

Mailing Address:
P.O. Box 7130
Westchester, IL 60154

Association for Child Development
HOUSEHOLD ELIGIBILITY APPLICATION
PARENT/GUARDIANS LETTER

Tel. (800)284-5273
Fax (708)236-0872
www.acdkids.org

Dear Parent or Guardian:

Your day care home provider participates in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP) and receives Federal funds to offer healthy meals and snacks to all of the enrolled children. The amount of reimbursement the day care home provider receives is based on the information you provide on the attached Household Eligibility Application. To receive meal reimbursement payments, your day care home provider must follow menu planning guidelines, keep accurate meal records each day and agree to monitoring visits by our staff while children are in their care.

Your day care home provider will receive a higher rate of reimbursement if your household income meets or is below the Income Eligibility Guidelines listed in this letter or if a member of your family (child or adult) receives Supplemental Nutrition Assistance Program (SNAP); Temporary Assistance for Needy Families (TANF); Women, Infants, and Children (WIC); or other state or federal program benefits for your children. Also, if you care for a foster child that is the legal responsibility of the Department of Children and Family Services (DCFS) or the court, these children are eligible for meal benefits regardless of your household income.

If your income(s) is over the income guidelines on the following page, you are not required to complete this application; however, it would be helpful if you would write your child's name on the application and return it to our day care home provider or mail to the address provided on the enclosed envelope. Please notify us, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the income eligibility standards.

The information you provide on the application will be used to determine your child's eligibility for meal benefits. The information will be kept confidential and only available to staff directly connected with administering the CACFP.

Please note that by signing Number 4 of the enclosed HEA for the Illinois *All Kids* Health Insurance that you are stating you do not want your information shared with the Illinois Department of Healthcare and Family Services. If you agree to disclose the application information, it may be used to identify your child(ren) for the health insurance program. If you would like more information on *All Kids*, call toll-free 866/255-5437 or 877/204-1012 (TTY).

INCOME ELIGIBILITY GUIDELINES
July 1, 2013 through June 30, 2014
Level for Reduced-Price Meals

Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	21,257	1,772	886	818	409
2	28,694	2,392	1,196	1,104	552
3	36,131	3,011	1,506	1,390	695
4	43,568	3,631	1,816	1,676	838
5	51,005	4,251	2,126	1,962	981
6	58,442	4,871	2,436	2,248	1,124
7	65,879	5,490	2,745	2,534	1,267
8	73,316	6,110	3,055	2,820	1,410
For Each Additional Family Member Add	7,437	620	310	287	144

If you have any questions or need help, please contact our day care home provider or sponsoring organization listed below.

Sincerely,

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free 866/632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at 800/877-8339; or 800/845-6136 (Spanish). USDA is an equal opportunity provider and employer.

PARENT INSTRUCTIONS FOR COMPLETING THE HOUSEHOLD ELIGIBILITY APPLICATION

Once properly approved for meal benefits, a child's Household Eligibility Application (HEA) will remain in effect for 12 months.

Complete the Household Eligibility Application (HEA) for one of the following areas:

- If anyone (child or adult) in your household receives Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) follows **Instruction A** below.
- If you or a child receives benefits from the Women, Infants, and Children Program (WIC); Low Income Home Energy Assistance Program; or free or reduced-priced meals from the National School Lunch and Breakfast Programs, please follow **Instruction B** below.
- If you have a foster child who remains the legal responsibility of the Department of Children and Family Services (DCFS) or the court, follow **Instruction C** below.
- If you receive income, follow **Instruction D** below.

Instructions A—Households Receiving SNAP or TANF

If any member (child or adult) of your household receives benefits from SNAP or TANF, provide the following information:

- **Number 1**—List the names of ALL people in your household (such as grandparents, other relatives, or friends who live with you) and the age(s) of the child(ren) attending the day care home.
- **Number 3**—Record a valid SNAP or TANF case number for any member (child or adult) of this household. Do not list your Illinois LINK card number. You may find your SNAP or TANF case number on your medical card or letter of eligibility for benefits.
- **Number 4 (OPTIONAL)**—*Illinois All Kids Health Insurance Program.*
- **Number 6**—Provide a signature of an adult household member and date the application.
- Your application is complete.

