

CACFP ESSENTIALS SERIES

Administration Essentials: Part 1

Participant Enrollment



Health and Nutrition Services
Arizona Department of Education





Disclaimer

This training was developed by the Arizona Department of Education (ADE) Health and Nutrition Services Division (HNS). The content in this training is intended for professionals operating one or more USDA Child Nutrition Programs in Arizona under the direction of ADE. The information in this training is subject to change. Attendees are encouraged to access professional development materials directly from the training library to prevent use of outdated content.

Intended Audience

This training is intended for **organizations operating the Child and Adult Care Food Program (CACFP)**.



This training is required for all new organizations who will be applying to participate in the CACFP.

Objectives

At the end of this training, attendees should be able to:

- understand the annual and monthly enrollment documentation requirements;
- explain how to classify participants as free, reduced-price, or paid; and,
- understand how to build a claiming roster.

TRAINING HOURS

Information to include when documenting this training for Continuing Education and Training Credit:

Training Title: Participant Enrollment

Hours of Instruction: 1 Hour

This training counts toward Empower Program training requirements. It is listed on the Arizona Early Childhood Workforce Registry. If you want this training to appear on your Registry transcript, please provide your ID in the completion survey.

Quiz Time



Throughout this guide, there will be comprehension quiz questions to test your knowledge and help you apply what you're learning. Be sure to review these quiz questions and answers available within the guide.

The question mark icon below will indicate a comprehension quiz question.



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Participant Enrollment

Exempt: Emergency Shelters & At-Risk Programs



SECTION 1

Participant Enrollment

ENROLLMENT REQUIREMENTS

Child Care Centers, Adult Care Centers, and Head Start facilities must keep Participant Enrollment records on-site.

- The differences in annual enrollment documentation for licensed child centers, head start programs, and adult care centers is specified on the coming slides.

All information must be legible and contain the following elements:



Participant's full legal name (*and any other names the participant may go by*)



Guardian's full legal name (*if applicable*)



Current phone number and address of the participant's caregiver or legal guardian



Date and caregiver or legal guardian's signature

Head Start

DOCUMENTATION REQUIREMENTS

Head Start Programs can simply use their enrollment packet to satisfy their CACFP enrollment documentation requirement.

- Please ensure this information is onsite and not at the office headquarters.
- If enrollment packets are not onsite each center must have immediate access to the required criteria mentioned in the previous slide.

Requirements:



Enrollment packet is acceptable.



One packet per participant.



Must be complete and signed/dated by caregiver or guardian.



Updated annually (form expires one year from the date of the original signature).

Adult Care Centers

DOCUMENTATION REQUIREMENTS

Adult participants may complete, sign and date their own forms if they can do so.

- ADE requires one form per participant, each form must be completed and signed and dated by participant, caregiver or guardian, filed and kept on-site and updated annually.
- Enrollment forms expire one year from the date of original signature.

Requirements:



One form per participant.



Filed and kept on-site.



Must be complete and signed/dated by participant, caregiver or guardian.



Updated annually (form expires one year from the date of the original signature).

Child Care Centers

DOCUMENTATION REQUIREMENTS

Most child care centers are licensed through the Arizona Department of Health Services and have already maintain enrollment documentation.

ADE will accept ADHS's Emergency, Information, and Immunization Record Cards, commonly referred to as Blue Cards, as enrollment documentation for the CACFP.

- ADHS's Emergency, Information, and Immunization Record Cards

Requirements:

-  One form per participant.
 -  Filed and kept on-site.
 -  Must be complete and signed/dated by caregiver or guardian.
 -  Updated annually (form expires one year from the date of the original signature).*
- *The form is valid for one year after the original signature date and may be valid for one additional year (or a total of two years) **if** the caregiver or legal guardian reviews the form within the first year for accuracy, makes any corrections to their current address, phone number, emergency contacts, etc., and writes an "updated date." The new updated date is on the top right corner of the first page.*

Child Care Centers

ANNUAL UPDATES EXAMPLE

Original Signature Date: Valid for one year.

Updated Date: Valid for one additional year.

- *Form can only be updated once before a new form is required*

For example, if a form was signed on 9/1/2024 then updated 7/10/2025, it would need to be replaced by 7/10/26.

	ADHS LICENSING	Arizona Department of Health Services Bureau of Child Care Licensing Emergency, Information and Immunization Record Card	CDC/SGH# or name: _____
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Child's Name:	Date Enrolled:	Updated:
Home Address (#, Street, City, State, Zip Code):		Date Disenrolled:
Home Phone:	Date of Birth:	Sex: ☐ male ☐ female

Parent or Guardian Name:	Home Address (#, Street, City, State, Zip Code):
Cell Phone (optional):	Contact Telephone Number:

Parent or Guardian Name:	Home Address (#, Street, City, State, Zip Code):
Cell Phone (optional):	Contact Telephone Number:

I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted: (Pursuant to R9-5-304.B, at least two contact persons are required.)

Name:	Contact Telephone Number:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:

If Medical care is necessary, call:

Health Care Provider*	Name:	Contact Telephone Number:
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*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.
 I hereby give authority to any hospital or doctor to render immediate aid as might be required at the time for his/her health and safety.

In case of injury or sudden illness, I request that this individual be called first:	
--	--

The following individual(s) may NOT remove my child from the facility:

Name(s):

Custody papers have been provided and are on file at the facility. ☐ yes ☐ no

Telephone Authorization Code (optional): _____

UPDATED DATE

Immunization Information (A licensee shall attach an enrolled child's written immunization record or exemption affidavit to the enrolled child's Emergency, Information and Immunization Record card.)			
For information regarding current immunization requirements go to: www.azdhs.gov/phs/immun/index.htm or contact the Arizona Immunization Program Office at (602)364-3630.			
One of these items must accompany the EIIR card at all times:			
☐	☐	Copy of current official documented immunization record attached	
☐	☐	Religious Beliefs exemption form signed by parent/guardian attached	
☐	☐	Medical Exemption form signed by physician and parent/guardian attached	
☐	☐	Signed Laboratory Proof of Immunity form attached	
Notification of immunizations needed sent to Parent(s) or Guardian(s):		mo /day/ yr	mo /day/ yr
Updated immunizations received and attached:		mo /day/ yr	mo /day/ yr
Medical Information			
Is child allergic to food or other substances?		☐ No ☐ Yes	
If yes, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:			
Is child usually susceptible to infections and if so, what precautions need to be taken?		☐ No ☐ Yes	
If yes, list precautions:			
Is child subject to convulsions and what should be our procedure if one occurs?		☐ No ☐ Yes	
If yes, specify procedure:			
Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)?		☐ No ☐ Yes	
If yes, list precautions:			
Additional comments:			
Other special instructions:			
This Emergency Information and Immunization Record Card is accurate and complete, front and back, and was provided by: Parent/Guardian PRINTED Name: _____ SIGNED Name: _____ DATE: _____			

G:\Forms\Emergency Information and Immunization Record Card (9/18)

ORIGINAL SIGNATURE

Participant Enrollment

Update Requirement:

All Enrollment Forms must be updated annually.

After 1 year, an update can be made on the same form. Future updates require a brand-new form.

Best Practice:

Issue new forms for all participants at the same time every year.

Tip: Provide new enrollment forms to all households in June every year with the Meal Benefit Forms. Enrollment Forms can be printed on a **different color paper** every year to make it easy to identify outdated forms!

Participant Attendance

Exempt: None



SECTION 2

Participant Attendance

Child Care Centers, Adult Care Centers, Head Start facilities, Emergency Shelters, and At-Risk Programs must keep accurate documentation of daily attendance. The record type varies depending on your type of operation.

Attendance records are used in the CACFP to verify that participants were present during the meal service time. Attendance records require the time and date of arrival and departure as well as a valid signature.

- *If a participant has an incomplete sign-in and out sheet, ADE or an external auditor cannot confirm if the participant was on-site during the meal service. This will result in the disallowance of meals and may result in the center returning funds to ADE for the participants that were not able to be verified as onsite when the meal was served, otherwise known as fiscal action.*



Use of electronic attendance systems requires prior ADE Approval.

Participant Attendance

CHILD & ADULT CENTERS, HEAD START PROGRAMS

Centers and Head Start programs must keep attendance records.

Sign-in/out records must contain:

- 1** The date and time of daily arrival and departure.
- 2** Valid signature.



These attendance requirements are the same for centers with an at-risk program.

Participant Attendance

AT-RISK PROGRAMS

Sites who participate in only the at-risk afterschool program can have different attendance records, depending on the type of afterschool programming that is offered. Regardless of the method used to count attendance at the afterschool program, it should be recorded daily and be made available upon request.

At-Risk Programs can keep attendance records in one of the following ways:

- 1 Sign-in/out sheets
- 2 Attendance rosters
- 3 Check-in system
- 4 ADE At-Risk Meal Count Sheet (Attendance Section)

Participant Attendance

EMERGENCY SHELTERS

Emergency shelters keep a list of eligible participants as verification of attendance.

The list must contain:

- 1** Participant Name
- 2** Date of Birth
- 3** Dates of Residency

Participant Eligibility

Exempt: Emergency Shelters, At-Risk Programs, and Head Start Programs



SECTION 3

Participant Eligibility

Child Care Centers and **Adult Care Centers** must keep Participant Eligibility records on-site.

Emergency Shelters, At-Risk Programs, and Head Start Programs are exempt from identifying participant eligibility because they are reimbursed at the 'Free' rate.

