OHIO CHILD AND ADULT FOOD CARE FOOD PROGRAM: FAMILY DAY CARE HOMES COMPONENT INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICED MEALS Fiscal Year 2017-2018

Income eligibility information on this not required to consent to this disci														
annually and are valid for 12 mor		JECISIO	n will not	anec	a trieir childre	ans engi	DIRLY TOT	nee an	io reduced	-price me	ais, Foillis IIII	ası ne ul	Juateu	
PART 1 - CHECK Application Type	ə:													
 □ 1. Provider requesting Tier I s INCOME IS REQUIRED to □ 2. Provider is requesting mea □ 3. Provider or Parent requesting household income. □ 4. Parent requesting child me 	qualify as a Tier is for own/reside ng meals for fos als with family cl	I provi ntial ch ter chil	ider by th nildren ei d. In cert re provide	nis app nrolle ain ca	plication, ed for childca ases, foster o	re. (may children a	only qu are eligib	ualify th	rough food ree and re	d assistand duced-prid	ce, OWF or inc ce meals rega	come.) rdless of		
Write the name of your ch														
PART 2 - CHILD INFORMATION:											NAME and C	ASE or II) Number	
	NT INFORMATION FOR ALL CHILDREN		I FAIN	r triat		CHECK IF A FOSTER CHILD (the legal responsibility of a welfare		LIST I CASE CONT	for Tier I meals. Enter the NAME and CASE or ID Number. LIST EACH CHILD'S FOOD ASSISTANCE, OWF or WIC CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 10 OR 12 DIGITS. DO NOT USE SWIPE CARD NUMBER.					
*NAME OF ENROLLED CHILD(RE	N)		* AGE		*BIRTH DATE			Circle	Circle type of benefit: FOOD ASSISTANCE, OWF or WIC					
1								CASE	NUMBER	٠				
2]	CASE	NIIMBEE	·				
-	<u></u>								CASE NUMBER:					
3	\$		 				╡	CASE	ASE NUMBER:					
_4,									NUMBEE				•	
PART 3 - TOTAL HOUSEHOLD Sinclude how much and how of	IZE AND TOTA often. If Part 2	L HOU IS CO	ISEHOLI mplete	D GR d, sk	oss INCOM	IE: LIST 4.	names	ot all	l nousen	ola mem	ibers. List a	II gross	income;	
a. LIST NAMES OF ALL HO			b.	c. 0	SROSS INC	OME dur	ing the la	ast mo	nth (amou	nt earned	before taxes (ther de	eductions)	
MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1			CHECK A					-		o weeks, twice monthly		y, monthly, annually		
					arnings from v ore deductions				pport, alimony Social S		ns, retirement, curity, SSI, VA	4. All Other Income		
1.				\$_			\$		<u>'</u>	\$	1	\$	1	
2.				\$_			\$		<u>'</u>	\$	Ι	\$		
3.				\$_	/_		\$			\$		\$	1	
4.				\$_			\$	/	<u>' </u>	\$		\$	1	
5.				\$_			\$	/	<u> </u>	\$	1	\$	1	
PART 4 – SIGNATURE AND SOC form must also list last four digit	s of his or her t	Social	Security	/ Num	nber or ched	k the bo	x mark	ed, "I d	do not ha	ve a Socia	al Security Nu	ımber."	-	
I certify that all information on this fairnformation. Lunderstand that CAC													on the	
	,				fr	FPART 3	is com	npleted	l,					
SIGNATURE OF ADULT HOUSEHOLD					ينا	insert last four digits of Social Security Number (check if applicable)								
MEMBER								ave a Social Security Number						
Print Name:		Dayti	me Phon	ne Nu	mber:			Work	k Phone N	umber		_		
Street / Apt:		•	State / Z	•				Cour	•			_		
PART 5: RACIAL/ETHNIC IDENTI		Please			riate boxes t	o identify	the race	e or ett	1 '		, ,	-		
American Indian or Alaska Native			Asian						Black or African American					
Native Hawaiian or Other		nnesti	White				k1 = 2		<u>lOther</u>		$\overline{}$	-		
Please mark one ethnic identity: Privacy Act Statement: The Richard if you do not, we cannot approve th household member who signs the a Nutrition Assistance Program (SNA case number for the participant or of Security Number, We will use your	B. Russell Nati e participant for application. The P), Temporary A other (FDPIR) ide	onal Sofree or Social Social Assista	reduced Security nce for N or when	nch A I price Numb Ieedy you i	e meals. You ber is not red Families (Tr indicate that	must ind juired wh ANF) Pro the adult	nation on clude the nen you a ogram or househ	n this a e last fo apply o r Food old me	our digits on behalf of Distribution ember sign	You do not the Soci of a foster on Program	al Security Nu child or you lis n on Indian Re plication does	mber of to t a Suppleservation not have	he adult emental is (FDPIR) a Social	
the Program. State Distribution:				n	T. 110 - 2 - 2 - 2 - 2			-						
Provider Tier I	Residential C		JST COMI Child Ti											
Approved					\$	Total Household Income \$			Signature of Official Date Note: If using parent signature date to determine effective/expiration date of all forms, then option must be selected on CRRS management plan.					
Denied					Total H	lousehold	ousehold Size							
									(From the i	tive Date first month of dat by sponsor/cente			on Date month of which form ized by sponsor/center corlier)	

