

CHILD CARE FOOD PROGRAM FREE AND REDUCED-PRICE MEAL APPLICATION

Child's Name: _____ Center Name & Address: _____

Please read the instructions and accompanying Parent Letter before completing this form. If you need assistance completing this form, call: () _____

STEP 1: Complete the following table for all INFANTS and CHILDREN through age 18 that reside in the household, even if not related. (include child listed at top of form)

Child's Name (Last Name, First Name)	Date of Birth	Attends this center? (circle)	Foster Child? (circle)	Migrant? (circle)	Homeless/Runaway? (circle)
		Yes No	Yes No	Yes No	Yes No
		Yes No	Yes No	Yes No	Yes No
		Yes No	Yes No	Yes No	Yes No
		Yes No	Yes No	Yes No	Yes No

STEP 2: Do any household members (children or adults) receive Food Assistance Program (FAP/SNAP) or Temporary Assistance for Needy Families (TANF) benefits?

If NO, go to STEP 3. If YES, enter one of the following case numbers, then go to STEP 5.

FAP/SNAP Case Number: _____ or TANF Case Number: _____

STEP 3: Children's Income Information (see reverse side for what types of income to report) (skip this step if you listed a case # in STEP 2)

Children's Income – sometimes children earn or receive income. Enter the total income received by all children listed in STEP 1, then check how often the income is received.

Children's income – Total: \$ _____ How often received? (check only one): ☐ Weekly ☐ Bi-Weekly ☐ Twice a Month ☐ Monthly ☐ Annually

STEP 4: Household income and adult household member information (see reverse side for what types of income to report) (skip this step if you listed a case # in STEP 2)

Adult Household Members and Income – list all adult household members (age 19 and up) even if they do not receive income. For each adult, list the total gross income (before taxes & deductions) from each source in whole dollars only (no cents) and how often it is received (i.e., weekly, bi-weekly, twice a month, monthly, or annually). For an adult that does not receive income from any source, write "none" or "0." If you enter "none" or "0" or leave any income fields blank, you are certifying that there is no income to report.

Adult Household Member's Name (Last Name, First Name)	Earnings from Work (\$ Amount / How often?)	Public Assistance/Child Support/Alimony (\$ Amount / How often?)	Pensions/Retirement/All Other Income (\$ Amount / How often?)
	/ Weekly Biweekly Monthly Twice a Month Annually	/ Weekly Biweekly Monthly Twice a Month Annually	/ Weekly Biweekly Monthly Twice a Month Annually
	\$ _____	\$ _____	\$ _____
	/ Weekly Biweekly Monthly Twice a Month Annually	/ Weekly Biweekly Monthly Twice a Month Annually	/ Weekly Biweekly Monthly Twice a Month Annually
	\$ _____	\$ _____	\$ _____

Total Household Members (Add STEP 1 & 4): _____ Last four digits of Social Security Number (SSN) of adult household member: _____ If no SSN, write "none."

STEP 5: Contact information and adult signature

By signing below, I am certifying (promising) that all information on this application is true and that all income is reported. I understand that this information is being given in connection with the receipt of federal funds and that institution officials may verify (check) the information. I am aware that if I purposely give false information, I may be prosecuted under applicable state and federal laws.

Home address (if available): _____ Daytime phone #: () _____

Street Address, City, State, Zip Code

Signature of adult household member: _____ Printed name: _____ Date signed: _____

OPTIONAL: Child's ethnic and racial identities We are required to ask for information about your child's ethnicity and race. This information is important and helps make sure that we are fully serving the community. Responding to this section is optional and does not affect your child's eligibility for free or reduced-price meals. Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

FOR CONTRACTOR USE ONLY:

Categorical Eligibility: ☐ FAP/SNAP or TANF Household ☐ Foster Child ☐ Total Household Size: _____ Total Household Income: \$ _____

Eligibility Determination: ☐ Free ☐ Reduced-Price ☐ Non-needy ☐ How Often Income is Received (Frequency): ☐ Weekly ☐ Biweekly ☐ Twice a Month ☐ Monthly ☐ Annually

