

HOUSEHOLD LETTER FOR NON-PRICING INSTITUTIONS

Dear Parent or Guardian,

Please help us comply with the federal requirement mandating the annual submission of program Income Eligibility Applications. This application will be used only for eligibility determination, placed in our files, and treated as confidential information. In order for participants and the day care center to be considered eligible for program benefits, an adult household member must complete the program Income Eligibility Application (IEA) for each participant enrolled in the center as soon as possible, sign, date and return it to the day care center. Completion of the application is not mandatory unless you wish to be considered for eligibility as a free or reduced-price participant.

If you currently receive SNAP, Temporary Aid to Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR), you are not required to list household income. You may give your SNAP, TANF or FDPIR case number, sign, date and return the application. If an infant and/or child is a member of a SNAP or FDPIR household or is a TANF recipient, the infant/child is automatically eligible to receive free program meal benefits, subject to completion of the application.

You should also note that if you have a foster infant/child the day care center is eligible for program benefits for the foster infant/child regardless of the income of your household. Households with foster and non-foster infants/children may choose to include the foster infant/child as a household member, as well as any personal income earned by the foster infant/child, on the same household application that includes their non-foster infants/children. Please contact the institution for further instructions.

You should list the name of everyone who lives in your household, including all infants, children, parents, grandparents, and other relatives. The Department of Agriculture defines a household as a group of related or unrelated individuals (not residents of an institution or boarding house) who are living as one economic unit (i.e. sharing living expenses).

The income reported **must** be the total gross income, before deductions, received by all members of the household last month (i.e. wages, public assistance, TANF or retirement, etc.). Military benefits received in cash, such as housing allowance for military households living off base and food or clothing allowance **must** be considered as income. If you have a household member whose last month's income was higher or lower than usual, list that person's expected average monthly income.

REDUCED GUIDELINES EFFECTIVE JULY 1, 2023 - JUNE 30, 2024*

HOUSEHOLD SIZE	YEARLY	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
1	\$26,973	\$2,248	\$1,124	\$1,038	\$519
2	\$36,482	\$3,041	\$1,521	\$1,404	\$702
3	\$45,991	\$3,833	\$1,917	\$1,769	\$885
4	\$55,500	\$4,625	\$2,313	\$2,135	\$1,068
5	\$65,009	\$5,418	\$2,709	\$2,501	\$1,251
6	\$74,518	\$6,210	\$3,105	\$2,867	\$1,434
7	\$84,027	\$7,003	\$3,502	\$3,232	\$1,616
8	\$93,536	\$7,795	\$3,898	\$3,598	\$1,799
For each additional family member add:	\$9,509	\$793	\$397	\$366	\$183

*Households with income less than or equal to these levels are eligible for free or reduced-price meals.

You may submit an Infant and Child Income Eligibility Application any time during the fiscal year. Participants having family members who become unemployed are eligible for free or reduced-price meals during the period of unemployment, provided that the loss of income causes the family's income during the period of unemployment to be within the eligibility standards for those meals.

INSTRUCTIONS

Please complete the Infant and Child Income Eligibility Applications using the instructions below. The application must be signed in number 6 and returned to the child care center.

1-PARTICIPANT'S INFORMATION:

- a. Print the name(s) and birth date(s) of the infant(s) and/or child/children enrolled in the center.

2-HOUSEHOLD GETTING SNAP, TANF, OR FDPIR BENEFITS:

- a. If you participate in SNAP, TANF, or FDPIR provide your case or identification number and skip number 4.
- b. If you do not participate in any of these programs, go on to number 3.

3-FOSTER, HOMELESS, or MIGRANT INFANT/CHILD:

- a. Indicate if either infant/child on the application is a foster infant/child, homeless, or an infant/child from a migrant family.
- b. Households with foster and non-foster infants/children may choose to include the foster infant/child as a household member, as well as any personal income earned by the foster infant/child, on the same household application that includes their non-foster infants/children.
- c. Host families applying for free and reduced priced meals for their own infants/children may include the homeless family as household members if the host family provides financial support to the homeless family. In such cases, the host family must also include any income received by the homeless family.
- d. If the infant(s) and/or child/children listed are foster, homeless, or from a migrant family, number 4 may be skipped.

4- HOUSEHOLD INCOME:

- a. List the names of all other household members.
- b. Write the amount of income (the amount before taxes or anything else is taken out), the frequency of income (i.e. weekly, every two weeks, twice a month, or monthly) received **last month** for each household member and where it came from, such as earnings, public assistance, pensions and other income (refer to examples below for types of income to report). If any amount last month was less than usual, write the person's usual income.

INCOME TO REPORT

<u>Earnings from Employment</u>	<u>Pensions/Retirement/Social Security</u>	<u>Other Income</u>
<ul style="list-style-type: none"> • Wage/salaries/tips • Strike benefits • Unemployment compensation • Net income from self-owned business or farm • Worker's compensation 	<ul style="list-style-type: none"> • Pensions • Supplemental security income • Retirement income • Veteran's payments • Social Security 	<ul style="list-style-type: none"> • Disability benefits • Cash withdrawn from savings • Interest/dividends • Income from estates/trusts/investments • Regular contributions from persons not living in the household • Net royalties/annuities/ net rental income • Any other income
<p><u>Public Assistance/Child Support/Alimony</u></p> <ul style="list-style-type: none"> • Public assistance payments • TANF payments • Alimony/Child support payments 	<p><u>Military Households</u></p> <ul style="list-style-type: none"> • All cash income, including military benefits received in cash such housing/uniform allowances. 	