FREE AND LOW COST HEALTH CARE

Families with children eligible for school meals may be eligible for free low cost health coverage. For more information, please contact Healthy Start & Healthy Families at 1-800-324-8680 or www.state.oh.us/odjfs/ohp/bcps/hshf/index.stm Note: If you have an Ohio Medicaid Card, you already receive this coverage.

HOW TO COMPLETE THE OHIO CACFP FAMILY DAY CARE INCOME ELIGIBILITY APPLICATION

- PART 1 Mark the box that applies in PART 1. If marking box 4, enter the home care provider's name in the space.
- 2. PART 2 Enter the names of all children who will be claimed for meal reimbursement. If you are receiving benefits from programs such as food assistance, Ohio Works First (OWF) or Women, Infants and Children (WIC), enter the case number. PARENTS checking #4 in Part 1 and qualifying through other categorically eligible benefit programs enter the name for the benefit program and the case or identification number. The Family Child Care Sponsoring Organization may request additional documentation to verify participation.
- 3. PART 3 Complete this part only if benefit name and case number in PART 2 are blank. Enter the names of all household members. A household is defined as a group of related or unrelated individuals who are living as one economic unit that share housing and/or significant income and expenses of its members. Income is any money received on a recurring basis, including gross earned income. Enter the gross income (amount before taxes are taken out) for the past month for each person with income. Monthly Income Conversion: Weekly x 52, Every two weeks x 26, Twice a Month x 24. Proof of income is required for providers qualifying for Tier I by application (attach the documents that support the income entries).
- 4. PART 5 A household member (provider, when using income to determine Tier eligibility, parent or guardian) must sign and date the form. If <u>PART 3 is completed, the last four digits of your social security number must be entered</u>. If the adult does not have a social security number, check the box that indicates they do not have one. If a valid food assistance, Ohio Works First (OWF) or Women, Infants and Children (WIC) case number is listed in Part 2, a social security number is not required. Enter the address and phone number information. REMINDER: Please sign and date the form.
- 5. PART 6 Complete the racial/ethnic, check the appropriate box. Parents/guardians are not required to complete this section.

Households with i	Guideline	es to be effective from	GIBILITY GUIDELINES – 185% n July 1, 2017 through June 3 rice values below are eligible i	0. 2018	meal benefits.		
HOUSEHOLD SIZE	ANNUAL	<u>MONTH</u>	TWICE PER MONTH	EVERY TWO WEEKS	WEEK		
1	22,311	1,860	930	859	430		
2	30,044	2,504	1,252	1,156	578		
3	37,777	3,149	1,575	1,453	727		
4	45,510	3,793	1,897	1,751	876		
5	53,234	4,437	2,219	2.048	1,024		
6	60,976	5,082	2,541	2,346	1,173		
7	68,709	5,726	2,863	2,643	1,322		
8	76,442	6,371	3,186	2,941	1,471		
For each additional family member, add	7,733	645	323	298	149		