NOTE: If different income frequencies are listed, convert all income to an annual amount. Annual Income Conversion: Weekly x 52, Biweekly x 26, Twice a Month x 12

Reason for Non-needy Status: ☐ Income too High ☐ Incomplete Application ☐ Other Reason: _____

Determining Official's Signature: _____ Date: _____ Second Party Check Signature: _____ Date: _____

Florida Department of Health Child Care Food Program Child Participation Form

Name of Child: _____ Name of Facility: _____

Dear Parent:

Please fill out the following information so that your child may participate in the Child Care Food Program, which reimburses child care providers for serving nutritious, well-balanced meals to children in child care.

☐ Check here and sign/date below if your child does not receive meals while in care

If child care hours are the same every day, please complete this chart.

Day	Normal Hours in Care	Meals Normally Received While in Care		
Mon – Fri	a.m. _____ a.m. _____ p.m. _____ to _____ p.m. _____	Breakfast <input type="checkbox"/>	AM Snack <input type="checkbox"/>	Lunch <input type="checkbox"/>
		PM Snack <input type="checkbox"/>	Supper <input type="checkbox"/>	Eve Snack <input type="checkbox"/>

OR

If child care hours are not the same every day, please complete this chart.

Monday	a.m. _____ a.m. _____ p.m. _____ to _____ p.m. _____	Breakfast <input type="checkbox"/>	AM Snack <input type="checkbox"/>	Lunch <input type="checkbox"/>
		PM Snack <input type="checkbox"/>	Supper <input type="checkbox"/>	Eve Snack <input type="checkbox"/>
Tuesday	a.m. _____ a.m. _____ p.m. _____ to _____ p.m. _____	Breakfast <input type="checkbox"/>	AM Snack <input type="checkbox"/>	Lunch <input type="checkbox"/>
		PM Snack <input type="checkbox"/>	Supper <input type="checkbox"/>	Eve Snack <input type="checkbox"/>
Wednesday	a.m. _____ a.m. _____ p.m. _____ to _____ p.m. _____	Breakfast <input type="checkbox"/>	AM Snack <input type="checkbox"/>	Lunch <input type="checkbox"/>
		PM Snack <input type="checkbox"/>	Supper <input type="checkbox"/>	Eve Snack <input type="checkbox"/>
Thursday	a.m. _____ a.m. _____ p.m. _____ to _____ p.m. _____	Breakfast <input type="checkbox"/>	AM Snack <input type="checkbox"/>	Lunch <input type="checkbox"/>
		PM Snack <input type="checkbox"/>	Supper <input type="checkbox"/>	Eve Snack <input type="checkbox"/>
Friday	a.m. _____ a.m. _____ p.m. _____ to _____ p.m. _____	Breakfast <input type="checkbox"/>	AM Snack <input type="checkbox"/>	Lunch <input type="checkbox"/>
		PM Snack <input type="checkbox"/>	Supper <input type="checkbox"/>	Eve Snack <input type="checkbox"/>
Saturday	a.m. _____ a.m. _____ p.m. _____ to _____ p.m. _____	Breakfast <input type="checkbox"/>	AM Snack <input type="checkbox"/>	Lunch <input type="checkbox"/>
		PM Snack <input type="checkbox"/>	Supper <input type="checkbox"/>	Eve Snack <input type="checkbox"/>
Sunday	a.m. _____ a.m. _____ p.m. _____ to _____ p.m. _____	Breakfast <input type="checkbox"/>	AM Snack <input type="checkbox"/>	Lunch <input type="checkbox"/>
		PM Snack <input type="checkbox"/>	Supper <input type="checkbox"/>	Eve Snack <input type="checkbox"/>

☐ Check here and sign/date below if your child has no regularly scheduled hours of care

Signature of Parent/Guardian: _____ Date: _____

Printed Name: _____ Phone Number: _____