Instructions B—Individuals receiving WIC or Low Income Home Energy Assistance Program

If any member (child or adult) of your household receives benefits from WIC or Low Income Home Energy Assistance Program, provide the following information:

- **Number 1**—List the names of ALL people in your household (such as grandparents, other relatives, or friends who live with you) and the age(s) of the child(ren) attending the day care home.
- **Number 3**—Identify the individual that is receiving WIC and record a valid WIC case number for that member (child or adult) of this household. If an individual or household is receiving assistance from Low Income Home Energy Assistance Program; or free or reduced-priced meals from the National School Lunch and Breakfast Programs identify the individual that is receiving benefits and mark the Other Extended Categorical.
- **Number 4 (OPTIONAL)**—*Illinois All Kids Health Insurance Program.*
- **Number 6**—Provide a signature of an adult household member and date the application.
- Your application is complete.

Instructions C—Application for a Foster Child(ren). A foster child remains the legal responsibility of DCFS or the court.

- 1) If you have a legal document from DCFS or the court for your foster child, please provide a copy; you do not need to complete this application. If you don't have a legal document, follow Step 2 or 3 below.
- 2) If all children in your household (who attend this day care home) are foster children provide the following information:
 - **Number 1**—List the name(s) and age(s) of your foster child(ren) attending this day care home.
 - **Number 2**—Check the box(es) indicating the child is a foster child(ren).
 - **Number 4 (OPTIONAL)**—*Illinois All Kids Health Insurance Program.*
 - **Number 6**—Provide a signature of an adult household member and date the application.
 - Your application is complete.
- 3) If you have a foster child(ren) along with other children attending this day care home, please provide the following information:
 - **Number 1**—List the names of ALL household members including the foster child(ren) and the age(s) of the child(ren) attending the day care home.
 - **Number 2**—Check the box(es) identifying the foster child(ren).
 - **Number 4 (OPTIONAL)**—*Illinois All Kids Health Insurance Program.*
 - **Next Go to Instruction D—Households Reporting Income** below and complete Numbers 5 and 6.

Instructions D—Households Reporting Income

It is not necessary to complete income information if you provided SNAP or TANF information in Number 3. However, if no one in your household receives SNAP or TANF benefits, please report all household income. The Household Eligibility Application must include the following information:

- **Number 1**—List the names of ALL household members and the age(s) of the child(ren) attending the day care home.
- **Number 4 (OPTIONAL)**—*Illinois All Kids Health Insurance Program.*
- **Number 5**—List total gross income (before deductions), not your take-home pay; and the frequency, how often the money is received, for each household member for last month. If the income last month was not the usual amount you normally receive, you may provide a projected amount that better represents your gross income.
 - For ONLY the self-employed, list monthly income after expenses. This is for your business, farm, or rental property.
 - If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.
- **Number 6**—Provide the last four digits of the social security number for the adult household member signing the application. If you refuse to provide the last four digits of the social security number, the application cannot be approved. If the adult does not have a social security number, mark the box, *I do not have a social security number.*
- Your application is complete.

CHILD AND ADULT CARE FOOD PROGRAM – HOUSEHOLD ELIGIBILITY APPLICATION FOR PARENT/GUARDIANS OF ENROLLED CHILDREN IN A DAY CARE HOME

