This form MUST be filled out as required by the State of Maine

STATE OF MAINE
DEPARTMENT OF EDUCATION
23 STATE HOUSE STATION
AUGUSTA, ME 04333-0023

JANET T. MILLS
GOVERNOR

A. PENDER MAKIN
COMMISSIONER

CHILD CARE CENTERS
July 1, 2024 to June 30, 2025

Dear Parent:

The Child Care Center in which you are enrolling your child participates in the U.S. Department of Agriculture's Child and Adult Care Food Program (CACFP). This means the Center must serve meals and snacks that meet or exceed the nutritional requirements set forth by the U.S. Government.

In return for serving meals and snacks that meet these requirements, the Center receives payment from the USDA based on the income levels of the families being served. CACFP gives more support if your household income is less than or equal to the limits on this chart:

Eligibility Scale for "Reduced-Price" Meals
July 1, 2024 to June 30, 2025

Family Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	27,861	2,322	1,161	1,072	536
2	37,814	3,152	1,576	1,455	728
3	47,767	3,981	1,991	1,838	919
4	57,720	4,810	2,405	2,220	1,110
5	67,673	5,640	2,820	2,603	1,302
6	77,626	6,469	3,235	2,986	1,493
7	87,579	7,299	3,650	3,369	1,685
8	97,532	8,128	4,064	3,752	1,876
Each Additional Family Member	9,953	830	415	383	192

In order to determine the level of reimbursement to be received by the Center for meals or supplements served to your child, the USDA requests you to complete the attached application and to include all of the following information on the appropriate lines.

1. The name and age of the child for whom you are making application.

2. If the child for whom you are making application, or any other person in your household, is a member of a Supplemental Nutrition Assistance Program (SNAP) Household (formerly known as Food Stamps), Temporary Assistance to Needy Families (TANF) Assistance Unit, or a household that receives benefits under the Food Distribution Program on Indian Reservations (FDPIR), you may give their SNAP, TANF, or FDPIR case number in PART I and then skip to PART III.

3. IN PART II, you must include the name of each person living in the "household." A "household" is any group of persons living together sharing income and living expenses. These persons may or may not all be related to each other.

4. The last four (4) digits of the Social Security number of the household member or guardian who signs the application form.

5. The total income, before deductions, from all sources, for all persons living in the household.

6. The signature, address, and telephone number of the person completing the application form. The date the form was signed must also be included.

A form will not be considered "complete" unless the applicable information listed above is provided. The person who signs the form must understand that if the household income section of the form is left blank, that person is certifying that the household has zero income. The center staff will then consider your child to be in that category of eligibility which qualifies the center to receive the highest level of payment for the meals and supplements your child will receive. Thank you.

Sincerely,

Child and Adult Care Food Program

APPLICATION FOR "FREE" OR "REDUCED-PRICE" MEALS
CHILD AND ADULT CARE FOOD PROGRAM (CACFP) July 1, 2024 to June 30, 2025

CHILD FOR WHOM APPLICATION IS BEING MADE: Name:
Age: _____

Days of the Week in Care	Hours in Care (i.e. 7:30 – 5:00)	Meals Received While in Care*
☐ **Monday**		☐ **Br** ☐ **AM S** ☐ **Lu** ☐ **PM S** ☐ **Su** ☐ **E S**
☐ **Tuesday**		☐ **Br** ☐ **AM S** ☐ **Lu** ☐ **PM S** ☐ **Su** ☐ **E S**
☐ **Wednesday**		☐ **Br** ☐ **AM S** ☐ **Lu** ☐ **PM S** ☐ **Su** ☐ **E S**
☐ **Thursday**		☐ **Br** ☐ **AM S** ☐ **Lu** ☐ **PM S** ☐ **Su** ☐ **E S**
☐ **Friday**		☐ **Br** ☐ **AM S** ☐ **Lu** ☐ **PM S** ☐ **Su** ☐ **E S**
☐ **Saturday**		☐ **Br** ☐ **AM S** ☐ **Lu** ☐ **PM S** ☐ **Su** ☐ **E S**
☐ **Sunday**		☐ **Br** ☐ **AM S** ☐ **Lu** ☐ **PM S** ☐ **Su** ☐ **E S**

* Br = Breakfast AM S = AM Snack Lu = Lunch PM S = PM Snack Su = Supper E S = Evening Snack

NOTE: If you are applying for CACFP benefits on behalf of a Foster Child, please check this box and notify the person to whom you return this form. ☐ Foster Child

PART I: HOUSEHOLDS RECEIVING SNAP, TANF, OR FDPIR BENEFITS:
If you, your child, or any other person living in your household currently receives SNAP, TANF, or FDPIR benefits, please provide their SNAP, TANF, or FDPIR case number. DO NOT COMPLETE Part II; skip to Part III. Part III must include the **printed name** and **signature of the adult who completes this application**. The **date the application was completed** needs to be included also.