- Head Start facilities and emergency shelters do **not** need to maintain any participant eligibility documentation. Their attendance and claiming documentation, which will be covered in the next section, is sufficient.
- At-Risk Afterschool Programs *are exempt from determining participant eligibility* because they must be *area* eligible and must offer organized, regular enrichment activities. *If you have questions about At-Risk eligibility, please complete the Introduction to CACFP course.*

Participant Eligibility

Child Care Centers and Adult Care Centers have *different* forms that they provide to every household upon initial enrollment and annually, every June.

The household has the opportunity on this form to report categorical eligibility or household income.

- Both forms are available on the HNS' CACFP Forms and Resources webpage.

MEAL BENEFIT INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS

[illegible]

MEAL BENEFIT INCOME ELIGIBILITY FORM FOR ADULT CARE CENTERS

Part 1. All Household Members - Name of Enrolled Adult(s):				
Names of Adult Participants (First, Middle Initial, Last)		DATE OF BIRTH (MM/DD/YYYY)	CHECK IF NO INCOME	

Part 2. Benefits: If any member of your household received SNAP, FDIPIR, State SSI or AHCCCS, provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME: _____ CASE NUMBER: _____

Part 3. Total Household Gross Income (income before any deductions) —You must tell us how much and how often

A. Name (List all people living in the household, including spouse and/or children)	B. Gross Income and how often it was received: Identify weekly, every other week, monthly, yearly			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	how much/how often	how much/how often	how much/how often	how much/how often
\$ /	\$ /	\$ /	\$ /	\$ /
\$ /	\$ /	\$ /	\$ /	\$ /
\$ /	\$ /	\$ /	\$ /	\$ /
\$ /	\$ /	\$ /	\$ /	\$ /
\$ /	\$ /	\$ /	\$ /	\$ /

Part 4. Signature and Last Four Digits of Social Security Number: A responsible adult must sign this form. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or write the word None if the signer doesn't have a Social Security Number. (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center 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.

Sign here: _____ Print name: _____ Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: ____-____-____-____. If no SSN, write the word "None."

Part 5. Participant's ethnic and racial identities (optional):

Mark one ethnic identity ☐ Hispanic or Latino ☐ Not Hispanic or Latino	Mark one or more racial identities ☐ Asian ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
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Don't fill out this part. This is for official use only:

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ☐ Week, ☐ Every 2 Weeks, ☐ Twice A Month, ☐ Month, ☐ Year Household size: _____

Categorical/Income Eligibility: Free _____ Reduced _____ Paid _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Income Eligibility Guidelines

If a household reported income, the Income Eligibility Guidelines are then used by the center to classify a participant as free, reduced, or paid.

- The household size is the number of names reported on the form.
- The income is the total household income reported.

Child Nutrition Programs

Income Eligibility Guidelines

The following are the income guidelines to be used by child nutrition program operators when processing meal benefit income eligibility forms using reported income.
Effective July 1, 2024 – June 30, 2025
For Determining Official's Use Only

Household Size*	How often was income received?									
	Weekly		Bi-Weekly		2x Month		Monthly		Annually	
	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced
1										
2										
3										
4										
5										
6										
7										
8										
Additional members, add:										

*Household size must be supported by the number of names listed on the meal benefit income eligibility form.

Annual Income Conversion for Multiple Reported Incomes:

If a household reports only one income or multiple incomes with the same frequency, do not convert to annual income. If a household reports multiple income sources with different frequencies (e.g., 1 income is received weekly, another income is received monthly), convert all reported incomes to annual using the conversion factors below. Then, add the income together and compare it to the annual income guidelines to make a determination.

Weekly income x 52	Bi-Weekly income x 26	2x Month income x 24	Monthly income x 12
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Example: A household has returned their meal benefit income eligibility form. The enrolled individuals are not categorically eligible so they must be categorized based on income. On their application, they reported two incomes: \$200 weekly and \$3,000 monthly. To determine their eligibility status, their incomes must be converted to annual income.

\$200 weekly x Weekly Income Conversion + \$200 x 52 = \$10,400 Total Annual Income
\$3,000 monthly x Monthly Income Conversion + \$3,000 x 12 = \$36,000 Total Annual Income
The incomes are then added together to determine total annual income. Total Income: \$10,400 + \$36,000 = \$46,400
There are four listed names on their meal benefit income eligibility form – demonstrating a household's size of four. The annual income cap for a household of four to be free is \$40,560 and reduced is \$57,720. This household's annual income is \$46,400 – greater than \$40,560, less than \$57,720. Therefore, this household qualifies for reduced-price meals.

March 2024 | Health and Nutrition Services | Arizona Department of Education | This institution is an equal opportunity provider.

INCOME ELIGIBILITY GUIDELINES

Updated annually by USDA.

Let's Practice...

Review the following scenario. Using the Income Eligibility Guidelines, identify if the participant eligibility qualifies as free, reduced-price, or paid based on household income.

- Please note, the Income Guidelines used in the following examples are intended for this exercise only. Operators must always obtain the Income Eligibility Guidelines from ADE HNS' webpage to ensure the most up-to-date guidelines are used.*

There are four, full names reported on the form – a household of 4. Household income is reported weekly. The total household income reported is \$635 per week.

Based on the income guidelines provided, if you have a family of four bringing in a weekly total income of \$635, would the participant eligibility be free, reduced-price, or paid?

	How often was income received?									
	Weekly		Bi-Weekly		2x Month		Monthly		Annually	
Household Size*	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced
1	\$377	\$536	\$753	\$1,072	\$816	\$1,161	\$1,632	\$2,322	\$19,578	\$27,861
2	\$511	\$728	\$1,022	\$1,455	\$1,108	\$1,576	\$2,215	\$3,152	\$26,572	\$37,814
3	\$646	\$919	\$1,291	\$1,838	\$1,399	\$1,991	\$2,798	\$3,981	\$33,566	\$47,767
4	\$780	\$1,110	\$1,560	\$2,220	\$1,690	\$2,405	\$3,380	\$4,810	\$40,560	\$57,720
5	\$915	\$1,302	\$1,829	\$2,603	\$1,982	\$2,820	\$3,963	\$5,640	\$47,554	\$67,673
6	\$1,049	\$1,493	\$2,098	\$2,986	\$2,273	\$3,235	\$4,546	\$6,469	\$54,548	\$77,626
7	\$1,184	\$1,685	\$2,367	\$3,369	\$2,565	\$3,650	\$5,129	\$7,299	\$61,542	\$87,579
8	\$1,318	\$1,876	\$2,636	\$3,752	\$2,856	\$4,064	\$5,712	\$8,128	\$68,536	\$97,532
Additional members, add:	\$135	\$192	\$269	\$383	\$292	\$415	\$583	\$830	\$6,994	\$9,953

Let's Practice...

Review the following scenario. Using the Income Eligibility Guidelines, identify if the participant eligibility qualifies as free, reduced-price, or paid based on household income.

- Please note, the Income Guidelines used in the following examples are intended for this exercise only. Operators must always obtain the Income Eligibility Guidelines from ADE HNS' webpage to ensure the most up-to-date guidelines are used.

There are four, full names reported on the form – a household of 4. Household income is reported weekly. The total household income reported is \$635 per week.

Based on the income guidelines provided, if you have a family of four bringing in a weekly total income of \$635, would the participant eligibility be **free**, reduced-price, or paid?

	How often was income received?									
	Weekly		Bi-Weekly		2x Month		Monthly		Annually	
	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced
Household Size*										
1	\$377	\$536	\$753	\$1,072	\$816	\$1,161	\$1,632	\$2,322	\$19,578	\$27,861
2	\$511	\$728	\$1,022	\$1,455	\$1,108	\$1,576	\$2,215	\$3,152	\$26,572	\$37,814
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4	\$780	\$1,110	\$1,560	\$2,220	\$1,690	\$2,405	\$3,380	\$4,810	\$40,560	\$57,720
5	\$915	\$1,302	\$1,829	\$2,603	\$1,982	\$2,820	\$3,963	\$5,640	\$47,554	\$67,673
6	\$1,049	\$1,493	\$2,098	\$2,986	\$2,273	\$3,235	\$4,546	\$6,469	\$54,548	\$77,626
7	\$1,184	\$1,685	\$2,367	\$3,369	\$2,565	\$3,650	\$5,129	\$7,299	\$61,542	\$87,579
8	\$1,318	\$1,876	\$2,636	\$3,752	\$2,856	\$4,064	\$5,712	\$8,128	\$68,536	\$97,532
Additional members, add:	\$135	\$192	\$269	\$383	\$292	\$415	\$583	\$830	\$6,994	\$9,953

\$635 per week for a family of four classifies the participant eligibility as free.

Child Care Centers

ELIGIBILITY DOCUMENTATION

The following slides will provide a detailed overview of the eligibility documentation for child care centers, including what information is required and what information is best practice to report.

- If required information is missing, the form is considered incomplete.

Program Forms and Resources CACFP

The following are program forms and resources for operators of the Child and Adult Care Food Program.

