providing income information?** Your provider will receive a higher reimbursement for meals served to foster children and children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Transitional Aid to Families with Dependent Children (TAFDC), or Food Distribution Program on Indian Reservations (FDPIR). Children in households participating in WIC also may qualify for the higher reimbursement.

**4. Who qualifies for the higher reimbursement based on income?** Your provider may receive a higher reimbursement for the meals served to your children if your household income is within the reduced price limits on the Federal Income Chart, shown on this application. Children in households participating in WIC may be eligible for the higher reimbursement.

**5. May I fill out a form if someone in my household is not a U.S. citizen?** Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the day care home.

**6. Who should I include as members of my household?** You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include any foster children living with you.

**7. How do I report income information and changes in employment status?** The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the family day care home will receive a higher level of reimbursement. Once properly approved for the higher reimbursement rate, whether through income or by providing a current SNAP, TAFDC, or FDPIR case number, you will remain eligible for those benefits for 12 months. You should, however, notify us if you or someone in your household becomes unemployed and the loss of income unemployment causes your household income to be within the eligibility standards.

**8. What if my income is not always the same?** List the amount that you normally get. For example, if you normally get \$1000 each month, but you missed some work last month and only got \$900, put down that you get \$1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.

**9. What if I have foster children?** Foster children that are under the legal responsibility of a foster care agency or court automatically qualify for the higher reimbursement. Any foster child in the household qualifies regardless of income. Households may include foster children on the Meal Benefit Form, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children should contact **Executive Director, Yours for Children, Inc, 303-313 Washington St., Auburn MA 01501. 800.222.2731.**

**10. We are in the military, do we include our housing and supplemental allowances as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability. If you have other questions or need help, call 800.222.2731.

Sincerely,

**Yours for Children, Inc.**

July 2016



## INSTRUCTIONS FOR COMPLETING THE CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Family Day Care)

**Follow these instructions, if your household gets SNAP, TAFDC or participates in Head Start or is homeless:**

**Part 1:** List all enrolled children and household members.

**Part 2:** For family day care homes, list participant's name and a SNAP, TAFDC case number or indicate Head Start participation or homelessness. The correct SNAP number is not found on the participants EBT card, but on the award letter that the participant receives.

**Part 3:** Skip this part.

**Part 4:** Sign the form. The last four digits of a Social Security Number are **not** necessary.

**Part 5:** Answer this question if you choose.

**If you are applying on behalf of a FOSTER CHILD, use a separate application for each foster child and follow these instructions:**

If **all** children you are applying for are foster children, or if you are only applying for benefits for the foster child:

**Part 1:** List all foster children. Check the box indicating that the child is a foster child.

**Part 2:** Please contact us at **800.222.2731**.

**Part 3:** Skip this part.

**Part 4:** Sign the form. A Social Security Number is **not** necessary.

**Part 5:** Answer this question if you choose to.

If some of the children in the household are foster children.

**Part 1:** List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.

**Part 2:** If the household does not have a case number, skip this part.

**Part 3:** Follow these instructions to report total household income for this month or last month.

**Column A – Name:** List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

**Column B – Gross Income and How Often it was Received:** For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

**Box 1:** List the **gross income**, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

**Box 2:** List the amount each person got for the month from welfare, child support, alimony.

**Box 3:** List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

**Box 4:** List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For **ONLY** the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

**Part 4:** Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

**Part 5:** Answer this question if you choose.



## INSTRUCTIONS FOR COMPLETING THE CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Family Day Care)

**ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:**

**Part 1:** List all enrolled children and household members. For any people, including children, with no income, you must check the “No Income Box.”

**Part 2:** Skip this part.

**Part 3:** Follow these instructions to report total household income form this month or last month.

**Column A – Name:** List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

**Column B – Gross Income and How Often it was Received:** For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

**Box 1:** List the **gross income**, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

**Box 2:** List the amount each person got from the month from welfare, child support, alimony.

**Box 3:** List retirement, Social Security, Supplemental Security Income (SSI), Veteran’s (VA) benefits, disability benefits.

**Box 4:** List ALL OTHER INCOME SOURCES including Worker’s Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

**Part 4:** Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn’t have one.

**Part 5:** Answer this question if you choose.

**Privacy Act Statement:** This explains how we will use the information you give us.

**Non-discrimination Statement:** This explains what to do if you believe you have been treated unfairly.



# CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Family Day Care)

PROVIDER NAME: \_\_\_\_\_ YFCI PROVIDER NUMBER: \_\_\_\_\_

### Part 1. All Household Members

**PLEASE PRINT CLEARLY**

#### A. Name of Child(ren) Enrolled with this Child Care Provider:

- 1) \_\_\_\_\_ 3) \_\_\_\_\_  
 2) \_\_\_\_\_ 4) \_\_\_\_\_

#### B. Names of all household members

(First, Middle Initial, Last)

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

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"/>

### Part 2. Benefits: If any member of your household received SNAP or TAFDC cash assistance, provide the name and case number for the person who receives benefits or indicate Head Start or homelessness. If no one receives these benefits, proceed to part 3.

