



a program of Info Line, Inc.

Proudly serving Mahoning, Medina, Portage, Stark, Summit & Trumbull counties

703 S. Main Street, Suite 211 * Akron, Ohio 44311 * 1-800-407-5437 * FAX 1-800-777-0655 * www.childcare-connection.org

FY 2017 Ohio CACFP Family Day Care Homes Household Letter

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled at a family day care home. [Name of day care home] 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 Income Eligibility Application.

- 1. Am I required to complete an Income Eligibility Application 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, **Child Care Connection**. If you would like to provide your form directly to the sponsor, return the completed form to: **Child Care Connection, 703 S. Main St, Akron, OH 44311, 1-800-407-5437**

_____ Initial here if you consent to allowing **Your Family Day Care Provider** to collect your form and provide it to the Sponsor. **Your Provider** will not review your form.

- 2. Do I need to fill out Income Eligibility Application for each of my children in day care?** You may complete and submit one CACFP Income Eligibility Application 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 Food Assistance Program (formerly Food Stamps), Ohio Works First (OWF), or Food Distribution Program on Indian Reservations (FDPIR) benefits. Children in households participating in WIC also 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 are 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 Food Assistance, OWF, FDPIR, or WIC 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 Income Eligibility Application, 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 **Child Care Connection, 703 S. Main St, Akron, OH 44311 1-800-407-5437**

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If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.



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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 **1-800-407-5437**

Nondiscrimination statement: "The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

Sincerely,
Teresa A. Moe- CACFP Coordinator
Brittany Thomas- CACFP Specialist

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OHIO CHILD AND ADULT FOOD CARE FOOD PROGRAM: FAMILY DAY CARE HOMES COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICED MEALS
 Fiscal Year 2016-2017

Income eligibility information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure and their decision will not affect their children's eligibility for free and reduced-price meals. **Forms must be updated annually and are valid for 12 months.**

PART 1 – CHECK Application Type:

- 1. Provider requesting Tier I status by application (may only qualify through food assistance, Ohio Works First (OWF) or income. **PROOF OF INCOME IS REQUIRED** to qualify as a Tier I provider by this application.
- 2. Provider is requesting meals for own/residential children **enrolled** for childcare. (may only qualify through food assistance, OWF or income.)
- 3. Provider or Parent requesting meals for foster child. In certain cases, foster children are eligible for free and reduced-price meals regardless of household income.
- 4. Parent requesting child meals with family child care provider: (may qualify through food assistance, OWF, WIC, Healthy Start or income.)

Write the name of your child care provider here:

PART 2 – CHILD INFORMATION: Print information below for all children whose meals will be claimed on the CACFP.

BENEFIT INFORMATION: Enter the benefit program from PART 1 that automatically qualifies a child for Tier I meals. Enter the NAME and CASE or ID Number.

PRINT INFORMATION FOR ALL CHILDREN ENROLLED IN CARE			CHECK IF A FOSTER CHILD (the legal responsibility of a welfare agency or court).	LIST EACH CHILD'S FOOD ASSISTANCE, OWF or WIC CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 10 OR 12 DIGITS. DO NOT USE SWIPE CARD NUMBER.
* NAME OF ENROLLED CHILD(REN)	* AGE	* BIRTH DATE		Circle type of benefit: FOOD ASSISTANCE, OWF or WIC
1.			<input type="checkbox"/>	CASE NUMBER:
2.			<input type="checkbox"/>	CASE NUMBER:
3.			<input type="checkbox"/>	CASE NUMBER:
4.			<input type="checkbox"/>	CASE NUMBER:

PART 3 – TOTAL HOUSEHOLD SIZE AND TOTAL HOUSEHOLD GROSS INCOME: List names of all household members. List all gross income; include how much and how often. If Part 2 is completed, skip to Part 4.

a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	b. CHECK IF NO/ZERO INCOME	c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN RECEIVED: Weekly, every two weeks, twice monthly, monthly, annually			
		1. Earnings from work before deductions	2. Welfare payments, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA	4. All Other Income
1.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
2.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
3.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
4.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
5.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

PART 4 – SIGNATURE AND SOCIAL SECURITY NUMBER: Adult household member must sign form. If PART 3 is completed, the adult signing the form must also list last four digits of his or her Social Security Number or check the box marked, "I do not have a Social Security Number."