Calendars and Checklists

- [CACFP At a Glance Calendar](#)
- [Claims Processing Calendar](#)
- [Renewal Preparation Checklist](#)

Administration Forms

- Permanent Agreement
 - [Manual Permission](#)
 - [Electronic Permission](#)
- [Unique Entity Identification](#)
- [Administrative Review](#)
- [Procedures for Complaints](#)
- [State of Arizona W-9](#)
- [State of Arizona ACH](#)
- [ADEConnect Request](#)
- [Computer Software](#)

Required Postings

- [Building for the Future](#)
- [Current WIC Flyer \(English\)](#)
- [To order And Justice](#)

Training Staff

- [Civil Rights Compliance](#)
- [Annual Staff CACFP](#)
- [CACFP Trainer's Tool](#)
- [Template Training Agreement](#)

Participant Enrollment and Eligibility

- [Participant Menu Modification Form](#)
- Child Care Center Enrollment
 - [DHS Emergency, Information, and Immunization Record Card \(Blue Card\)](#)
 - [Meal Benefit Income Eligibility Form \(English\) \(Spanish\)](#)
 - Required Resources to Provide Families:
 - [Instructions \(English\) \(Spanish\)](#)
 - [Letter to Household \(English\) \(Spanish\)](#)
 - [Income Eligibility Guidelines PY 24-25](#)
 - [Claiming Rosters \(PDF\) \(Excel\)](#)
- Adult Care Center Enrollment
 - [Meal Benefit Income Eligibility Form](#)
 - Required Resources to Provide Families: [\(Instructions\)](#) [\(FAQ\)](#)
 - [Income Eligibility Guidelines](#)
 - [Claiming Rosters \(PDF\) \(Excel\)](#)

Templates and forms are available on [ADE HNS' CACFP Forms and Resources webpage](#).

Child Care Centers

ELIGIBILITY DOCUMENTATION: 3 FORMS

When the Meal Benefit Income Eligibility Form is provided to households, the Letter to Household and Instructions must also be provided.

- Letter to Household:** Child care centers have a parent letter that should accompany the meal benefit income eligibility application. Please ensure your letters are complete prior to handing out to families. The parent letter is important as it provides the parents with an outline of the CACFP and why it is beneficial for the center to participate as well as the current USDA household income guidelines.
- Application Instructions** are broken down per step and displayed in English and Spanish.

MEAL BENEFIT INCOME ELIGIBILITY FORM

The form is titled "Meal Benefit Income Eligibility Form" and includes instructions for completion. It is divided into four main steps: Step 1: List ALL children, infants, and students up to and including grade 12. Step 2: Do any household members (including you) participate in SNAP, TANF, or FDIPIR? Step 3: List ALL household members and income for each member (before taxes and deductions). Step 4: Contact information and adult signature. The form includes various checkboxes, input fields for names, addresses, and income, and a section for the adult signature and date.

INSTRUCTIONS

The instructions page provides detailed guidance on how to fill out the form. It includes sections for "Instructions" and "Contact Information". The instructions section explains the purpose of the form and provides step-by-step directions for each part of the form. The contact information section provides a space for the center's name, address, and phone number.

LETTER TO HOUSEHOLD

The letter to household template is addressed to the parent or guardian of the child. It explains the purpose of the CACFP and provides information on how to fill out the form. It includes a section for the parent's signature and date, and a section for the center's name, address, and phone number. The letter also includes a table for the Federal Income Standards for Reduced-Price Meals for July 1, 20__ - June 30, 20__.

Templates and forms are available on [ADE HNS' CACFP Forms and Resources webpage](#).

Child Care Centers

MEAL BENEFIT INCOME ELIGIBILITY FORM

A household can complete the Meal Benefit Income Eligibility Form in four steps.

Step 1: The household will list all household members who are infants, children, and students up to and including age 18. This should reflect all children 18 and under that live in the household; they do not have to be related to be a part of their household, and they do not have to be enrolled in the center.

- **Required Information:**
 - First and last name of every child in the household
 - Select foster, homeless, migrant, or runaway, if applicable
- **Best Practice:**
 - Age of child
 - Indication if the child is enrolled - yes or no

Input Program Year Meal Benefit Income Eligibility Form

Complete one application per household. Please use a pen (not a pencil).

APPLY ONLINE:

RETURN TO:

ADDRESS:

STEP 1 List ALL children, infants, and students up to and including grade 12. Attach another sheet of paper if you need space for more names.

List ALL children in the household. Do not forget to list infants, children attending other schools, children not in school, and children not applying for benefits. This includes children not related to you in your household.

Child's First Name	MI	Child's Last Name	Age	Foster Child	Migrant	Runaway	Homeless

If you checked any of these boxes, please refer to the Application Instruction's Step 1: Part C & Part D.

STEP 2 Do any household members (including you) participate in: SNAP, TANF, or FDIPIR?

☐ **NO** → Go to STEP 3.
 ☐ **YES** → Write case number here and proceed to STEP 4.

CASE NUMBER (NOT EBT NUMBER):

Write only one case number in this space.

STEP 3 List ALL household members and income for each member (before taxes and deductions)

A. All Adult Household Members (Anyone who is living with you and shares income and expenses, even if not related, including you.)

List all Adult Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes and deductions) for each source in whole dollars (no cents) only. If they do not receive income from any source, write "0". If you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often received?					Public Assistance, Child Support, Alimony	How often received?				Pensions, Retirement, Social Security, SSI, VA Benefits, All Other	How often received?				
		Weekly	Every 2 Weeks	2 Months	Monthly	Annual		Weekly	Every 2 Weeks	2 Months	Monthly		Weekly	Every 2 Weeks	2 Months	Monthly	
	\$						\$					\$					
	\$						\$					\$					
	\$						\$					\$					
	\$						\$					\$					
	\$						\$					\$					
	\$						\$					\$					
	\$						\$					\$					

Total Household Members (Children and Adults)

Last Four Numbers of Social Security Number of Primary Wage Earner or other Adult Household Member (if Applicable)

Check if no Social Security Number ☐

B. Child Income

Sometimes children in the household earn or receive income. Include the TOTAL income (before taxes and deductions) received by ALL children listed in STEP 1 here.

Child Income \$

How often received?				
Weekly	Every 2 Weeks	2 Months	Monthly	Annual

STEP 4 Contact information and adult signature. **RETURN COMPLETED FORM TO** Insert address here

I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (confirm) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws.

Print Name of Adult Signing the Form

Mailing Address (if available)

Signature of Adult

City State Zip

Today's Date

Phone (optional)

Email (optional)

Please see application's back for list of income sources.

Child Care Centers

MEAL BENEFIT INCOME ELIGIBILITY FORM

Households will then complete Step 2 or Step 3.

Step 2: The household will report any household member's case number if participating in SNAP, TANF, or FDPIR. If this section is completed, then Step 3 can be skipped.

- **Required Information:**
 - SNAP, TANF, FDPIR case number, if applicable

Input Program Year Meal Benefit Income Eligibility Form

Complete one application per household. Please use a pen (not a pencil).

APPLY ONLINE:
RETURN TO:
ADDRESS:

STEP 1 List ALL children, infants, and students up to and including grade 12. Attach another sheet of paper if you need space for more names.

List ALL children in the household. Do not forget to list infants, children attending other schools, children not in school, and children not applying for benefits. This includes children not related to you in your household.

Child's First Name	MI	Child's Last Name	Age	Foster Child	Migrant	Runaway	Homeless
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐

Check all that apply

If you checked any of these boxes, please refer to the Application Instruction's Step 1: Part C & Part D.

STEP 2 Do any household members (including you) participate in: SNAP, TANF, or FDIPIR?

☐ **NO** → Go to STEP 3.
 ☐ **YES** → Write case number here and proceed to STEP 4.

CASE NUMBER (NOT EBT NUMBER):

Write only one case number in this space.

STEP 3 List ALL household members and income for each member (before taxes and deductions)

A. All Adult Household Members (Anyone who is living with you and shares income and expenses, even if not related, including you.)

List all Adult Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes and deductions) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often received?					Public Assistance, Child Support, Alimony	How often received?				Pensions, Retirement, Social Security, SSI, VA Benefits, All Other	How often received?			
		Weekly	Every 2 Weeks	2 Months	Monthly	Annual		Weekly	Every 2 Weeks	2 Months	Monthly		Weekly	Every 2 Weeks	2 Months	Monthly
	\$	☐	☐	☐	☐	☐	\$	☐	☐	☐	☐	\$	☐	☐	☐	☐
	\$	☐	☐	☐	☐	☐	\$	☐	☐	☐	☐	\$	☐	☐	☐	☐
	\$	☐	☐	☐	☐	☐	\$	☐	☐	☐	☐	\$	☐	☐	☐	☐
	\$	☐	☐	☐	☐	☐	\$	☐	☐	☐	☐	\$	☐	☐	☐	☐
	\$	☐	☐	☐	☐	☐	\$	☐	☐	☐	☐	\$	☐	☐	☐	☐
	\$	☐	☐	☐	☐	☐	\$	☐	☐	☐	☐	\$	☐	☐	☐	☐

Total Household Members (Children and Adults)

Last Four Numbers of Social Security Number of Primary Wage Earner or other Adult Household Member (if Applicable)

Check if no Social Security Number ☐

B. Child Income

Sometimes children in the household earn or receive income. Include the TOTAL income (before taxes and deductions) received by ALL children listed in STEP 1 here.

Child Income \$

How often received?

☐ Weekly
 ☐ Every 2 Weeks
 ☐ 2 Months
 ☐ Monthly
 ☐ Annual

STEP 4 Contact information and adult signature. **RETURN COMPLETED FORM TO** Insert address here

I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (confirm) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws.

Print Name of Adult Signing the Form

Signature of Adult

Today's Date

Mailing Address (if available)

City

State

Zip

Phone (optional)

Email (optional)

Child Care Centers

MEAL BENEFIT INCOME ELIGIBILITY FORM

If Step 2 was not completed, then Step 3 must be completed.

Step 3: The household will report all adult household members and their income.

- **Required Information:**
 - When income is provided, it is required that the head of household also reports either the last four digits of their social security number or checks “No SSN.”
 - Total number of household members should match the total number of adults plus the total number of children listed on the form.

