



Child Development Associates, Inc.

Our Mission is to encourage and support the success and well-being of children, families and the child care community...

July 2017

Dear Provider:

To qualify for tier I reimbursement for meals served to children in your care, or if you wish to receive reimbursement for meals served to your own children under the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP), you must complete, sign, and return the enclosed *Eligibility Form* to us.

Establishing Eligibility as a Tier I Day Care Home

In order to qualify for the higher tier I reimbursement for meals served to children enrolled for care in your day care home, you must meet one of the following criteria:

1. Be located in an area of economic need as determined by attendance area boundaries of eligible elementary, middle, or high school enrollment data or census data.
2. Establish individual economic need through the *Eligibility Form*.

Since you do not meet the area eligibility criteria, our office will determine your eligibility as a tier I day care home based on information you provide on the *Eligibility Form*. To be eligible for tier I reimbursement under individual economic need you must:

- Submit a completed and signed *Eligibility Form*.
- Ensure you report all household income, not just your day care home business income.
- Provide sufficient documentation of your income to determine your eligibility based on individual economic need. (*See page 4 of the Eligibility Form.*)
- Check the box in Section 1 indicating that you are a day care home provider applying for tier I benefits.

We are required by law to verify the income information you report on your Eligibility Form. Please include income documentation with your completed Eligibility Form (See page 4 of the Eligibility Form).

If you operated a day care home business last year, please attach a copy of your 2016 tax return (page 1 & 2 of 1040), including Schedule C. Income documentation may include:

- Payment statements from salaried work for all members of your household, including your spouse.
- A copy of your most recent tax return forms showing your accurate income.
- Statements from other forms of income for all household members.
- Proof of your gross household income for last month along with an income and expenses statement for that month.

Sincerely,

Deborah Zaragoza
Nutrition Program Manager

180 Otay Lakes Road, Suite 300
Bonita, CA 91902
Tel: 619.427.4922
Fax: 619.434.5110

**INCOME ELIGIBILITY GUIDELINES
 For Day Care Home Providers Qualifying as Tier I
 Effective from July 1, 2017, through June 30, 2018**

Recipients of the following programs are automatically eligible for Tier I reimbursement rates:

- CalFresh Program (formerly known as Food Stamps)
- California Work Opportunity and Responsibility to Kids Program
- Food Distribution Program on Indian Reservation
- Foster Care Program
- Head Start or Even Start

The eligibility scale is for determining the participant’s eligibility category for federal meal reimbursement if they are not recipients of any of the previous programs. Participants from households with total gross incomes at or below the following levels may be eligible for Tier I reimbursement rates.

| EFFECTIVE FROM JULY 1, 2017, THROUGH JUNE 30, 2018 | | | | | |
|--|---------------|----------------|------------------------|------------------------|---------------|
| Children from households with incomes at or below the following levels are eligible for free or reduced-price meal benefits. | | | | | |
| GROSS INCOME OF HOUSEHOLD | | | | | |
| HOUSEHOLD SIZE | ANNUAL | MONTHLY | TWICE PER MONTH | EVERY TWO WEEKS | WEEKLY |
| 1 | \$ 22,311 | \$1,860 | \$ 930 | \$ 859 | \$ 430 |
| 2 | 30,044 | 2,504 | 1,252 | 1,156 | 578 |
| 3 | 37,777 | 3,149 | 1,575 | 1,453 | 727 |
| 4 | 45,510 | 3,793 | 1,897 | 1,751 | 876 |
| 5 | 53,243 | 4,437 | 2,219 | 2,048 | 1,024 |
| 6 | 60,976 | 5,082 | 2,541 | 2,346 | 1,173 |
| 7 | 68,709 | 5,726 | 2,863 | 2,643 | 1,322 |
| 8 | 76,442 | 6,371 | 3,186 | 2,941 | 1,471 |
| FOR EACH ADDITIONAL FAMILY MEMBER ADD: | \$ 7,733 | \$ 645 | \$ 323 | \$ 298 | \$ 149 |

* Household is synonymous with family and means a group of related or unrelated individuals who are not residents of an institution or boarding house but who are living as one economic unit sharing housing and all significant income and expenses.

