

Dropped Date: _____ Re-Entered Date: _____ Transferred Date: _____

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
MEAL BENEFIT INCOME ELIGIBILITY FORM
FREE AND REDUCED PRICE MEAL (FRPM) APPLICATION FORM (October 1, 2023 – September 30, 2024)
INSTITUTION NAME: AppleTree Academy FACILITY NAME: Same

PART 1. CHILD OR ADULT ENROLLED TO RECEIVE DAY CARE (USE A SEPARATE APPLICATION FOR EACH PARTICIPANT)

Print Name of Participant:	(First, Middle Initial, Last)	Age	DOB (mm/dd/yy)
Foster Child?	Yes: _____ No: _____	If participant is in Foster Care, Eligibility is FREE.	
Enter CID # for Child or Adult Care, if applicable:		Enter Foster Child's Personal Income Earned in Part 2, Section 4 (if applicable)	
Enter FITAP or FDPFR # for Child or Adult Care, if applicable:			
Enter SSI/Medicaid #			
for Adult Day Care Only			

PART 2. Total Household Gross Income

If you listed a CID/FITAP/FDPFR/SSI/Medicaid # above, Eligibility is FREE (Skip Part 2.)

A. Name (List everyone in household, including child listed above)	B. Gross income and how often it was received				C. Check if NO income
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement	4. All Other Income	
	\$ /	\$ /	\$ /	\$ /	<input type="checkbox"/>
	\$ /	\$ /	\$ /	\$ /	<input type="checkbox"/>
	\$ /	\$ /	\$ /	\$ /	<input type="checkbox"/>
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	\$ /	\$ /	\$ /	\$ /	<input type="checkbox"/>
	\$ /	\$ /	\$ /	\$ /	<input type="checkbox"/>

PART 3. USDA Supplemental Annual Enrollment Information: (This section must be completed annually by an adult household member for all children enrolled at Child Care Centers participating in the USDA Child and Adult Care Food Program.)

Expected Days of participation: _____ Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday

Expected Hours of participation: From _____ To _____ or Before School: From _____ To _____ After school: From _____ To _____

Expected Meal participation: _____ Breakfast _____ Lunch _____ Snack _____

PART 4. Adult Signature, Social Security Number, and Contact Information

An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on page 2.)

I certify that all information on this form is true and that all income is reported. I understand that the center will get Federal funds based on 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: _____

Social Security Number: XXX-XX-____ I do not have a Social Security Number

Part 5. Participant's ethnic and racial identities (optional)

Mark one ethnic identity: Hispanic or Latino Not Hispanic or Latino Mark one or more racial identities: Asian White Black or African American American Indian or Alaskan Native Native Hawaiian or Other Pacific Islander

For Official Use Only: Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: Month, Twice a month, Every two weeks, Week, Year Household size: _____

Eligibility Determination: _____ Free CID (Food Stamp)/FITAP/FDPFR/SSI/Medicaid Eligible _____ Reduced _____ Above/Paid

Extended Categorical Eligibility Validation Attached _____ YES _____ NO

Determining Official's Signature: _____ Date: _____