Input Program Year

Meal Benefit Income Eligibility Form

APPLY ONLINE:
RETURN TO:
ADDRESS:

Complete one application per household. Please use a pen (not a pencil).

STEP 1

List ALL children, infants, and students up to and including grade 12. Attach another sheet of paper if you need space for more names.

List ALL children in the household. Do not forget to list infants, children attending other schools, children not in school, and children not applying for benefits. This includes children not related to you in your household.

Child's First Name	MI	Child's Last Name	Age	Check all that apply
				Foster Child Migrant Runaway Homeless

If you checked any of these boxes, please refer to the Application Instruction's Step 1: Part C & Part D.

STEP 2

Do any household members (including you) participate in: SNAP, TANF, or FDIPIR?

☐ NO → Go to STEP 3.

☐ YES → Write case number here and proceed to STEP 4.

CASE NUMBER (NOT EBT NUMBER):

STEP 3

List ALL household members and income for each member (before taxes and deductions)

A. All Adult Household Members (Anyone who is living with you and shares income and expenses, even if not related, including you.)

List all Adult Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes and deductions) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often received?					Public Assistance, Child Support, Alimony	How often received?					Pensions, Retirement, Social Security, SSI, VA Benefits, All Other	How often received?				
		Weekly	Every 2 Weeks	2 Months	Monthly	Annul		Weekly	Every 2 Weeks	2 Months	Monthly	Annul		Weekly	Every 2 Weeks	2 Months	Monthly	
	\$						\$					\$						
	\$						\$					\$						
	\$						\$					\$						
	\$						\$					\$						
	\$						\$					\$						

Total Household Members (Children and Adults)

Last Four Numbers of Social Security Number of Primary Wage Earner or other Adult Household Member (if Applicable)

Check if no Social Security Number

Please see application's back for list of income sources.

B. Child Income

Sometimes children in the household earn or receive income. Include the TOTAL income (before taxes and deductions) received by ALL children listed in STEP 1 here.

Child Income

How often received?

Weekly Every 2 Weeks 2 Months Monthly Annul

STEP 4

Contact information and adult signature.

RETURN COMPLETED FORM TO: insert address here

I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (confirm) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws.

Print Name of Adult Signing the Form

Signature of Adult

Today's Date

Mailing Address (if available)

City

State

Zip

Phone (optional)

Email (optional)

Child Care Centers

MEAL BENEFIT INCOME ELIGIBILITY FORM

Step 4: In the final section completed by the household, contact information will be provided, and the adult will sign. It is best practice that an address and daytime phone number is also reported.

- **Required Information:**

- Signature of adult
- Date the form is signed

- **Best Practice:**

- Street address, city, state, zip
- Daytime phone and email
- Printed name of adult

Input Program Year **Meal Benefit Income Eligibility Form** **APPLY ONLINE:**
RETURN TO:
ADDRESS:

Complete one application per household. Please use a pen (not a pencil).

STEP 1 List ALL children, infants, and students up to and including grade 12. Attach another sheet of paper if you need space for more names.

List ALL children in the household. Do not forget to list infants, children attending other schools, children not in school, and children not applying for benefits. This includes children not related to you in your household.

Child's First Name	MI	Child's Last Name	Age	Check all that apply	Four Child	Migrant	Romney	Homeless

If you checked any of these boxes, please refer to the Application Instruction's Step 1: Part C & Part D.

STEP 2 Do any household members (including you) participate in: SNAP, TANF, or FDIPIR?

☐ NO → Go to STEP 3. ☐ YES → Write case number here and proceed to STEP 4. CASE NUMBER (NOT EBT NUMBER):

STEP 3 List ALL household members and income for each member (before taxes and deductions)

A. All Adult Household Members (Anyone who is living with you and shares income and expenses, even if not related, including you.)
 List all Adult Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes and deductions) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often received?				Public Assistance, Child Support, Alimony	How often received?				Pensions, Retirement, Social Security, SSI, VA Benefits, All Other	How often received?			
		Weekly	Every 2 Weeks	2 Months	Monthly		Weekly	Every 2 Weeks	2 Months	Monthly		Weekly	Every 2 Weeks	2 Months	Monthly
	\$					\$				\$					
	\$					\$				\$					
	\$					\$				\$					
	\$					\$				\$					
	\$					\$				\$					

Total Household Members (Children and Adults)

Last Four Numbers of Social Security Number of Primary Wage Earner or other Adult Household Member (if Applicable)

Check if no Social Security Number

B. Child Income
 Sometimes children in the household earn or receive income.

Child's Name	Child Income	How often received?				
		Weekly	Every 2 Weeks	2 Months	Monthly	Annual

STEP 4 Contact information and adult signature. RETURN COMPLETED FORM TO: Insert address here

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (confirm) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form: Signature of Adult: Today's Date:

Mailing Address (if available): City: State: Zip: Phone (optional): Email (optional):

Child Care Centers

MEAL BENEFIT INCOME ELIGIBILITY FORM

Optional: The back of the form contains an area where households can self-report their child’s race and ethnicity.

- **Best Practice:**
 - This information is not required and does not impact meal benefit eligibility.

SOURCES AND EXAMPLES OF INCOMEFor additional information on income, please refer to the instructions that accompany this application.

Sources of Income			Examples of Income for Children
Earnings from Work • Salary, wages, cash bonuses, tips, commissions • Net income from self-employment (farm or business) If you are in the U.S. Military: • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	Public Assistance/Alimony/Child Support • Unemployment benefits • Workers' compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	Pensions/Retirement/All other sources of income • Social Security/Disability (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household	• A child has a regular full or part-time job where they earn a salary or wages • A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits • A friend or extended family member regularly gives a child spending money • A child receives regular income from a private pension fund, annuity, or trust

OPTIONAL

Children's ethnic and racial identities. This information is kept confidential and may be protected by the Privacy Act of 1974.

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.

Ethnicity (check one): ☐ Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin, regardless of race) ☐ Not Hispanic or Latino

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

Return this completed form to your child's school. ***Do not mail, fax, or email completed applications to the U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights.**

DO NOT FILL OUT

For official use only.

Annual Income Conversion: Weekly × 52, Every 2 Weeks × 26, Twice a Month × 24, Monthly × 12. Do not annualize income to determine eligibility unless more than one income frequency is listed.

Total Income How often? ☐ Weekly ☐ Every 2 Weeks ☐ 2x/Month ☐ Monthly ☐ Annual Household size Categorical Eligibility ☐ Eligibility ☐ Free ☐ Reduced ☐ Paid Eligibility For Family Day Care Homes ☐ Tier I ☐ Tier II

Determining Official's Signature Date Confirming Official's Signature Date Verifying Official's Signature Date

Use of Information Statement

The Richard B. Russell National School Lunch Act requires that we use information from this application to see who qualifies for free or reduced price meals. We can only approve complete forms. We may share your eligibility information with education, health, and nutrition programs to help them deliver program benefits to your household. Inspectors and law enforcement may also use your information to make sure that program rules are met.

Please be sure to provide the last four numbers of the Social Security number of the adult household member who signs the application. If the adult does not have one, check if no Social Security Number. Applications for a foster child do not need to list a Social Security number. Applications for children in households receiving Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR) do not need to list a Social Security number. Some children qualify for free meals without an application. Please contact your school to get free meals for a foster child, and children who are homeless, migrant, or runaway.

The contact information below is solely to file a complaint of discrimination

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

*MAIL: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (833) 256-1665 or (202) 690-7442; or
EMAIL: program.intake@usda.gov

***Do not mail applications to this address, only complaints of discrimination.**

This institution is an equal opportunity provider.

Child Care Centers

MEAL BENEFIT INCOME ELIGIBILITY FORM

The following information is required. If any information is missing, please ask the household to fill in the missing information. If missing information persists, the form is incomplete, and the participant is placed in the “paid category.”

Child centers must make sure, at minimum, that all eligibility applications contain the following required information:

-  First and Last Name of every child in the household
-  Mark Foster, Homeless, Migrant, or Runaway *if applicable*
-  Case Number or Adult Names, Income, Income Frequency, & last 4 of SSN or check “No SSN”
-  Signature of Adult and Date Signed

Child Care Centers

DETERMINING ELIGIBILITY

When forms are turned into the center and deemed complete, the determining official(s) at the center will analyze the information and classify participants as free, reduced-price, or paid.



Classify as Free

Participants are classified as free if they are marked as foster, homeless, migrant or runaway, if a case number is reported, or if they qualify based on reported income.



Classify as Reduced-Price

Participants are classified as reduced-price if they qualify based on reported income.



Classify as Paid

Participants are classified as paid if they qualify based on reported income or if the application is incomplete or not returned to the center. It is important to note that households can refuse to complete the form, and if that happens, centers will simply classify all children as “paid.”

Child Care Centers

COMPLETE ‘OFFICIAL USE ONLY’ SECTION

On the back of every eligibility application, the Determining Official will report total income, frequency, and household size OR tick the box for categorical eligibility if the child is foster, homeless, migrant, or runaway, or if a case number was reported. Based on this information, either free, reduced-price, or paid will be selected.

Then, at least one determining official must sign and date the form. It is best practice for centers to identify two determining officials, such as the director and assistant director, who will serve as an edit check to ensure accuracy.

SOURCES AND EXAMPLES OF INCOMEFor additional information on income, please refer to the instructions that accompany this application.