<p>1 LIST EVERYONE IN HOUSEHOLD (Children and Adults)</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">NAME (First, Middle and Last)</th> <th style="width:10%;">Check If No Income</th> <th style="width:10%;">Date of Birth</th> <th style="width:10%;">Ages of Children Enrolled in Day Care Home</th> <th style="width:10%;"></th> </tr> </thead> <tbody> <tr><td> </td><td><input type="checkbox"/></td><td>/ /</td><td> </td><td><input type="checkbox"/></td></tr> <tr><td> </td><td><input type="checkbox"/></td><td>/ /</td><td> </td><td><input type="checkbox"/></td></tr> <tr><td> </td><td><input type="checkbox"/></td><td>/ /</td><td> </td><td><input type="checkbox"/></td></tr> <tr><td> </td><td><input type="checkbox"/></td><td>/ /</td><td> </td><td><input type="checkbox"/></td></tr> <tr><td> </td><td><input type="checkbox"/></td><td>/ /</td><td> </td><td><input type="checkbox"/></td></tr> <tr><td> </td><td><input type="checkbox"/></td><td>/ /</td><td> </td><td><input type="checkbox"/></td></tr> <tr><td> </td><td><input type="checkbox"/></td><td>/ /</td><td> </td><td><input type="checkbox"/></td></tr> <tr><td> </td><td><input type="checkbox"/></td><td>/ /</td><td> </td><td><input type="checkbox"/></td></tr> </tbody> </table>	NAME (First, Middle and Last)	Check If No Income	Date of Birth	Ages of Children Enrolled in Day Care Home			<input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	/ /		<input type="checkbox"/>		<input type="checkbox"/>	/ /		<input type="checkbox"/>	<p>2 FOSTER CHILD Check box for all foster children that are a legal responsibility of DCFS or the court.</p> <input type="checkbox"/>	<p>3 CATEGORICAL ELIGIBILITY FOR FEDERAL OR STATE PROGRAMS</p> <p>Name of Child: _____</p> <p>SNAP or TANF Number: _____</p> <p>WIC Number _____</p> <p>OTHER CATEGORICAL ELIGIBILITY –</p> <p><input type="checkbox"/> Low Income Home Energy Assistance Program</p> <p><input type="checkbox"/> Other Extended Categorical</p>
NAME (First, Middle and Last)	Check If No Income	Date of Birth	Ages of Children Enrolled in Day Care Home																																												
	<input type="checkbox"/>	/ /		<input type="checkbox"/>																																											
	<input type="checkbox"/>	/ /		<input type="checkbox"/>																																											
	<input type="checkbox"/>	/ /		<input type="checkbox"/>																																											
	<input type="checkbox"/>	/ /		<input type="checkbox"/>																																											
	<input type="checkbox"/>	/ /		<input type="checkbox"/>																																											
	<input type="checkbox"/>	/ /		<input type="checkbox"/>																																											
	<input type="checkbox"/>	/ /		<input type="checkbox"/>																																											
	<input type="checkbox"/>	/ /		<input type="checkbox"/>																																											

4 OPTIONAL—SHARING INFORMATION WITH ALL KIDS INSURANCE PROGRAM
 May we share your information on this application with *All Kids Insurance Program*, the complete health insurance program for every child in Illinois? If yes, do not sign below.
 No, I do not want my information from this application shared with *All Kids Insurance Program*. Sign here: _____

5 HOUSEHOLD MEMBERS WITH INCOME—List only the names of individuals living in the household, their gross income, and how often it is received. If a person has a second job, list that income in the last column. After completing, go to Number 6.

NAMES (List only individuals with income)	Earnings from Work (Gross before Deductions)		Income from Welfare, Child Support, Alimony		Income from Retirement, Pensions, SSI, Social Security		Income Received From Savings, Investments, Trust Accounts, and Other Resources	
	How Much?	How Often?	How Much?	How Often?	How Much?	How Often?	How Much?	How Often?
	\$ /		\$ /		\$ /		\$ /	
	\$ /		\$ /		\$ /		\$ /	
	\$ /		\$ /		\$ /		\$ /	
	\$ /		\$ /		\$ /		\$ /	
	\$ /		\$ /		\$ /		\$ /	

6 Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Number 5 above is completed the adult signing the form must also list the last four digits of his or her social security number or mark the box I do not have a social security number.

X X X - X X - _____
Social Security Number

I certify all information on this application is true and all income is reported. I understand the day care provider will get federal funds based on the information I give. I understand the institution, Illinois State Board of Education, or Office of Inspector General, may verify this information on the application. Deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Date	Printed Name of Adult Household Member	Signature of Adult Household Member	Address of Adult Household Member
------	--	-------------------------------------	-----------------------------------

PRIVACY ACT STATEMENT: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced-price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program, or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced-price meals, and for administration and enforcement of the Child and Adult Care Food Program. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

NON-DISCRIMINATION STATEMENT: In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free 866/632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at 800/877-8339; or 800/845-6136 (Spanish). USDA is an equal opportunity provider and employer.

SPONSOR REPRESENTATIVE USE ONLY—ELIGIBILITY DETERMINATION—Follow the instructions provided in the Household Income instructions.

Mark one of the boxes below to show how you are going to determine eligibility.

<p><input type="checkbox"/> Categorically Eligible for Federal or State Program</p> <p>CONVERSION TABLE To convert all income to annual income use the following conversion calculations: Weekly Income x 52 Every 2 Weeks x 26 Twice a Month x 24 Monthly x 12</p>	<p><input type="checkbox"/> Income Household Use the conversion table to convert income to total annual income. Total the number of household members from Section 5.</p> <p>Total Household Annual Income \$ _____</p> <p>Total Household Size _____</p>
<p><input type="checkbox"/> Approved for Tier I Meal Rate</p> <p><input type="checkbox"/> Denied</p>	
<p>Effective Date of Application _____</p> <p>Signature of Representative _____</p>	