

**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 PARTICIPANT'S NAME & DATE OF BIRTH:

INSTITUTION NAME: _____

First Name _____ Last Name _____ Date of Birth _____

AGREEMENT#: _____

First Name _____ Last Name _____ Date of Birth _____

FACILITY NAME: _____

2. SNAP, TANF or FDPIR: If a child is a member of a SNAP or FDPIR household or TANF recipient, the child is automatically eligible to receive free Program meal benefits, subject to the completion of the application. If the household currently receives SNAP, TANF or FDPIR benefits give the case number.

Case number is: **SNAP #** _____ **TANF#:** _____ **FDPIR #** _____
If you have provided the case number; **DO NOT complete #3 and #4. Complete #5 and #6.**

3. A foster child is automatically eligible to receive free Program meal benefits, and a Head Start participant 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.

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: (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.

Check if no SSN

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 if 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 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 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.

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: _____

Withdrawn on (Date): _____

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

Signature of Eligibility Official (Individual at the Institution Level) – REQUIRED _____ Date _____