

**OHIO CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT**  
**INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED PRICE MEALS**  
**2007 - 2008**

**INSTRUCTIONS:** To apply for free and reduced price meals, read the Household Letter/instructions on backside. Complete application and return to the center. In accordance with the NSLA, 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. **Part 1** is to be completed by all households. **Part 2** is to be used only for a child living in a household receiving Food Stamps or Ohio Works First (OWF) benefits. **Part 3** is only for children NOT receiving Food Stamp or OWF benefits. **Part 4** is to be completed for foster children.

\* Asterisks indicate information that must be completed. Form must be updated annually and is valid for only 12 months including the month signed.

PART 1 – PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER			PART 2 – LIST EACH CHILD'S FOOD STAMP OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 10 OR 12 DIGITS. DO NOT USE SWIPE CARD NUMBER.
*CHILD(REN) NAME	AGE*	BIRTH DATE*	Circle type of benefit FOOD STAMP OR OWF
1.			CASE NUMBER:
2.			CASE NUMBER:
3.			CASE NUMBER:
4.			CASE NUMBER:

**PART 3 – HOUSEHOLD SIZE AND HOUSEHOLD INCOME:** If Part 2 is completed skip to Part 5.

Monthly Income Conversion: Weekly x 4.33, Every 2 weeks x 2.15, Twice a week x 2.

*LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	*Gross MONTHLY Earnings (before deductibles)		*MONTHLY Welfare Payments, Child Support, Alimony	*MONTHLY Pensions, Retirement, Social Security	*ANY OTHER MONTHLY Income
	Job 1	Job 2			
1.	\$	\$	\$	\$	\$
2.	\$	\$	\$	\$	\$
3.	\$	\$	\$	\$	\$
4.	\$	\$	\$	\$	\$
5.	\$	\$	\$	\$	\$

**PART 4 – FOSTER CHILD:**  (check) List foster child's monthly personal use income. Enter "0" if none. \$

**PART 5 – SIGNATURE AND SOCIAL SECURITY NUMBER:** I certify that the above information is true and correct and that all income is reported. I understand that this information is being given for 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 statutes.

§ _____ * SIGNATURE OF ADULT HOUSEHOLD MEMBER	§ _____ * DATE	§ _____ SOCIAL SECURITY NUMBER (SSN) Required only for Part 3 Write "None" if adult signer doesn't have a SSN.
Print Name:	Daytime Phone Number:	Work Phone Number:
Street / Apt:	City / State / Zip:	County:

**PART 6: RACIAL/ETHNIC IDENTITY (Optional):** Please check appropriate box to identify the race or ethnicity of your child(ren).

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

Privacy Act Statement: Section 9 of the National School Lunch Act (NSLA) requires that, unless your child's food stamp or OWF case number is provided, you must include the social security number of the adult household member signing the application or indicate that the household member does not have a social security number. Provision of a social security number is not mandatory, but if a social security number is not given or an indication is not made that the signer does not have such a number, the application cannot be approved. This notice must be brought to the attention of the household member whose social security number is disclosed. The social security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application or shared with other persons directly connected with the administration or enforcement of the program under the NSLA or Child Nutrition Act of 1966 to determine program eligibility. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a food stamp or welfare office to determine current certification for receipt of food stamps or OWF benefits, contacting the state employment security office to determine the amount of benefits received and checking the documentation produced by household members to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal action if incorrect information is reported.

**State Distribution: Week of 6/10/07**

-----FOR CENTER USE ONLY-----

<b>Zero Income</b>	Total from Part 5, if applicable:	<input type="checkbox"/> Free	<input type="checkbox"/> Food Stamps/OWF
Temporary Free Approval Until: _____	Total Household Size _____	<input type="checkbox"/> Reduced	<input type="checkbox"/> Foster Child
Must be reviewed in 45 days.	Total Monthly Income \$ _____	<input type="checkbox"/> Paid	<input type="checkbox"/> Household Size & Income
		Reason: <input type="checkbox"/> Income Too High <input type="checkbox"/> Invalid <input type="checkbox"/> Incomplete	

Signature of Center Official	Today's Date	Effective Date (No earlier than first of current month)
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