MEAL BENEFIT FORM FOR PROVIDERS

Complete, sign, and return this form to your day care home sponsor**:** **Solano Family & Children's Services**
421 Executive Court North, Fairfield CA 94534-4019

If you need assistance completing this form, call: Teresa Godfrey at (707) 864-4630

First and Last name of day care home provider (you):	☐ Check here if your child(ren) is/are enrolled for care in your home.
Are you applying for eligibility as a Tier I home?	☐ Yes ☐ No
Are you applying for Tier I meal benefits for your own child(ren)?	☐ Yes ☐ No

Part 1–Children's Information: Enter the name(s) of all children from your household enrolled in your care.

Last Name	First Name	Birthdate	Foster Child *
			☐
			☐
			☐
			☐

* If the foster child receives personal-use income, please enter the amount, and the frequency it is received, in the last column in Part 3.

Part 2–Categorical Eligibility (Household): If anyone in your household receives CalFresh (formerly Food Stamps), California Work Opportunity and Responsibility to Kids (CalWORKs), or Food Distribution Program on Indian Reservations (FDPIR), enter that person's name below, check the appropriate program box and enter the program case number.

Last Name, First Name	Check One	Case Number
	☐ CalFresh ☐ CalWORKs ☐ FDPIR	

Part 3–Income Eligibility (Not required if you reported a case number in Part 2)

☐ Check this box if no one in the household receives income.

Household Members' Names List **all** household members not listed in Part 1.	**List Gross Income** and how often it was received (e.g., weekly, every 2 weeks, twice a month, monthly, or annually**)			
	Earnings from Work Before Deductions	Alimony, Child Support, Public Assistance	Retirement, Pensions, Social Security	All Other Income (include foster child's personal-use income here)
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$

Enter the total number of household members
(Children listed in Part 1 + other household members listed in Part 3): _____ (Go to Part 4.)

Applicants without income are requested to write **zero in the applicable field or mark **no income**. Any income field left blank is a positive indication of no income and certifies that there is no income to report. Applications with blank income fields will be processed as complete.

Part 4–Last Four Digits of Social Security Number (SSN) and Signature and Certification

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the CalFresh, CalWORKs, or FDPIR, or other eligible program case number is current, correct, or that all income is reported. I understand that this information is being given for the receipt of federal funds, that agency officials may verify the information on the Meal Benefit Form and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Printed Name of Adult: Signature of Adult:		Date:
Last four digits of Social Security Number (SSN):		☐ I do not have a Social Security Number
Address:	City/State/Zip Code:	Daytime Phone Number:

Part 5–Racial/Ethnic Identity (Optional)

Ethnicity:	☐ Hispanic or Latino	☐ Not Hispanic or Latino	
Race (select one or more):	☐ American Indian or Alaska Native	☐ Asian	☐ Black or African American
	☐ Native Hawaiian or Other Pacific Islander		☐ White

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; or **fax:** (833) 256-1665 or (202) 690-7442; or **email:** Program.Intake@usda.gov
This institution is an equal opportunity provider.

Privacy Act Statement: The Richard B. Russel 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 the participant for free or reduce-priced meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The last four digits of the Social Security Number are not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP, or CalFresh), Temporary Assistance for Needy Families (TANF, or CalWORKs) Program, or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier 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 the participant is eligible for free or reduced-Price meals, and for the administration and enforcement of the program. The last four digits of the SSN may be used to identify the household member in verifying the correctness of the information stated on the form. This may include program reviews, audits and investigations, and may include contacting employers to determine income, contacting a CalFresh, CalWORKs, or FDPIR, contacting the state employment security office to determine the amount of benefits received, and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported. The last four digits of the SSN may also be disclosed to programs as authorized under the NSLA and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain federal, state, and local education, and health and nutrition programs.

