Submit

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North Carolina
Department of Health and Human Services
Women's and Children's Health
CHILD AND ADULT CARE FOOD PROGRAM
CHILD ELIGIBILITY APPLICATION

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

First Name Last Name Date of Birth

First Name Last Name Date of Birth

NAME OF INSTITUTION: _____

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 SNAP 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 Salaries	Monthly Social Security Earnings	Monthly Public Assistance/ Child Support Earnings	Monthly Retirement Pensions Earnings	Monthly Other Earnings
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$

5. ETHNIC IDENTITY: (Please check one).
☐ Hispanic or Latino ☐ Not Hispanic or Latino

RACE OF PARTICIPANT: (Please check one or more).
☐ White ☐ Black or African American ☐ American Indian or Alaskan 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 laws.

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 it you do not; we cannot approve your child 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 last four digits of the social security number is not required when your apply on behalf of a foster child or you list a SNAP, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (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 Head Start statement of income eligibility or income eligibility documentation.

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:
Verified by:_____ Date:_____
Verified classification: ☐ Free ☐ Reduced ☐ Denied
Reason for change in classification:_____

Signature of Eligibility Official Date

CAC 11 (6/12) Nutrition Services