Sources of Income			Examples of Income for Children
Earnings from Work - Salary, wages, cash bonuses, tips, commissions - Net income from self-employment (farm or business) If you are in the U.S. Military: - Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) - Allowances for off-base housing, food, and clothing	Public Assistance/Alimony/Child Support - Unemployment benefits - Workers' compensation - Supplemental Security Income (SSI) - Cash assistance from State or local government - Alimony payments - Child support payments - Veterans benefits - Strike benefits	Pensions/Retirement/All other sources of income - Social Security/Disability (including railroad retirement and black lung benefits) - Private Pensions or disability benefits - Income from trusts or estates - Annuities - Investment income - Earned interest - Rental income - Regular cash payments from outside household	- A child has a regular full or part-time job where they earn a salary or wages - A child is blind or disabled and receives Social Security benefits - A parent is disabled, retired, or deceased, and their child receives Social Security benefits - A friend or extended family member regularly gives a child spending money - A child receives regular income from a private pension fund, annuity, or trust

OPTIONAL

Children's ethnic and racial identities. This information is kept confidential and may be protected by the Privacy Act of 1974.

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.

Ethnicity (check one): ☐ Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin, regardless of race) ☐ Not Hispanic or Latino

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

Return this completed form to your child's school. ***Do not mail, fax, or email completed applications to the U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights.**

DO NOT FILL OUT

For official use only.

Annual Income Conversion: Weekly × 52, Every 2 Weeks × 26, Twice a Month × 24, Monthly × 12. Do not annualize income to determine eligibility unless more than one income frequency is listed.

Total Income How often? ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Annul Household size Categorical Eligibility ☐ Eligibility ☐ Free ☐ Reduced ☐ Paid Eligibility For Family Day Care Homes ☐ Tier I ☐ Tier II

Determining Official's Signature Date Confirming Official's Signature Date Verifying Official's Signature Date

Use of Information Statement

The Richard B. Russell National School Lunch Act requires that we use information from this application to see who qualifies for free or reduced price meals. We can only approve complete forms. We may share your eligibility information with education, health, and nutrition programs to help them deliver program benefits to your household. Inspectors and law enforcement may also use your information to make sure that program rules are met.

Please be sure to provide the last four numbers of the Social Security number of the adult household member who signs the application. If the adult does not have one, Check if no Social Security Number.* Applications for a foster child do not need to list a Social Security number. Applications for children in households receiving Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR) do not need to list a Social Security number. Some children qualify for free meals without an application. Please contact your school to get free meals for a foster child, and children who are homeless, migrant, or runaway.

The contact information below is solely to file a complaint of discrimination

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

*MAIL: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (833) 256-1665 or (202) 690-7442; or
EMAIL: program.intake@usda.gov

***Do not mail applications to this address, only complaints of discrimination.**

This institution is an equal opportunity provider.

- **Requirement:** At least one Official’s Signature.
- **Best Practice:** Two Official’s Signatures
 - *Two eyes are always better than one!*

Adult Centers

ELIGIBILITY DOCUMENTATION

Now, let's talk about adult centers. Although similar to child care centers, there are some differences, including the form.

The following slides will provide a detailed overview of the eligibility documentation for adult centers, including what information is required and what information is best practice to report.

- If required information is missing, the form is considered incomplete.

ARIZONA DEPARTMENT OF EDUCATION

Select Language ▼

Parents Educators & Administrators Programs About ADE Data & Systems ADEConnect Q

Home / Health and Nutrition Services / Program Forms and Resources CACFP

Program Forms and Resources CACFP

The following are program forms and resources for operators of the Child and Adult Care Food Program.

Administrators and School Leaders ▼

Parents and Families ▼

Child Nutrition Program Operators ▼

Peer to Peer Support for Child Nutrition Professionals

Free and Reduced-Price Percentage Report

Calendars and Checklists

- [CACFP At a Glance Calendar](#)
- [Claims Processing Calendar](#)
- [Renewal Preparation Checklist](#)

Administration Forms

- Permanent Agreement
 - [Manual Perm](#)
 - Electronic Per emailed to sign
- [Unique Entity Identifi](#)
- [Administrative Review](#)
- [Procedures for Comp](#)
- [State of Arizona W-9](#)
- [State of Arizona ACH](#)
- [ADEConnect Request](#)
- [Computer Software A](#)

Required Postings

- [Building for the Futur](#)
- Current WIC Flyer (Ed
- To order And Justice

Training Staff

- Civil Rights Complian
- [Annual Staff CACFP](#)
- [CACFP Trainer's Tool](#)
- [Template Training Ag](#)

Participant Enrollment and Eligibility

- [Participant Menu Modification Form](#)
- Child Care Center Enrollment
 - [DHS Emergency, Information, and Immunization Record Card \(Blue Card\)](#)
 - Meal Benefit Income Eligibility Form ([English](#)) ([Spanish](#))
 - Required Resources to Provide Families:
 - Instructions ([English](#)) ([Spanish](#))
 - Letter to Household ([English](#)) ([Spanish](#))
 - [Income Eligibility Guidelines PY 24-25](#)
 - Claiming Rosters ([PDF](#)) ([Excel](#))
- Adult Care Center Enrollment
 - [Meal Benefit Income Eligibility Form](#)
 - Required Resources to Provide Families: ([Instructions](#)) ([FAQ](#))
 - [Income Eligibility Guidelines](#)
 - Claiming Rosters ([PDF](#)) ([Excel](#))

Templates and forms are available on [ADE HNS' CACFP Forms and Resources webpage](#).

Adult Centers

ELIGIBILITY DOCUMENTATION: 3 FORMS

When the Meal Benefit Income Eligibility Form and letter is provided to households, the FAQ and Instructions must also be provided.

- **FAQ:** The FAQ informs the participant or their legal guardian about CACFP, how the center benefits from the participant completing the meal benefit income eligibility application, and the adult population the program is designed for.
- **Instructions** are broken down per step and displayed in English and Spanish.

MEAL BENEFIT INCOME ELIGIBILITY FORM & LETTER

CACFP Meal Benefit Income Eligibility Letter for Adult Day Centers

Dear Participant/Guardian:

The Child and Adult Care Food Program (CACFP) offers meal reimbursements to adult day care centers which provide structured comprehensive services to nonresidential adults who are functionally impaired or aged 60 and older. By completing the attached Meal Benefit Income Eligibility Form, the centers will be able to receive reimbursement, which is based on the number of enrolled participants that are eligible for free or reduced-price meals. Below are frequently asked questions and answers that will provide additional information to you.

Part 1. All Household Members - Name of Enrolled Adults:

Names of Adult Participants (First, Middle Initial, Last)	DATE OF BIRTH (MM/DD/YYYY)	CHECK IF NO INCOME

Part 2. Benefits: If any member of your household received SNAP, FDIAP, SSI or AHCCCS, provide the name and case number for that person who receives benefits. If no one receives these benefits, skip to part 3.

Part 3. Total Household Gross Income (Income before any deductions): You must tell us how much and how often.

A. Name (List all people living in the household, including spouse and/or partner)	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pension, retirement, Social Security, IRA, VA	4. All Other Income
	How much/how often	How much/how often	How much/how often	How much/how often
	\$ / /	\$ / /	\$ / /	\$ / /
	\$ / /	\$ / /	\$ / /	\$ / /
	\$ / /	\$ / /	\$ / /	\$ / /
	\$ / /	\$ / /	\$ / /	\$ / /

Part 4. Signature and Last Four Digits of Social Security Number: A responsible adult must sign this form. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or write the word None if the signer doesn't have a Social Security Number. (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center 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.

Sign here _____ First name _____ Date _____

Address _____ Phone Number _____

City _____ State _____ Zip Code _____

Last four digits of Social Security Number: + + + + + _____ (No SSN, write the word "None")

Part 5. Participant's ethnic and racial identities (optional):

Check all that apply	Mark one or more racial identities	
1. Hispanic or Latino	1. Asian	2. American Indian or Alaska Native
2. Not Hispanic or Latino	3. Native Hawaiian or Other Pacific Islander	3. Black or African American

Don't fill out this part. This is for official use only.

Annual Income Categories: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ For: 12 Week, 12 Every 2 Weeks, 12 Twice A Month, 12 Month, 12 Year Household size: _____

Categorical Income Eligibility: Free _____ Reduced _____ Part _____

Determining Official's Signature _____ Date _____

Confirming Official's Signature _____ Date _____

This institution is an equal opportunity provider.

INSTRUCTIONS

Instructions for Completing the CACFP Meal Benefit Income Eligibility Form for Adult Participants

If your household receives SNAP, FDIAP, SSI or AHCCCS, follow these instructions:

Part 1: List only the adult participant's names. For any participant with no income, you must check the "No Income Box."

Part 2: List the case number for any household member receiving SNAP, FDIAP, SSI or AHCCCS benefits.

Part 3: Skip this part.

Part 4: A responsible adult must sign the form. The last four digits of a Social Security Number is not necessary.

Part 5: Optional. Answer this question if you choose.

ALL OTHER HOUSEHOLDS, follow these instructions:

Part 1: List only the adult participant's names. For any participant with no income, you must check the "No Income Box."

Part 2: Skip this part.

Part 3: Follow these instructions to report total household income from this month or last month:

Column A = Name: List only the first and last name of each person living in your household, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if needed.

Column B = Gross Income and How Often It Was Received: For each household member who is a spouse, or dependent of the participant, list each type of income received for the month. You must tell us how often the money is received - weekly, every other week, twice a month or monthly.

Box 1: List the gross income, not the take-home pay. Gross income is the amount earned before:

- Box 2: List the amount each person received that month from welfare, child support, and alimony.
- Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits.

Box 4: List all other income sources, including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, etc. Do not include income from SNAP, FDIAP, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or receive combat pay, do not include this housing allowance as income. For the self-employed, under Earnings from Work, report business, farm, or rental property income after expenses.

