Paul R. LePage
Governor

STATE OF MAINE
DEPARTMENT OF EDUCATION
CHILD NUTRITION
23 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0023

For Use in **CHILD CARE CENTERS**
July 1, 2018 to June 30, 2019

Dear Parent:

The Child Care Center in which you are enrolling your child participates in the U.S. Department of Agriculture's Child and Adult Care Food Program. This means the Center must serve meals and supplements that meet or exceed the nutritional requirements set forth by the U.S. Government.

In return for serving meals and supplements that meet these requirements, the Center receives payment from the USDA based on the income levels of the families being served. The higher the number of children served by the Center who come from low income households, the higher is the level of reimbursement received by the Center for the meals and supplements it serves.

In order to determine the level of reimbursement to be received by the Center for meals or supplements served to your child, USDA requests you to complete the attached application and to include all of the following information on the appropriate lines.

1. The name and age of the child for whom you are making application.

2. If the child for whom you are making application, or any other person in your household, is a member of a Supplemental Nutrition Assistance Program (SNAP) Household (formerly known as Food Stamps), Temporary Assistance to Needy Families (TANF) Assistance Unit or a household that receives benefits under the Food Distribution Program on Indian Reservations (FDPIR), you may give their SNAP, TANF or FDPIR case number in PART I and then skip to PART III.

3. IN PART II you must include the name of each person living in the "household". A "household" is any group of persons living together sharing income and living expenses. These persons may or may not all be related to each other.

4. The last four (4) digits of the Social Security number of the household member or guardian who signs the application form.

5. The total income, before deductions, from all sources, for all persons living in the household.

6. The signature, address, and telephone number of the person completing the application form. The date the form was signed must also be included.

By regulation, if any of the above required information is not included on the application form, the Center has to consider your child to be in that category of eligibility which qualifies it to receive the lowest level of payment for the meals and supplements your child will receive.

The following chart shows the upper income level for the 'Tier I' category for the period **July 1, 2018 to June 30, 2019**. If the total income for your household size is equal to or less than the amount shown, the center serving your child will be able to receive the Tier I, or highest, level of reimbursement for meals or supplements served to your child.

Eligibility Scale for "Reduced-Price" Meals

Family Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	22,459	1,872	936	864	432
2	30,451	2,538	1,269	1,172	586
3	38,443	3,204	1,602	1,479	740
4	46,435	3,870	1,935	1,786	893
5	54,427	4,536	2,268	2,094	1,047
6	62,419	5,202	2,601	2,401	1,201
7	70,411	5,868	2,934	2,709	1,355
8	78,403	6,534	3,267	3,016	1,508
Each Additional Family Member	7,992	666	333	308	154

If a member of your household becomes unemployed, your child may become eligible for "Free" or "Reduced-Price" meals during the period of unemployment, provided the loss of income causes the household income to fall within the eligibility guidelines for your household size.

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 (866) 632-9992 (voice) or (800) 877-8339 (TTY) or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

Thank you.

Sincerely,

Staff:
Child and Adult Care Food Program

APPLICATION FOR "FREE" OR "REDUCED-PRICE" MEALS
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

CHILD FOR WHOM APPLICATION IS BEING MADE: Name:_____ Age: _____

Days of the Week in Care	Hours in Care (i.e. 7:30 – 5:00)	Meals Received While in Care*
☐ Monday		☐ Br ☐ AM S ☐ Lu ☐ PM S ☐ Su ☐ E S
☐ Tuesday		☐ Br ☐ AM S ☐ Lu ☐ PM S ☐ Su ☐ E S
☐ Wednesday		☐ Br ☐ AM S ☐ Lu ☐ PM S ☐ Su ☐ E S
☐ Thursday		☐ Br ☐ AM S ☐ Lu ☐ PM S ☐ Su ☐ E S
☐ Friday		☐ Br ☐ AM S ☐ Lu ☐ PM S ☐ Su ☐ E S
☐ Saturday		☐ Br ☐ AM S ☐ Lu ☐ PM S ☐ Su ☐ E S
☐ Sunday		☐ Br ☐ AM S ☐ Lu ☐ PM S ☐ Su ☐ E S

* Br = Breakfast AM S = AM Snack Lu = Lunch PM S = PM Snack Su = Supper E S = Evening Snack

NOTE: If you are applying for CACFP benefits on behalf of a Foster Child, please check this box and notify the person to whom you return this form. ☐ Foster Child

PART I: HOUSEHOLDS RECEIVING SNAP, TANF OR FDPIR BENEFITS:

If you, your child, or any other person living in your household, currently receives SNAP, TANF or FDPIR benefits, please provide their SNAP, TANF or FDPIR case number. DO NOT COMPLETE Part II; skip to Part III. Part III must include the **printed name** and **signature of the adult who completes this application**. The **date the application was completed** needs to be included also.