Day Care Home Sponsor Use Only

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

Check **all** that apply: ☐ Tier I ☐ Tier II	Enter **Total Gross Income** below, and check the frequency it is received: $ _____	☐ Weekly ☐ Monthly	☐ Every 2 Weeks ☐ Annually
Categorical Eligibility:	☐ CalFresh ☐ CalWORKs ☐ FDPIR ☐ Foster Child		

Provider eligible for Tier I reimbursement:	☐ Yes	☐ No
Provider's own child(ren) eligible for Tier I reimbursement:	☐ Yes	☐ No

Determining Official Print Name:	Certification Date:
Determining Official Signature:	

This form must be signed and dated by the agency's official

INSTRUCTIONS FOR COMPLETING THE MEAL BENEFITS FORM FOR PROVIDERS

If you need help, please call: Teresa Godfrey at (707) 864-4630

Name of Day Care Home Provider

a) Print your name. (Not the name of the facility).

b) If your child(ren) is/are enrolled for care in your home, check the box in second column marked, "Check here if your child(ren) is/are enrolled or care in your home."

c) Indicate whether or not you are applying for eligibility as a Tier I home by checking "Yes", or "No" in the second column.

d) Indicate whether or not you are applying for Tier I meal benefits for your own child(ren) by checking "Yes", or "No" in the second column.

Part 1–Children's Information

a) Print the name(s) of your child(ren) enrolled in care and their birthdate(s).

b) If your child is a foster child, check the box to the right of the child's birthdate in the column marked "Foster Child."

Part 2–Categorical Eligibility (Household): If anyone in your household receives CalFresh (formerly Food Stamps), CalWORKs, or FDPIR; complete Part 2, and sign the form in Part 4. Do not complete Part 3.

a) Print the benefit recipient's name. Only one benefit recipient is needed.

b) Check the box corresponding with the program that qualifies the household for higher reimbursement.

c) Write the CalFresh, CalWORKs, or FDPIR case number.

d) Skip Part 3. Complete Part 4. Part 5 is optional.

All children in the household are categorically eligible for Tier I reimbursement if any member of the household receives CalFresh, CalWORKs, or FDPIR benefits.

Part 3–Income Eligibility: Complete this section if you do not receive benefits listed in Part 2.

a) Print the names of all household members not listed in Part 1. Do not list the children in care. Include household members even if they do not have income. Include yourself, your spouse, or your significant other, and all other household members such as your grandmother, etc. if they are part of your household.

b) Write the amount of income each person received before taxes or any other deductions were made, and how often it was received. If no income, indicate no income. Do not leave blank. Each income amount should be entered in the appropriate column on the form. If you have foster children in your care and are completing this section to qualify other children for higher reimbursement, list any personal use income of the foster child. Foster payments you receive from the placing agency for the care of the child do not need to be reported.

c) If anyone is self-employed, write the net amount of income that person earns from self-employment. Call the number listed at the top of the form if you need assistance.

d) If your household currently has no income, check the box marked, "Check here if no household income."

e) Enter the total number of household members. Count the children in Part 1 and the household members in Part 3.

f) Go to Part 4.

INCOME TO REPORT		
Earnings from Work Wages/salaries/tips Strike benefits Unemployment compensation Worker's Compensation Net income from self-employment **Alimony/Child Support** Public assistance payments Alimony/child support payments	**Pensions/Retirement/Social Security** Pensions Supplemental security income Retirement income Veteran's payments Social Security	**Other Monthly Income/Self-Employment** Disability benefits Cash withdrawn from savings Interest dividends Interest from: estates/trusts/investments Regular contributions from persons not living in the household Net royalties/annuities/net income rental Military allowance for off-base housing Any other income

Part 4–Signature and Certification

a) Print the name of the household member signing this form.

b) The form must have the signature of an adult household member.

c) The adult household member who signs the statement must include the last four digits of his/her Social Security Number. If (s)he does not have a Social Security Number, check the "**I do not have a Social Security Number**" box. A Social Security Number is not needed if you listed a CalFresh, CalWORKs, or FDPIR case number.

Part 5–Racial/Ethnic Identity: You are not required to answer this question to get meal benefits, but completion of this information will assist with the fair and equitable treatment of all participants.

a) Ethnicity:

1) Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central America, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino."

2) Not Hispanic or Latino.

b) Race: Select one or more.

1) American Indian or Alaskan Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

2) Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

3) Black or African American: A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

4) Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

5) White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.