Part 4: A responsible adult must sign the form and list the last four digits of their Social Security Number.

Part 5: Optional. Answer this question if you choose.

This institution is an equal opportunity provider.

FAQ

Frequently Asked Questions: Adult Care CACFP Meal Benefit Income Eligibility Form

The Child and Adult Care Food Program (CACFP) offers meal reimbursements to adult day care centers which provide structured comprehensive services to nonresidential adults who are functionally impaired or aged 60 and older. By completing the attached Meal Benefit Income Eligibility Form, the centers will be able to receive reimbursement, which is based on the number of enrolled participants that are eligible for free or reduced-price meals. Below are frequently asked questions and answers that will provide additional information to you.

- Do I need to fill out a Meal Benefit Form for each adult in day care?**
You may complete and submit one CACFP Meal Benefit Income Eligibility Form for the adults enrolled in day care in your household only if they are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. Return the completed form to this center.
- May I fill out a form if someone in my household is not a U.S. citizen?**
Yes. You or the adult in your care do not have to be U.S. citizens to qualify for meal benefits offered at the center.
- Who should I include as members of my household?** You must only include your spouse and your dependents who share income and expenses.
- How do I report income information and changes in employment status?**
The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amount indicated for your household's size on the attached Income Chart, the adult day care will receive a higher level of reimbursement. Once properly approved for free or reduced-price benefits, whether through income or proof of benefits as supported by a current SNAP, FDIAP case number or a SSI or Medicaid assistance number, you will remain eligible for those benefits for a period not to exceed 12 months. You should, however, notify us if you or someone in your household become unemployed and the loss of income during the period of unemployment causes your household income to be eligible for free or reduced-price meals.
- What if my income is not always the same?**
List the amount that you normally earn. For example, if you normally earn \$1,000 each month, but you missed some work last month and only received \$500, put down that you earn \$1,000 per month. If you normally receive overtime, include it, but do not include it if you only work overtime occasionally. If you have lost a job or had your hours or wages reduced, use your current income.
- We are in the military - do we include our housing allowance as income?**
If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

In the operation of the CACFP, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, please let us know.

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Templates and forms are available on [ADE HNS' CACFP Forms and Resources webpage](#).

Adult Centers

MEAL BENEFIT INCOME ELIGIBILITY FORM

The meal benefit form for adult participants is broken down into five parts.

Part 1: The adult participant’s full name should be reported. Any participants with no income will select the “no income” box.

- **Required Information:**
 - First and last name the adult participant(s)
 - Check if no income, if applicable
- **Best Practice:**
 - Date of birth

Part 1. All Household Members - Name of Enrolled Adult(s):

Names of Adult Participants (First, Middle Initial, Last)	DATE OF BIRTH (MM/DD/YY)	CHECK IF NO INCOME

Part 2. Benefits: If any member of your household received SNAP, FDPIR, State SSI or AHCCCS, provide the name and case number for the person who receives benefits. If no one receives these benefits, skip to part 3.

NAME: _____ CASE NUMBER: _____

Part 3. Total Household Gross Income (Income before any deductions) —You must tell us how much and how often

A. Name (List all people living in the household, including spouse and/or children)	B. Gross income and how often it was received: identify weekly, every other week, monthly, yearly...			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	how much/how often	how much/how often	how much/how often	how much/how often
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____

Part 4. Signature and Last Four Digits of Social Security Number: A responsible adult must sign this form. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or write the word None if the signer doesn't have a Social Security Number. (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center 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.

Sign here: _____ Print name: _____ Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: ____ * ____ * ____ * ____ * ____ If no SSN, write the word "None." _____

Part 5. Participant's ethnic and racial identities (optional):

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

Don't fill out this part. This is for official use only:

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ☐ Week, ☐ Every 2 Weeks, ☐ Twice A Month, ☐ Month, ☐ Year Household size: _____

Categorical/Income Eligibility: Free _____ Reduced _____ Paid _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

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Adult Centers

MEAL BENEFIT INCOME ELIGIBILITY FORM

Households will then complete Part 2 or Part 3.

Part 2: The household will report any household member’s case number if participating in SNAP, FDPIR, SSI or AHCCCS benefits. If no one in the household receives these benefits, then the household can skip this section and must complete part 3. If the household does report a case number, then they can skip part 3.

- **Required Information:**
 - Case number, if applicable

Part 1. All Household Members - Name of Enrolled Adult(s):

Names of Adult Participants (First, Middle Initial, Last)	DATE OF BIRTH (MM/DD/YY)	CHECK IF NO INCOME

Part 2. Benefits:

If any member of your household received SNAP, FDPIR, State SSI or AHCCCS, provide the name and case number for the person who receives benefits. If no one receives these benefits, skip to part 3.

NAME: _____ CASE NUMBER: _____

Part 3. Total Household Gross Income (income before any deductions) — You must tell us how much and how often

A. Name (List all people living in the household, including spouse and/or children)	B. Gross income and how often it was received: identify weekly, every other week, monthly, yearly...			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	how much/how often	how much/how often	how much/how often	how much/how often
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____

Part 4. Signature and Last Four Digits of Social Security Number:

A responsible adult must sign this form. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or write the word None if the signer doesn't have a Social Security Number. (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center 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.

Sign here: _____ Print name: _____ Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: ____ * ____ * ____ * ____ * ____ If no SSN, write the word "None." _____

Part 5. Participant's ethnic and racial identities (optional):

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

Don't fill out this part. This is for official use only:

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ☐ Week, ☐ Every 2 Weeks, ☐ Twice A Month, ☐ Month, ☐ Year Household size: _____

Categorical/Income Eligibility: Free _____ Reduced _____ Paid _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

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Adult Centers

MEAL BENEFIT INCOME ELIGIBILITY FORM

If Part 2 was not completed, then Part 3 must be completed.

Part 3: List the total household gross income. Households must list all members, all earnings from work, welfare, child support, alimony, pensions, retirement, social security, SSI, VA benefits, and any other consistent income and state how much and how often they receive the income (weekly, every other week, monthly, yearly, etc).

- **Required Information:**

- First and last name of every household member
- All income and how often

Part 1. All Household Members - Name of Enrolled Adult(s):		DATE OF BIRTH (MM/DD/YY)	CHECK IF NO INCOME
Names of Adult Participants (First, Middle Initial, Last)			

Part 2. Benefits: If any member of your household received SNAP, FDIPIR, State SSI or AHCCCS, provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME: _____ CASE NUMBER: _____

Part 3. Total Household Gross Income (Income before any deductions) —You must tell us how much and how often

A. Name (List all people living in the household, including spouse and/or children)	B. Gross income and how often it was received: Identify weekly, every other week, monthly, yearly...			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	how much/how often	how much/how often	how much/how often	how much/how often
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

Part 4. Signature and Last Four Digits of Social Security Number: A responsible adult must sign this form. **If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or write the word None if the signer doesn't have a Social Security Number.** (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center 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.

Sign here: _____ Print name: _____ Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _ * _ * _ * _ * _ * _____ If no SSN, write the word "None." _____

Part 5. Participant's ethnic and racial identities (optional):

Mark one ethnic identity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	Mark one or more racial identities: ☐ Asian ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
--	---

Don't fill out this part. This is for official use only:

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ☐ Week, ☐ Every 2 Weeks, ☐ Twice A Month, ☐ Month, ☐ Year Household size: _____

Categorical/Income Eligibility: Free _____ Reduced _____ Paid _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Adult Centers

MEAL BENEFIT INCOME ELIGIBILITY FORM

Part 4: An adult household member must provide a signature and a date, and (if income was reported in Part 3) either the last four digits of their SSN or check “No SSN.” By signing the application, the household member promises that all information has been truthfully and completely reported. It is best practice to report an address and daytime phone number.

- **Required Information:**

- Signature of adult.
- Date the form is signed.
- Last four of SSN or “None” (if income reported)

- **Best Practice:**

- Street address, city, state, zip
- Daytime phone and email
- Printed name of adult

Part 1. All Household Members - Name of Enrolled Adult(s):		DATE OF BIRTH (MM/DD/YY)	CHECK IF NO INCOME
Names of Adult Participants (First, Middle Initial, Last)			

Part 2. Benefits: If any member of your household received SNAP, FDIPIR, State SSI or AHCCCS, provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME: _____ CASE NUMBER: _____

Part 3. Total Household Gross Income (Income before any deductions) —You must tell us how much and how often

A. Name (List all people living in the household, including spouse and/or children)	B. Gross income and how often it was received: identify weekly, every other week, monthly, yearly...			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	how much/how often	how much/how often	how much/how often	how much/how often
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

Part 4. Signature and Last Four Digits of Social Security Number: A responsible adult must sign this form. **If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or write the word None if the signer doesn't have a Social Security Number.** (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center 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.

Sign here: _____ Print name: _____ Date: _____

Address: _____ Phone Number: _____

- - - - -

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _ * _ * _ * _ * _____ If no SSN, write the word "None." _____

Part 5. Participant's ethnic and racial identities (optional):

Mark one ethnic identity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	Mark one or more racial identities: ☐ Asian ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
---	--

Don't fill out this part. This is for official use only:

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ☐ Week, ☐ Every 2 Weeks, ☐ Twice A Month, ☐ Month, ☐ Year Household size: _____

Categorical/Income Eligibility: Free _____ Reduced _____ Paid _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Adult Centers

MEAL BENEFIT INCOME ELIGIBILITY FORM

Part 5 optional: The final part is optional and contains an area where households can self-report the race and ethnicity of the participant.

- **Best Practice:**
 - This information is not required and does not impact meal benefit eligibility.

