



Delaware Child Nutrition Program
 2008 Fiscal Year Child and Adult Care Food Program (CACFP)
Family-Size and Income Application (FSIA)
 for Family Day Care Homes (FDCH)

Tier Determination

_____ Tier I
 _____ Tier II
 _____ II-L
 _____ II-H
 _____ II-M

FDCH-3A Rev. (7/07)

For Sponsor Use Only:

1. Indicate type of application: **Provider** **Parent/Guardian**

2. **Provider's Name:** _____ **Provider Number:** _____

Part 3. Print CHILD'S NAME (first and last).

Part 4. List FOOD STAMP, TANF¹, or FDPIR² case number, if any. Skip to PART 5.

NAME	Age	Birth Date	FOOD STAMP NUMBER	or	TANF NUMBER	or	FDPIR NUMBER
_____	_____	_____	_____		_____		_____
_____	_____	_____	_____		_____		_____
_____	_____	_____	_____		_____		_____
_____	_____	_____	_____		_____		_____
_____	_____	_____	_____		_____		_____
_____	_____	_____	_____		_____		_____

Part 4a. Expanded Categorical Eligibility

Part 5. FOSTER CHILD:

ONLY PARENT/GUARDIAN OF TIER II HOMES

- | | |
|--|--|
| <input type="checkbox"/> WIC ³ | <input type="checkbox"/> Refugee Assistance |
| <input type="checkbox"/> Federally Funded Head Start | <input type="checkbox"/> NSLP/SBP ⁴ |
| <input type="checkbox"/> Title XX | <input type="checkbox"/> Commodity Supplemental Food Program |
| <input type="checkbox"/> Energy Program (LIHEAP) | <input type="checkbox"/> Child Care Development Fund |

List the child's monthly *personal use* income. Write 0 if the child had no *personal use* income.
 \$ _____

Part 6. Household Gross Income

Gross Income and How Often it Was Received

Example: \$100/monthly \$100 twice a month \$100/every other week \$100/weekly

Name (List everyone in household)	Earnings from Work Before Deductions	Welfare, Child Support, Alimony	Pensions, Retirement, Social Security	All Other income	Check if NO Income
(Example)	\$ 200/weekly	\$ 150/weekly	\$ 100/monthly	\$ ____/____	<input type="checkbox"/>
	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____	<input type="checkbox"/>
	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____	<input type="checkbox"/>
	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____	<input type="checkbox"/>
	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____	<input type="checkbox"/>
	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____	<input type="checkbox"/>
	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____	<input type="checkbox"/>
	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____	<input type="checkbox"/>

¹ Temporary Assistance for Needy Families
² Food Distribution Program on Indian Reservations

³ Women, Infants, and Children
⁴ National School Lunch Program/School Breakfast Program

**Over Please
Must fill out back of form.**

Part 7. SIGNATURE AND SOCIAL SECURITY NUMBER:

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds, that institution 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 laws.

X _____ Date _____
Signature of Adult household member

X _____ I do not have a social security number
Social Security Number** (See reverse page)

Home Phone _____ Work Phone _____ Printed Name _____

Street/Apt _____ City/State/Zip _____

Part 8. Children's Racial and Ethnic Identities (Optional):

Mark one or more racial identities:

Asian
 White
 Black/African American

American Indian or Alaska Native
 Native Hawaiian or Other Pacific Islander
 Other

Mark one ethnic identity

Hispanic or Latino
 Not Hispanic or Latino

Part 9. OTHER BENEFITS: You do not have to complete this part to participate in the CACFP.

Health Insurance Yes, I want health insurance for my children. The Sponsoring Organization may give information from my Family -Size and Income Application to the free Sooner Care Health Benefits officials so that they can send me information about free or low-cost health insurance for my children.

No, **IDO NOT** want information from my Application for Free and Reduced-Price Meals shared with Medicaid or the State Children's Health Insurance Program.

I certify that I am the parent/guardian of the children for whom application is being made.

I understand that I will be releasing information that will show that I applied for free meals for my children. I give up my rights to confidentiality for this purpose only.

Signature of Parent/Guardian: _____ Date: _____

***PRIVACY STATEMENT:** Federal law (P.L. 97-35) requires that, unless your child's food stamp, TANF, or FDPIR 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. The social security number may be used to identify the household member in carrying out our efforts to verify the correctness of information stated on the application. 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 stamp or TANF or FDPIR benefits, contacting the State Employment Security Office to determine the amount of benefits received, and checking the documentation provided 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 actions if incorrect information is reported. **Your social security number may be released for children's health insurance benefits if the box in Part 9 is checked Yes.**

Part 10. FOR SPONSOR USE ONLY

Annual Income Conversion: Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Monthly X 12
Monthly Income Conversion: Weekly X 4.33 Every 2 Weeks X 2.15 Twice a Month X 2

TOTAL HOUSEHOLD SIZE _____ TOTAL ANNUAL INCOME _____

Food Stamp TANF FDPIR Foster Child

EXPANDED CATEGORICAL ELIGIBILITY: _____
Name of program

ELIGIBILITY DETERMINATION _____ or REASON FOR INELEGIBILITY _____
_____ Approved Tier I _____ Income Too High
_____ Approved Tier II _____ Incomplete Application
_____ Provider's Own Child _____ Other _____

Signature of Sponsor Representative _____ Approval Verification Date _____