Effective July 01, 2014

North Carolina

Department of Health and Human Services
Women's and Children's Health

CHILD AND ADULT CARE FOOD PROGRAM

CHILD FOOD PROGRAM ELIGIBILITY/ENROLLMENT APPLICATION

1. PRINT THE PARTICIPANT'S NAME AND DATE OF BIRTH:

First Name ______ Last Name ______ Date of Birth ______

NAME OF INSTITUTION: Child Care Networks, Inc.
AGREEMENT NUMBER: ______
FACILITY NAME: ______

2. SNAP, TANF or FDPIR : If the household currently receives SNAP, TANF or FDPIR benefits give the case number. Yes, we receive SNAP, TANF or FDPIR benefits. Case number is: SNAP # ______
TANF# ______ **FDPIR#** ______

If yes, and you have provided the case number, **DO NOT complete #3 and #4. Complete #5(voluntary) and #6.** If a child is a member of a food stamp or FDPIR household or TANF assistance unit, the child is automatically eligible to receive free Program meal benefits, subject to the completion of the application.

3. Is this a Foster Child? ☐ Yes ☐ No Households with foster and non-foster children may choose to include the foster child as a household member, as well as any personal income earned by the foster child, on the same household application that includes their non-foster children.

Is this a homeless child or a child evacuated from Japan or Bahrain? ☐ Yes ☐ No Certification from the agency that assisted with the evacuation or is providing shelter is required

4. HOUSEHOLD MEMBERS MONTHLY INCOME: List all others living in your household, **DO NOT** include participant listed above. List all gross income **(before deductions)** received last month. If you did not give a SNAP, TANF or FDPIR case number or if this is not a foster child, you must complete the income information.

Names of all Other Household Members	Monthly Wages	Monthly Social Security Earnings	Monthly Public Assistance/ Child Support Earnings	Monthly Retirement Pensions	Monthly Other Earnings
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$

5. ETHNIC IDENTITY: (Please check one) You are NOT required to answer this question.
☐ Hispanic or Latino ☐ Not Hispanic or Latino

RACE OF PARTICIPANT: (Please check one or more). You are NOT required to answer this question.
☐ White ☐ Black or African American ☐ America Indian/Alaska Native
☐ Asian ☐ Native Hawaiian or Other Pacific Islander

6. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that Program officials may verify the information on the application and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal criminal

Signature of Adult Household Member (Required) ______ **Date:** ______ Last Four Digits of Social Security Number (Required for households qualifying by income) ______

Printed Name ______ Home Telephone # ______ Work Telephone # ______

Address ______ City: ______ Zip Code: ______

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 your child for free or reduced price meals. You must include 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 Food Stamp, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservation (FDPIR) case number for your child 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 your child is eligible for free or reduced price meals and for administration and enforcement of the Program. If a child is a Head Start participant, the child is automatically eligible to receive free Program meal benefits, subject to submission by Head Start officials of a

Required Child Enrollment Verification: **Date of Enrollment:** ______

Sex: ☐ Male ☐ Female Food Allergies: ☐ Yes ☒ **No** If "yes" specify: ______

(If the participant cannot be served the CACFP Meal Pattern, a statement from the participant's Health Care Provider must be provided.)

Check Days of Normal Care at facility: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Check meals normally eaten at facility: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

Please list the normal times of arrival and departure (check am or pm) **Arrive:** ______ **am** **pm** **Depart:** ______ **am** **pm**

Signature of Adult Household Member (Required)

For Institution To be classified and completed by institution/sponsor:

TOTAL HOUSEHOLD SIZE ______ TOTAL HOUSEHOLD MONTHLY INCOME $ ______

Approved ☐ Free ☐ Reduced ☐ Denied

Reason for Denial ☐ Income too high ☐ Incomplete Application ☐ Other

Withdrew on date:

For state use only: Date: ______
Verified by:
Verified classification:
☐ Free ☐ Reduced ☐ Denied
Reason for change in classification: ______

Signature of Eligibility Official ______ Date: ______

CAC 11 (6/11) Nutrition Services