Part 1. All Household Members - Name of Enrolled Adult(s):

Names of Adult Participants (First, Middle Initial, Last)	DATE OF BIRTH (MM/DD/YY)	CHECK IF NO INCOME

Part 2. Benefits: If any member of your household received SNAP, FDIPIR, State SSI or AHCCCS, provide the name and case number for the person who receives benefits. If no one receives these benefits, skip to part 3.

NAME:CASE NUMBER:

Part 3. Total Household Gross Income (Income before any deductions) —You must tell us how much and how often

A. Name (List all people living in the household, including spouse and/or children)	B. Gross income and how often it was received: identify weekly, every other week, monthly, yearly...			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	how much/how often	how much/how often	how much/how often	how much/how often
	\$ /	\$ /	\$ /	\$ /
	\$ /	\$ /	\$ /	\$ /
	\$ /	\$ /	\$ /	\$ /
	\$ /	\$ /	\$ /	\$ /

Part 4. Signature and Last Four Digits of Social Security Number: A responsible adult must sign this form. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or write the word None if the signer doesn't have a Social Security Number. (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center 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.

Sign here:Print name:Date:

Address:Phone Number:

City:State:Zip Code:

Last four digits of Social Security Number: * * * * *If no SSN, write the word "None."

Part 5. Participant's ethnic and racial identities (optional):

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

Don't fill out this part. This is for official use only:

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income:Per: ☐ Week, ☐ Every 2 Weeks, ☐ Twice A Month, ☐ Month, ☐ YearHousehold size:

Categorical/Income Eligibility: FreeReducedPaid

Determining Official's Signature:Date:

Confirming Official's Signature:Date:

Adult Centers

MEAL BENEFIT INCOME ELIGIBILITY FORM

The following information is required. If any information is missing, please ask the household to fill in the missing information. If missing information persists, the form is incomplete, and the participant is placed in the “paid category.”

Child centers must make sure, at minimum, that all eligibility applications contain the following required information:

-  First and Last Name of adult participant(s)
-  First, Last Name, and Income of every household member
-  Case Number or Income, Income Frequency, and last 4 of SSN or “None”
-  Signature of Adult and Date Signed

Adult Centers

DETERMINING ELIGIBILITY

When forms are turned into the center and deemed complete, the determining official(s) at the center will analyze the information and classify participants as free, reduced-price, or paid.



Classify as Free

Participants are classified as free if a case number is reported or if they qualify based on reported income.



Classify as Reduced-price

Participants are classified as reduced if they qualify based on reported income.



Classify as Paid

Participants are classified as paid if they qualify based on reported income or if the application is incomplete or not returned to the center. It is important to note that households can refuse to complete the form, and if that happens, centers will simply classify all participants as “paid.”

Adult Centers

COMPLETE ‘OFFICIAL USE ONLY’ SECTION

On the bottom of every eligibility application, the determining official will report total income, frequency, and household size OR select categorical eligibility if the participant reported a case number. Based on this information, either free, reduced-price, or paid will be selected.

Then, at least one determining official must sign and date the form. It is best practice for centers to identify two determining officials, such as the director and assistant director, who will serve as an edit check to ensure accuracy.

- **Requirement:** At least one Official’s Signature.
- **Best Practice:** Two Official’s Signatures
 - *Two eyes are always better than one!*

Part 1. All Household Members - Name of Enrolled Adult(s):

Names of Adult Participants (First, Middle Initial, Last)	DATE OF BIRTH (MM/DD/YY)	CHECK IF NO INCOME

Part 2. Benefits:

If any member of your household received SNAP, FDIPIR, State SSI or AHCCCS, provide the name and case number for the person who receives benefits. If no one receives these benefits, skip to part 3.

NAME: _____ CASE NUMBER: _____

Part 3. Total Household Gross Income (Income before any deductions) —You must tell us how much and how often

A. Name (List all people living in the household, including spouse and/or children)	B. Gross income and how often it was received: identify weekly, every other week, monthly, yearly...			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	how much/how often	how much/how often	how much/how often	how much/how often
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____

Part 4. Signature and Last Four Digits of Social Security Number:

A responsible adult must sign this form. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or write the word None if the signer doesn't have a Social Security Number. (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center 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.

Sign here: _____ Print name: _____ Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: ____ * ____ * ____ * ____ * ____ If no SSN, write the word "None." _____

Part 5. Participant's ethnic and racial identities (optional):

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

Don't fill out this part. This is for official use only:

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ☐ Week, ☐ Every 2 Weeks, ☐ Twice A Month, ☐ Month, ☐ Year Household size: _____

Categorical/Income Eligibility: Free _____ Reduced _____ Paid _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Let's Practice...

Review the following scenarios. Using the Income Eligibility Guidelines, identify if the participant qualifies as free, reduced-price, or paid based on household income.

- *Please note, the Income Guidelines used in the following examples are intended for this exercise only. Operators must always obtain the Income Eligibility Guidelines from ADE HNS' webpage to ensure the most up-to-date guidelines are used.*

Let's Practice...

Scenario One: A household has reported the following information on their complete eligibility application:

- Household size = 5
- Total household income = \$1400
- Frequency = Bi-Weekly

Are these participants classified as free, reduced-price or paid?

	How often was income received?									
	Weekly		Bi-Weekly		2x Month		Monthly		Annually	
Household Size*	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced
1	\$377	\$536	\$753	\$1,072	\$816	\$1,161	\$1,632	\$2,322	\$19,578	\$27,861
2	\$511	\$728	\$1,022	\$1,455	\$1,108	\$1,576	\$2,215	\$3,152	\$26,572	\$37,814
3	\$646	\$919	\$1,291	\$1,838	\$1,399	\$1,991	\$2,798	\$3,981	\$33,566	\$47,767
4	\$780	\$1,110	\$1,560	\$2,220	\$1,690	\$2,405	\$3,380	\$4,810	\$40,560	\$57,720
5	\$915	\$1,302	\$1,829	\$2,603	\$1,982	\$2,820	\$3,963	\$5,640	\$47,554	\$67,673
6	\$1,049	\$1,493	\$2,098	\$2,986	\$2,273	\$3,235	\$4,546	\$6,469	\$54,548	\$77,626
7	\$1,184	\$1,685	\$2,367	\$3,369	\$2,565	\$3,650	\$5,129	\$7,299	\$61,542	\$87,579
8	\$1,318	\$1,876	\$2,636	\$3,752	\$2,856	\$4,064	\$5,712	\$8,128	\$68,536	\$97,532
Additional members, add:	\$135	\$192	\$269	\$383	\$292	\$415	\$583	\$830	\$6,994	\$9,953

Let's Practice...

Scenario One: A household has reported the following information on their complete eligibility application:

- Household size = 5
- Total household income = \$1400
- Frequency = Bi-Weekly

Are these participants classified as free, reduced-price or paid?

	How often was income received?									
	Weekly		Bi-Weekly		2x Month		Monthly		Annually	
Household Size*	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced
1	\$377	\$536	\$753	\$1,072	\$816	\$1,161	\$1,632	\$2,322	\$19,578	\$27,861
2	\$511	\$728	\$1,022	\$1,455	\$1,108	\$1,576	\$2,215	\$3,152	\$26,572	\$37,814
3	\$646	\$919	\$1,291	\$1,838	\$1,399	\$1,991	\$2,798	\$3,981	\$33,566	\$47,767
4	\$780	\$1,110	\$1,560	\$2,220	\$1,690	\$2,405	\$3,380	\$4,810	\$40,560	\$57,720
5	\$915	\$1,302	\$1,829	\$2,603	\$1,982	\$2,820	\$3,963	\$5,640	\$47,554	\$67,673
6	\$1,049	\$1,493	\$2,098	\$2,986	\$2,273	\$3,235	\$4,546	\$6,469	\$54,548	\$77,626
7	\$1,184	\$1,685	\$2,367	\$3,369	\$2,565	\$3,650	\$5,129	\$7,299	\$61,542	\$87,579
8	\$1,318	\$1,876	\$2,636	\$3,752	\$2,856	\$4,064	\$5,712	\$8,128	\$68,536	\$97,532
Additional members, add:	\$135	\$192	\$269	\$383	\$292	\$415	\$583	\$830	\$6,994	\$9,953

\$1,400 bi-weekly for a family of five classifies the participant as free.

Let's Practice...

Scenario Two: A household has reported the following information on their complete eligibility application:

- Household size = 7
- Total household income = \$4296
- Frequency = Monthly

Are these participants classified as free, reduced-price or paid?

	How often was income received?									
	Weekly		Bi-Weekly		2x Month		Monthly		Annually	
Household Size*	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced
1	\$377	\$536	\$753	\$1,072	\$816	\$1,161	\$1,632	\$2,322	\$19,578	\$27,861
2	\$511	\$728	\$1,022	\$1,455	\$1,108	\$1,576	\$2,215	\$3,152	\$26,572	\$37,814
3	\$646	\$919	\$1,291	\$1,838	\$1,399	\$1,991	\$2,798	\$3,981	\$33,566	\$47,767
4	\$780	\$1,110	\$1,560	\$2,220	\$1,690	\$2,405	\$3,380	\$4,810	\$40,560	\$57,720
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8	\$1,318	\$1,876	\$2,636	\$3,752	\$2,856	\$4,064	\$5,712	\$8,128	\$68,536	\$97,532
Additional members, add:	\$135	\$192	\$269	\$383	\$292	\$415	\$583	\$830	\$6,994	\$9,953

Let's Practice...

Scenario Two: A household has reported the following information on their complete eligibility application:

- Household size = 7
- Total household income = \$6296
- Frequency = Monthly

Are these participants classified as free, reduced-price or paid?

