YES Food & Nutrition Program

Bright from the Start: Georgia Department of Early Care and Learning

Child and Adult Care Food Program Income Eligibility Statement

Day Care Center:_____ **F R P**

PARTI: Child(ren) or Adult enrolled to receive daycare-

Name:(Last, First and Middle Initial) CHILDS NAME	DOB	Food Stamp,TANF,orFDPIR case number, Assistant Unit(AU),or Client ID number for children only .All the above, or SSI or Medicaid case number for Adults .Note: Do not use EBT numbers.	Head Start Participant	Foster Child
1.		9 Digits Only:	☐	☐
2.			☐	☐
3.			☐	☐
4.			☐	☐

PARTII A:

A.Name
(List everyone in household, including foster and non-foster children)

B. Gross income and how often it is received
Example:$100/monthly,$100/twice a month,$100/everyotherweek,$100/weekly

	1. Earnings from work before deductions	2. Welfare, child support, alimony	3.SocialSecurity,pensions, retirement	4. All other income	C. Check if NO Income
1._____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
2._____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
3._____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
4._____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
5._____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
6._____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
7._____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐

PARTIII: ENROLLMENT INFORMATION: Children Only

My child is normally in attendance at the facility between the hours of **6 am** [am/pm] to **7pm** [am/pm]on the following days:
Check here if only before/afterschool care is provided.

(Circle all that apply).Sunday ☒Monday ☒Tuesday ☒Wednesday ☒Thursday ☒Friday
Saturday My child will normally receive the following meals while in care:
(Circle all that apply): ☒Breakfast AM Snack ☒Lunch ☒PM Snack ☒Supper ☒Evening Snack

PARTIV: Signature and Social Security Number (Adult must sign).

An adult household member must sign this form. If Part II is completed the adult signing the form must also list his or her Social Security number or mark the "I don't have a Social Security Number" box.(See Privacy Act Statement on next page).

*I certify that all information on this form is true and that **all** income is reported. I understand that the center or day care home will get Federal fundsbasedontheinformationIgive.IunderstandthatCACFPofficialsmayverifytheinformation. I understand that if I purpose fully give false information, the participant receiving meals may lose the meal benefits ,and I may be prosecuted. This signature also acknowledges that the child(ren) listed on the form in Part I are enrolled for care*

Signature: X_____ **Print Name**_____ **Date**_____

Address:_____ **City**_____ **State: GA** **Zip**_____ **Phone**_____

Last four Digits of Social Security Number XXX-XX_____ ☐ **I do not have a Social Security Number**

PARTV: Participant's ethnic and racial identities(optional)

Mark one ethnic identity:
☐Hispanic/ Latino
☐ Not Hispanic/

Mark one or more racial identities:
☐Asian ☐White ☐Black or African American ☐American Indian or Alaska Native ☐Native Hawaiian or other Pacific Islander

Official Use Only Section for Provider: 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 Eligibility: (check if applicable) ☐ **Date withdrawn:** _____ **Eligibility: (check one) Free** ☐ **Reduced** ☐ **Paid** ☐
Day Care Homes Only: (check one) Tier I _____ **Tier II** _____

Determining Official's Signature: _____ **Date:**_____
Confirming Official's Signature: _____ **Date:**_____
Follow Up Official's Signature: _____ **Date:**_____