I certify that all information on this form is true and correct and that all income is reported. I understand that the center will receive federal funds based on the information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

* _____
SIGNATURE OF ADULT HOUSEHOLD MEMBER

* _____
DATE

If PART 3 is completed, insert last four digits of Social Security Number
 (check if applicable)
 I do not have a Social Security Number

Print Name: _____ Daytime Phone Number: _____ Work Phone Number: _____
 Street / Apt: _____ City / State / Zip: _____ County: _____

PART 5: RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race or ethnicity of enrolled child(ren)

<input type="checkbox"/>	American Indian or Alaska Native	<input type="checkbox"/>	Asian	<input type="checkbox"/>	Black or African American
<input type="checkbox"/>	Native Hawaiian or Other Pacific Islander	<input type="checkbox"/>	White	<input type="checkbox"/>	Other

Please mark one ethnic identity: Hispanic or Latino Not Hispanic or Latino

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. **State Distribution: 07/15/2016**

-----SPONSOR MUST COMPLETE THIS SECTION-----

Approved	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Total Household Income \$ _____
Denied	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Total Household Size _____

Signature of Official _____ Date _____
 Note: If using parent signature date to determine effective/expiration date of all forms, then option must be selected on CRR5 management plan.

Effective Date _____ Expiration Date _____
 (From the first month of date (Valid until last day of month of which form categorized by sponsor/center) was dated and categorized by sponsor/center one year earlier)

FREE AND LOW COST HEALTH CARE

Families with children eligible for school meals may be eligible for free low cost health coverage. For more information, please contact Healthy Start & Healthy Families at 1-800-324-8680 or www.state.oh.us/odjfs/ohp/bcps/hshf/index.stm Note: If you have an Ohio Medicaid Card, you already receive this coverage.

HOW TO COMPLETE THE OHIO CACFP FAMILY DAY CARE INCOME ELIGIBILITY APPLICATION

1. PART 1 – Mark the box that applies in PART 1. If marking box 4, enter the home care provider's name in the space.
2. PART 2 – Enter the names of all children who will be claimed for meal reimbursement. If you are receiving benefits from programs such as food assistance, Ohio Works First (OWF) or Women, Infants and Children (WIC), enter the case number. PARENTS checking #4 in Part 1 and qualifying through other categorically eligible benefit programs enter the name for the benefit program and the case or identification number. The Family Child Care Sponsoring Organization may request additional documentation to verify participation.
3. PART 3 - Complete this part only if benefit name and case number in PART 2 are blank. Enter the names of all household members. A household is defined as a group of related or unrelated individuals who are living as one economic unit that share housing and/or significant income and expenses of its members. Income is any money received on a recurring basis, including gross earned income. Enter the gross income (amount before taxes are taken out) for the past month for each person with income. Monthly Income Conversion: Weekly x 52, Every two weeks x 26, Twice a Month x 24. Proof of income is required for providers qualifying for Tier I by application (attach the documents that support the income entries).
4. PART 5 – A household member (provider, when using income to determine Tier eligibility, parent or guardian) must sign and date the form. If PART 3 is completed, the last four digits of your social security number must be entered. If the adult does not have a social security number, check the box that indicates they do not have one. If a valid food assistance, Ohio Works First (OWF) or Women, Infants and Children (WIC) case number is listed in Part 2, a social security number is not required. Enter the address and phone number information. REMINDER: Please sign and date the form.
5. PART 6 – Complete the racial/ethnic, check the appropriate box. Parents/guardians are not required to complete this section.

REDUCED INCOME ELIGIBILITY GUIDELINES – 185%					
Guidelines to be effective from July 1, 2016 through June 30, 2017					
Households with incomes less than or equal to the reduced price values below are eligible for free or reduced-price meal benefits.					
HOUSEHOLD SIZE	ANNUAL	MONTH	TWICE PER MONTH	EVERY TWO WEEKS	WEEK
1	21,978	1,832	916	846	423
2	29,637	2,470	1,235	1,140	570
3	37,296	3,108	1,554	1,435	718
4	44,955	3,747	1,847	1,730	865
5	52,614	4,385	2,193	2,024	1,012
6	60,273	5,023	2,512	2,319	1,160
7	67,951	5,663	2,832	2,614	1,307
8	75,647	6,304	3,152	2,910	1,455
For each additional family member, add	7,696	642	321	296	148