5-RACIAL/ETHNIC IDENTITY: Complete the Ethnic/Racial identity question.

6-SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: All households complete this part.

All Infant and Child Income Eligibility Applications must be signed by an adult household member. If qualifying by income, the adult household member who signs the certification statement must include the last four digits of his/her social security number. If he/she does not have a social security number, check the "No SSN" box. If the participant is a foster infant/child, homeless, or infant/child from a migrant family and/or listed a SNAP, TANF, or FDPIR number a social security number is not needed.



INFANT AND CHILD INCOME ELIGIBILITY APPLICATION

INSTITUTION NAME: CENT FACILITY NAME: Harris Learning Academy AGREEMENT#: 7461

1. PARTICIPANT'S NAME & DATE OF BIRTH:

First Name _____ Last Name _____ Date of Birth _____
 First Name _____ Last Name _____ Date of Birth _____

2. SNAP, TANF or FDPIR case number:

SNAP # _____ TANF# _____ FDPIR # _____
 If you have provided the case number; DO NOT complete #3 and #4. Skip to complete #5 and #6.

3. Is this application for a:
 Foster Infant/Child? Yes No Homeless Infant/Child? Yes No
 Infant/Child from a migrant family? Yes No

4. HOUSEHOLD MEMBERS MONTHLY INCOME:

Names of All Other Household Members	Monthly Wages / Salaries	Monthly Social Security	Monthly Public Assistance / Child Support	Monthly Retirement Pensions	Other Monthly Income
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$

5. ETHNIC IDENTITY: (Check one). Hispanic or Latino Not Hispanic or Latino
 RACE (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; that the application is being made in connection with the receipt of federal funds, that Program officials may verify the information on the application; and that deliberate misrepresentation of any of the information on the application may subject me to prosecution under applicable State and Federal criminal statutes.

Signature of Adult Household Member (Required) _____ Date _____
 Printed Name _____ Home Telephone # _____ Work Telephone # _____
 Address _____ City _____ Zip Code _____
 Check if no SSN
 Last Four Digits of Social Security Number (Required only if qualifying by income)

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 infant/child for free or reduced-price meals. You must include the last four digits of the social security number or check the "no SSN" box of the adult household member who signs the application if qualifying by income. The last four digits of the social security number is not required when you apply on behalf of a foster infant/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 your infant/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 infant/child is eligible for free or reduced-price meals and for administration and enforcement of the Program.

To be completed by Institution/Sponsor

TOTAL HOUSEHOLD SIZE _____ TOTAL HOUSEHOLD MONTHLY INCOME \$ _____
 Approved: Free Reduced-Price Denied
 Reason for denial: Income too high Incomplete application Other: _____
 Withdrew on (Date): _____

For state use only:
 Verified by: _____ Date: _____
 Verified classification:
 Free Reduced-Price Denied
 Reason for classification change: _____



Infant and Child Enrollment Form

INSTITUTION NAME: CACFP FACILITY NAME: Harris Learning Academy AGREEMENT#: 7461

Dear Parent/Guardian,

This center/program receives funding from the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). CACFP needs proof of enrollment for all infants and children. Please complete the table below for each infant and/or child in your family enrolled at this center/program. Be sure to sign and date in the space below.

The information below must be completed by the parent or guardian.

Infant/Child's First Name	Infant/Child's Last Name	Date of Birth	Normal/Typical Hours of Care	Normal/Typical Days of Care (Circle all that apply)	Meals Normally Eaten (Circle all that apply)
			_____ to _____	<input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> T <input checked="" type="checkbox"/> W <input checked="" type="checkbox"/> Th <input checked="" type="checkbox"/> F <input type="checkbox"/> Sat <input type="checkbox"/> Sun	<input checked="" type="checkbox"/> B <input type="checkbox"/> AM <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> PM <input type="checkbox"/> S <input type="checkbox"/> LPM
			_____ to _____	M T W Th F Sat Sun	B AM L PM S LPM
			_____ to _____	M T W Th F Sat Sun	B AM L PM S LPM
			_____ to _____	M T W Th F Sat Sun	B AM L PM S LPM
			_____ to _____	M T W Th F Sat Sun	B AM L PM S LPM

Normal/Typical Hours of Care: Write in each infant/child's usual arrival and departure time. Indicate a.m. or p.m.

Normal Days of Care: Circle the days of the week each infant/child is usually in attendance at the facility.

(M-Monday; T-Tuesday; W-Wednesday; Th-Thursday; F-Friday; Sat-Saturday; Sun-Sunday)

Meals Normally Eaten – Circle the meals each infant/child usually eats at the facility.

(B-Breakfast; AM-AM Snack; L-Lunch; PM-PM Snack; S-Supper; LPM-Late PM/Evening Snack)

Parent/Guardian Signature: _____ Date: _____

Print Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone Number: () _____ Work Telephone Number: () _____

For Facility/Provider Use Only:

Signature of Facility Representative/Provider: _____ Date: _____

Date each infant/child withdrew: _____

For State Use Only: Complete: _____ Incomplete: _____ Reason: _____ Verified by: _____ Date: _____

This institution is an equal opportunity provider.