Household Size*	How often was income received?									
	Weekly		Bi-Weekly		2x Month		Monthly		Annually	
	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced
1	\$377	\$536	\$753	\$1,072	\$816	\$1,161	\$1,632	\$2,322	\$19,578	\$27,861
2	\$511	\$728	\$1,022	\$1,455	\$1,108	\$1,576	\$2,215	\$3,152	\$26,572	\$37,814
3	\$646	\$919	\$1,291	\$1,838	\$1,399	\$1,991	\$2,798	\$3,981	\$33,566	\$47,767
4	\$780	\$1,110	\$1,560	\$2,220	\$1,690	\$2,405	\$3,380	\$4,810	\$40,560	\$57,720
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8	\$1,318	\$1,876	\$2,636	\$3,752	\$2,856	\$4,064	\$5,712	\$8,128	\$68,536	\$97,532
Additional members, add:	\$135	\$192	\$269	\$383	\$292	\$415	\$583	\$830	\$6,994	\$9,953

\$6,296 monthly for a family of seven classifies the participant as reduced-price.

Let's Practice...

Scenario Three: A household has reported the following information on their complete eligibility application:

- Household size = 2
- Household income = \$500
- Frequency = 2X Month
- Household income = \$50
- Frequency - Weekly

What is this household's total annual income?

Annual Income Conversion for Multiple Reported Incomes:

If a household reports only one income or multiple incomes with the same frequency, do not convert to annual income. If a household reports multiple income sources with different frequencies (e.g., 1 income is received weekly, another income is received monthly), convert all reported incomes to annual using the conversion factors below. Then, add the income together and compare it to the annual income guidelines to make a determination.

Weekly Income x 52	Bi-Weekly Income x 26	2x Month Income x 24	Monthly Income x 12
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Let's Practice...

Scenario Three: A household has reported the following information on their complete eligibility application:

- Household size = 2
- Household income = \$500
- Frequency = 2X Month
- Household income = \$50
- Frequency - Weekly

What is this household's total annual income?

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If a household reports only one income or multiple incomes with the same frequency, do not convert to annual income. If a household reports multiple income sources with different frequencies (e.g., 1 income is received weekly, another income is received monthly), convert all reported incomes to annual using the conversion factors below. Then, add the income together and compare it to the annual income guidelines to make a determination.

Weekly Income x 52	Bi-Weekly Income x 26	2x Month Income x 24	Monthly Income x 12
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When a household is paid on multiple frequencies the total household income must be converted to their total annual household income.

To do so for this scenario, take \$500 and multiply it by 24, then take \$50 and multiply that by 52. Now take the total, \$12,000 from the first income plus the total from the second income, \$2,600 and combine those totals for the total household income. The total annual household income is 14,600 dollars.

$$\$500 \times 24 = \$12,000$$

$$\$50 \times 52 = \$2,600$$

$$\$12,000 + \$2,600 = \$14,600$$

Let's Practice...

Scenario Three: A household has reported the following information on their complete eligibility application:

- Household size = 2
- Annual household income (based on figures below) = \$14,600
 - Household income = \$500
 - Frequency = 2X Month
 - Household income = \$50
 - Frequency - Weekly

Are these participants classified as free, reduced-price or paid?

	How often was income received?									
	Weekly		Bi-Weekly		2x Month		Monthly		Annually	
Household Size*	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced
1	\$377	\$536	\$753	\$1,072	\$816	\$1,161	\$1,632	\$2,322	\$19,578	\$27,861
2	\$511	\$728	\$1,022	\$1,455	\$1,108	\$1,576	\$2,215	\$3,152	\$26,572	\$37,814
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Additional members, add:	\$135	\$192	\$269	\$383	\$292	\$415	\$583	\$830	\$6,994	\$9,953

Let's Practice...

Scenario Three: A household has reported the following information on their complete eligibility application:

- Household size = 2
- Annual household income (based on figures below) = \$14,600
 - Household income = \$500
 - Frequency = 2X Month
 - Household income = \$50
 - Frequency - Weekly

Are these participants classified as free, reduced-price or paid?

	How often was income received?									
	Weekly		Bi-Weekly		2x Month		Monthly		Annually	
Household Size*	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced
1	\$377	\$536	\$753	\$1,072	\$816	\$1,161	\$1,632	\$2,322	\$19,578	\$27,861
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8	\$1,318	\$1,876	\$2,636	\$3,752	\$2,856	\$4,064	\$5,712	\$8,128	\$68,536	\$97,532
Additional members, add:	\$135	\$192	\$269	\$383	\$292	\$415	\$583	\$830	\$6,994	\$9,953

\$14,600 annually for a family of two classifies the participant as free.

Participant Eligibility

SUMMARY

- ✓ Eligibility applications are effective July 1 – June 30. Upon enrollment and every year, households complete the applications. ADE updates the forms every year and posts them on the ADE Webpage.
- ✓ Multiple participants on the same eligibility application may be classified differently. If a child participant is foster, they are automatically classified as “Free” and the other child participants are classified based on a reported case # or household income.

BEST PRACTICES

- ✓ ADE recommends eligibility applications be kept in a 3-ring binder, each tab labeled free, reduced, and paid.
- ✓ ADE recommends applications be alphabetized within each category.
- ✓ Children with different last names should be filed under the last name of the first child and a copy of the application filed under the last name of the subsequent enrolled siblings

Claiming Rosters

Exempt: Emergency Shelters and At-Risk Programs

SECTION 4



Claiming Rosters

Child Care Centers, Adult Care Centers, and Head Start Facilities must keep claiming rosters for their participants.

All information must be legible and satisfy the following requirements:

- ✓ Names on claiming rosters must match the names on participant attendance, enrollment, and eligibility forms
- ✓ There are three claiming rosters: free, reduced-price, and paid. Participants are listed on each roster, based on their annual classification.

Child and Adult Care Centers use the household's eligibility applications to generate their claiming rosters.

Before we dive into how to create a claiming roster from the completed eligibility applications, let's discuss Head Start centers.

Claiming Rosters

HEAD START PROGRAMS

As mentioned in the last section, Head Start facilities are exempt from identifying participant eligibility because they are reimbursed at the free rate.

For a Head Start to receive reimbursement at the free rate for all participants, they must maintain an official document showing participants qualify for Head Start per the Head Start income guidelines. This documentation must be signed by the Head Start Determining Official and kept on site.

A list of names provided by the Head Start Administrative Office or a monthly roster of enrolled participants is also an acceptable form of documentation.

Claiming Rosters

CHILD AND ADULT CENTERS

There are 3 claiming rosters used by Child and Adult Centers - Free, Reduced-price, and Paid.

Once a center checks an eligibility application for completeness and signs the form, classifying a participant as free, reduced-price, or paid – the participant's name must be written on one of the claiming rosters.



Although these forms are valid for the year, a household can report a change in income mid-year and complete a new form. In this case, the participant would be re-categorized for the remainder of the year.

[illegible]

Templates and forms are available on [ADE HNS' CACFP Forms and Resources webpage](#).

Claiming Rosters

CHILD AND ADULT CENTERS

Last Name, First Name

When eligibility is determined, write the participant's first and last name on a claiming roster – free, reduced-price, or paid.

Month Column

When a participant is signed into care at least one time during the month, place a check mark in the monthly column.

Total Participants

Count the total participants on every roster signed into care for the month. When submitting a monthly claim, totals from each category are reported.

[illegible]

Templates and forms are available on [ADE HNS' CACFP Forms and Resources](#) webpage.

Let's Practice...

Let's take a look at a claiming roster scenario.

Six children are listed on the free claiming roster. The director has placed a checkmark in the July column for every participant that was in attendance in July.

When submitting the July claim, how many free participants will you report?

[illegible]

Let's Practice...

Let's take a look at a claiming roster scenario.

Six children are listed on the free claiming roster. The director has placed a checkmark in the July column for every participant that was in attendance in July.

When submitting the July claim, how many free participants will you report?

Four.



Free Claiming Roster for Program Year 2025

List of participants that qualify for **FREE** meals based on complete Meal Benefit Income Eligibility Forms.

Sponsoring Organization: Example

Center Name: Example

CTDS# 00-00-00

CTDS# 00-00-00

Participant Name		Claiming Month											
		Mark participants who were in attendance during the claiming month, as supported by sign-in/out sheets.											
Last Name	First Name	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Anderson	Jackson	X											
Bartlett	Savanah	X											
Darien	Xavier												
Kennedy	Alanah	X											
Lopez	Mia	X											
Samson	Timothy												

Although there are 6 participants classified as “Free,” only 4 were in attendance in July.

CONTACT US

If you have a question or require additional assistance, please contact your assigned specialist or contact HNS.



602-542-8700



ContactHNS@azed.gov



www.azed.gov/hns





Congratulations

You have completed the training: Participant Enrollment

ADHS Empower Program

This training counts toward Empower Program training requirements.

Arizona Early Childhood Workforce Registry

This training is listed on the Arizona Early Childhood Workforce Registry. If you want this training to appear on your registry transcript, please provide your Workforce Registry ID when completing the survey.

Certificate

Requesting a training certificate

Please click the button to complete a brief survey about this online training. Once the survey is complete, you will be able to print your certificate of completion from Survey Monkey.



Training Title: Participant Enrollment

Length: 1 Hour

Please note, attendees must document the amount of training hours indicated on the training despite the amount of time it takes to complete it.





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1. **Mail:** U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Mail Stop 9410, Washington, D.C. 20250-9410;
2. **Fax:** (202) 690-7442; or
3. **Email:** program.intake@usda.gov.

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