NAME: \_\_\_\_\_ CASE NUMBER: \_\_\_\_\_  
(Agency ID Number from Award Letter, not EBT card number, applies to SNAP and TAFDC)

### Part 3. Total Household Gross Income—You must tell us how much and how often

#### B. Gross income and how often it was received

#### A. Name

(List **only** household members with income)

*(Example)*  
Jane Smith

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 4. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. If Part 3 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 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: \_ \* \_ \* - \_ \* \_ - \_ \_ \_ \_  I do not have a Social Security Number



## CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Family Day Care)

<b>Part 5. Participant's ethnic and racial identities (optional)</b>	
Mark one ethnic identity:	Mark one or more racial identities:
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<b>Don't fill out this part. This is for official use only.</b>	
Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12	
Total Income: _____ Per: <input type="checkbox"/> Week, <input type="checkbox"/> Every 2 Weeks, <input type="checkbox"/> Twice A Month, <input type="checkbox"/> Month, <input type="checkbox"/> Year Household size: _____	
Categorical Eligibility: _____ Eligible: _____ Not Eligible: _____ Tier I _____ Tier II _____	
Reason: _____	
Determining Official's Signature: _____ Date: _____	
Confirming Official's Signature: _____ Date: _____	

**The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.**

Effective July 1, 2017 to June 30, 2018	
Household size	Yearly
1	22,311
2	30,044
3	37,777
4	45,510
5	53,243
6	60,976
7	68,709
8	76,442
Each additional person:	+ 7,733

**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:** 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](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.



## SHARING INFORMATION WITH MEDICAID/SCHIP

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Dear Parent/Guardian:

If your children qualify for free or reduced price meals, they may also be able to get free or low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP). Children with health insurance are more likely to get regular health care and are less likely to become sick.

Because health insurance is so important to children's well-being, **the law allows us to tell Medicaid and SCHIP that your children are eligible for free or reduced price meals, unless you tell us not to.** Medicaid and SCHIP only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children in this health insurance program. Filling out the CACFP Meal Benefit Income Eligibility Forms does not automatically enroll your children in health insurance.

If you do not want us to share your information with Medicaid or SCHIP, fill out the form below and send it with your Income Eligibility Form to YFCI, 303-313 Washington St., Auburn MA 01501. (Sending in this form will not change whether your children get free or reduced price meals.).

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**No! I DO NOT** want information from my CACFP Meal Benefit Income Eligibility Form shared with Medicaid or the State Children's Health Insurance Program.

**If you checked no, fill out the form below.**

Child's Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Print Your Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

For more information, you may call **MassHealth** at **1-800-841-2900**

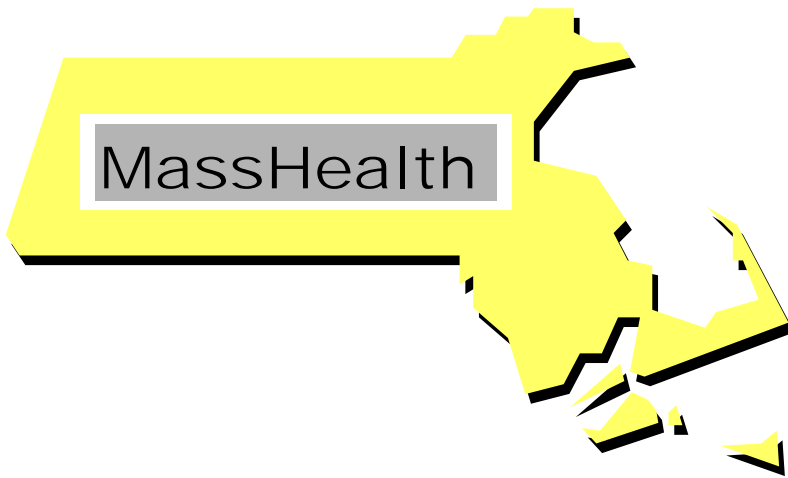
## MASSHEALTH INFORMATION

If your child is eligible for free or reduced school meals, your child may also be eligible for

**free or low cost health insurance**

through MassHealth.

**To learn more call: 1-800-841-2900**



Si su niño es eligible para almuerzo gratis o reducido, su niño pueda ser eligible para

**seguro de salud gratis o de bajo costo**

por medio de MassHealth.

**Para saber mas, llame al: 1-800-841-2900**

**Covering Kids**