(a) ☐ YES: A member of this household receives SNAP, TANF or FDPIR benefits.

(b) SNAP Case Number: # __ __ __ __ __ __ __ __ __ (**not** EBT number)

(c) TANF Case Number: # __ __ __ __ __ __ __ __ __

(d) FDPIR Case Number: # __ __ __ __ __ __ __ __ __

If applicable, your child's Free or Reduced-Price meal eligibility information will be disclosed to Medicaid and/or SCHIP unless you elect not to have the information disclosed. The information will be used to identify children eligible for, and to seek to enroll children in, a health insurance program. Your decision on whether to disclose this information will not affect your child's eligibility for Free or Reduced-Price meals.

If you elect not to have this information disclosed to Medicaid and/or SCHIP, please check this box: ☐

NOTE #1:

If no one in your household receives SNAP, TANF or FDPIR benefits, or if you do not provide their case number, you must complete Part II and Part III in order for your child to qualify for either "Free" or "Reduced-Price" meals. **You must also include the last four (4) digits of your Social Security Number on the line next to your signature.**

PART II: ALL OTHER HOUSEHOLDS:

(a) **Household Members**: List the name of every person living in your household. **Be sure to include yourself and the child listed above**.

(b) **Social Security Number**: Section 9 of the National School Lunch Act requires that, unless a SNAP or TANF case number is provided for your child, you must include the last four (4) digits of your Social Security number on the application. This must be the Social Security number of the adult household member signing the application. If the adult household member signing the application does not possess a Social Security number, he/she must indicate so on the application. Provision of a Social Security number is not mandatory, but if the last four (4) digits of the adult household member's Social Security number is not provided or an indication is not made that the adult household member signing the application does not have one, the application cannot be approved. This notice must be brought to the attention of the household member whose Social Security number is disclosed. The Social Security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application. These verification efforts may be carried out through program reviews, audits and investigations and may include contacting employers to determine income, contacting a SNAP, Indian Tribal Organization or Welfare Office to determine current certification for receipt of SNAP, FDPIR or TANF benefits, contacting the State Employment Security Office to determine the amount of benefits received and checking the documentation produced by household members to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal action if incorrect information is reported.

(C) **Income:** List **all** income from **all** sources received last month on the same line as the name of the person who received it. Income must be **gross**[1] that is, it must be the amount received **before deductions** for taxes, Social Security, dues, insurance, etc. List each amount under the correct column. ***If you are in the Military Privatized Housing Initiative or receive combat pay, please do not include these allowances as income.***

LIST ALL HOUSEHOLD MEMBERS:

Names of Household Members:	Age	Monthly Gross Wages or Net Self-Employment	Monthly TANF, Alimony, Welfare, Child Support	Monthly Pensions, SSI, Social Security, Workers Comp, Unemployment Comp, Insurance & Retirement
1.				
2.				
3.				
4.				
5.				
6.				
(Note: Weekly income x 4.333 weeks; Bi-weekly income x 2.15 weeks) **TOTAL MONTHLY HOUSEHOLD INCOME:**				

PART III:

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.

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PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that all income is reported. I understand this information is being given in connection with the receipt of Federal Funds and Program Officials may verify the information on the application and that deliberate misrepresentation of any of the information on this application may subject me to prosecution under applicable State and Federal Criminal Statutes.

(PRINT NAME OF ADULT)	**(LAST 4 DIGITS OF SS#)**	**(SIGNATURE OF ADULT)**	**(DATE)**
❑ I do not have a social security number_____			
(HOUSEHOLD ADDRESS OF ADULT)		**(HOME PHONE)**	**(WORK PHONE)**

ALL HOUSEHOLDS: Racial/Ethnic Identity:*

1. Ethnicity:

☐ **Hispanic or Latino**
☐ **Not Hispanic or Latino**

***This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws. Your response will not affect consideration of your application. If you decline to self-identify your child's race and ethnicity, a visual identification will be made and recorded.**

2. Race (mark one or more):

☐ **American Indian or Alaskan Native**
☐ **Asian**
☐ **Black or African American**
☐ **Native Hawaiian or Other Pacific Islander**
☐ **White**

THIS PORTION MUST BE COMPLETED BY CHILD CARE CENTER PERSONNEL:

Signature: _____ **Date:**_____

Child's Eligibility Category (Circle One): **Free** **Reduced-Price** **Paid**