# VIRGINIA CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (IEF)FOR CHILD CARE CENTERS and FAMILY DAY CARE HOMES

## 1 All Household Members

| NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children] | | | FOSTER CHILD | SNAP, TANF or FDPIR CASE # |
|---|---|---|---|---|
| First, Middle Initial, Last | Check if **NO** income | Ages of children in care | Skip to Part 6 if all are foster children. | kip to Part 6 if you list a SNAP, TANF or FDPIR case number. **SNAP AND TANF MUST BE NINE (9) DIGITS** |
| 1 | ☐ | | ☐ | |
| 2 | ☐ | | ☐ | |
| 3 | ☐ | | ☐ | |
| 4 | ☐ | | ☐ | |
| 5 | ☐ | | ☐ | |
| 6 | ☐ | | ☐ | |

## 4 Homeless, Migrant, or Runaway

☐ Homeless ☐ Migrant ☐ Runaway

If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box andcall your School Homeless Liaison or Migrant Coordinator.

## 5 Total Household Gross Income (before deductions). You must tell us how much and how often.

| NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME) | GROSS INCOME AND HOW OFTEN IT IS RECEIVED (Example: $100/month, $100/twice a month, $100/every other week, $100/week) | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Earnings From Work | | Welfare, Child Support, Alimony | | Pensions, Retirement, Social Security | | Worker's Comp, Unemployment, SSI, etc. | |
| | Amount | How often | Amount | How often | Amount | How often | Amount | How often? |
| i. | $ | | $ | | $ | | $ | |
| ii. | $ | | $ | | $ | | $ | |
| iii. | $ | | $ | | $ | | $ | |
| iv. | $ | | $ | | $ | | $ | |
| v. | $ | | $ | | $ | | $ | |

## 6 Signature and Social Security Number (Adult must sign)

**An adult household member must sign the application. If Part 5 is completed or if zero income is listed, the adult signing the formmust also list the last four digits of his or her social security number or mark the *I do not have a social security number* box.**

X X X – X X – _____
**Social Security Number**

☐ **I do not have a social security number.**

*I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the 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.*

*Date* *Printed Name of Adult Household Member* *Signature of Adult Household Member*

## 7 Contact Information (Optional)

*Work Telephone Number (Include Area Code)* ( ) *Home Telephone Number (Include Area Code)* *Home Address (Number, Street, City, State, Zip Code)*

## 8 Optional - Sharing Information with Virginia's Health Insurance Program for Children (FAMIS)

May we share your information on this application with the *FAMIS* , the complete health insurance program for every child in Virginia? If **yes**, do not sign below.

☐ No, I do not want my information from this application shared with the FAMIS.

Date:_____ Sign here: _____

## CHILD CARE REPRESENTATIVE USE ONLY – ELIGIBILITY DETERMINATION – COMPLETE SECTIONS A and B BELOW

**SECTION A** **Annual Income Conversion: Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12**

Convert income only if different frequencies of pay are reported.

TOTAL INCOME Per S_____ ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year **NUMBER IN HOUSEHOLD:** _____

| ☐ **FREE** based on: | | | ☐ **REDUCED** based on: | ☐ **DENIED** reason: | |
|---|---|---|---|---|---|
| ☐ foster child | ☐ migrant | ☐ SNAP, TANF, FDPIR | ☐ household income | ☐ income too high | ☐ incomplete application |
| ☐ homeless | ☐ runaway | ☐ household income | | | ☐ non-qualifying SNAP/TANF |

**SECTION B** **Signature of Determining Official:**_____ **Date:** _____

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(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights 1400
Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

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