(a) ☐ YES: A member of this household receives SNAP, TANF, or FDPIR benefits.

(b) SNAP Case Number: # __ __ __ __ __ __ __ __ __ (**not** EBT number)

(c) TANF Case Number: # __ __ __ __ __ __ __ __ __

(d) FDPIR Case Number: # __ __ __ __ __ __ __ __ __

If applicable, your child's Free or Reduced-Price meal eligibility information will be disclosed to Medicaid and/or SCHIP unless you elect not to have the information disclosed. The information will be used to identify children eligible for, and to seek to enroll children in, a health insurance program. Your decision on whether to disclose this information will not affect your child's eligibility for Free or Reduced-Price meals.
If you elect not to have this information disclosed to Medicaid and/or SCHIP, please check this box: ☐

NOTE #1:
If no one in your household receives SNAP, TANF, or FDPIR benefits, or if you do not provide their case number, you must complete Part II and Part III in order for your child to qualify for either "Free" or "Reduced-Price" meals. **You must also include the last four (4) digits of your Social Security Number on the line next to your signature.**

PART II: ALL OTHER HOUSEHOLDS:

(a) **Household Members**: List the name of every person living in your household. **Be sure to include yourself and the child listed above**.

(b) **Social Security Number**: Section 9 of the National School Lunch Act requires that, unless a SNAP or TANF case number is provided for your child, you must include the last four (4) digits of your Social Security number on the application. This must be the Social Security number of the adult household member signing the application. If the adult household member signing the application does not possess a Social Security number, they must indicate so on the application. Provision of a Social Security number is not mandatory, but if the last four (4) digits of the adult household member's Social Security number are not provided or an indication is not made that the adult household member signing the application does not have one, the application cannot be approved. This notice must be brought to the attention of the household member whose Social Security number is disclosed. The Social Security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a SNAP, Indian Tribal Organization, or Welfare Office to determine current certification for receipt of SNAP, FDPIR, or TANF benefits, contacting the State Employment Security Office to determine the amount of benefits received, and checking the documentation produced by household members to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal action if incorrect information is reported.

(C) **Income:** List **all** income from **all** sources received last month on the same line as the name of the person who received it. Income must be **gross**, that is, it must be the amount received **before deductions** for taxes, Social Security, dues, insurance, etc. List each amount under the correct column. ***If you are in the Military Privatized Housing Initiative or receive combat pay, please do not include these allowances as income.***

LIST ALL HOUSEHOLD MEMBERS:

Names of Household Members:	Age	Monthly Gross Wages or Net Self-Employment	Monthly TANF, Alimony, Welfare, Child Support	Monthly Pensions, SSI, Social Security, Workers Comp, Unemployment Comp, Insurance & Retirement
1.				
2.				
3.				
4.				
5.				
6.				
(Note: Weekly income x 4.333 weeks; Bi-weekly income x 2.15 weeks) **TOTAL MONTHLY HOUSEHOLD INCOME:**				

PART III:

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that all income is reported. I understand this information is being given in connection with the receipt of Federal Funds and Program Officials may verify the information on the application and that deliberate misrepresentation of any of the information on this application may subject me to prosecution under applicable State and Federal Criminal Statutes.

PRINT NAME OF ADULT	LAST 4 DIGITS OF SS#	SIGNATURE OF ADULT	DATE

❑ I do not have a social security number.

HOUSEHOLD ADDRESS OF ADULT	HOME PHONE	WORK PHONE

ALL HOUSEHOLDS: Racial/Ethnic Identity: *

1. **Ethnicity:**
   - ☐ **Hispanic or Latino**
   - ☐ **Not Hispanic or Latino**

***This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws. Your response will not affect consideration of your application.**

2. **Race (mark one or more):**
   - ☐ **American Indian or Alaska Native**
   - ☐ **Asian**
   - ☐ **Black or African American**
   - ☐ **Native Hawaiian or Other Pacific Islander**
   - ☐ **White**

THIS PORTION MUST BE COMPLETED BY CHILD CARE CENTER PERSONNEL:

Signature: _____ Date: _____

Child's Eligibility Category (Circle One): Free Reduced-Price Paid

Federal Non-Discrimination Statement

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/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.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:

(1) mail:

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

(2) fax:

(833) 256-1665 or (202) 690-7442; or

(3) email:
program.intake@usda.gov

This institution is an equal opportunity provider.