This institution is an equal opportunity provider.

TIER II PROVIDERS QUALIFICATIONS FOR TIER 1 (2017/2018)

Complete, sign, and return this form to Child Development Associates Attn: Cecy Torimaru.

If you need assistance completing this form, call: Cecy Torimaru @ 1-800-698-9798 or 1-619-427-4922

| | |
|---|---|
| Name of day care home provider and provider number: | <input type="checkbox"/> Check here if your child(ren) is/are enrolled for care in your home. |
| Are you applying for eligibility as a Tier I home? | <input type="checkbox"/> Yes <input type="checkbox"/> 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 * |
|-----------|------------|-----------|--------------------------|
| | | | <input type="checkbox"/> |
| | | | <input type="checkbox"/> |
| | | | <input type="checkbox"/> |
| | | | <input type="checkbox"/> |
| | | | <input type="checkbox"/> |
| | | | <input type="checkbox"/> |

*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 * Please remember to include a copy of most recent **Notice of Action**.

| Last Name, First Name | Check One | Case Number |
|-----------------------|--|-------------|
| | <input type="checkbox"/> CalFresh <input type="checkbox"/> CalWORKs <input type="checkbox"/> 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 two weeks, twice a month, monthly, or annually)** | | | |
|---|--|------------------------|---------------------------------------|--|
| | Earnings from Work Before Deductions | Alimony, Child Support | 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 a **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—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: | | Date: |
| Signature of Adult: | | |
| Last four digits of Social Security Number (SSN): XXX-XX- | | <input type="checkbox"/> I do not have an SSN |
| Address: | City/State/Zip Code: | Daytime Phone Number: |

Privacy Act Statement

The Richard B. Russel National School Lunch Act (NSLA) 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 reduced-price meals. You must include the last four digits of the SSN of the adult household member who signs the application. The last four digits of the SSN 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 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 an SSN. 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 office to determine current certification for CalFresh, CalWORKs, or FDPIR benefits, 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.

| Part 5—Racial/Ethnic Identity (Optional) | | | |
|--|--|---|--|
| Ethnicity: | <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Not Hispanic or Latino | |
| Race (select one or more): | <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Asian | <input type="checkbox"/> Black or African American |
| | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | <input type="checkbox"/> White | |

U.S. DEPARTMENT OF AGRICULTURE NONDISCRIMINATION STATEMENT

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form (AD 3027), found online at http://www.ascr.usda.gov/complaint_filing_cust.html and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Submit your completed form or letter 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
- (2) Fax: 202-690-7442
- (3) E-mail: program.intake@usda.gov

This institution is an equal opportunity provider.

INSTRUCTIONS FOR COMPLETING THE QUALIFICATION FORM FOR PROVIDERS

If you need help, please call: Cecy Torimaru @1-800-698-9798 or 1-619-427-4922

Name of DCH Provider

- a) Print your name.
- 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) Send a copy of most recent Notice of Action
- e) 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 receives before taxes or any other deductions that were made, and how often it was received. If no income, indicate no income. 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 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) **Submit copy of 2016 income tax form 1040 page 1 & 2 and Schedule C with an original signature.**
- g) Go to Part 4.

| INCOME TO REPORT | | |
|--|---|---|
| <p>Earnings from Work:</p> <ul style="list-style-type: none"> • Wages/salaries/tips • Strike benefits • Unemployment compensation • Worker's compensation • Net income from self-employment <p>Child Support/Alimony</p> <ul style="list-style-type: none"> • Public assistance payments • Alimony/child support payments | <p>Pensions/Retirement/Social Security</p> <ul style="list-style-type: none"> • Pensions • Supplemental security income • Retirement income • Veteran's payment • Social Security | <p>Other Monthly Income</p> <ul style="list-style-type: none"> • Disability benefits • Cash withdrawn from savings • Interest dividends • Income from estates/trusts/investments • Regular contributions from persons not living in the household • Net royalties/annuities/net rental income • 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 their SSN. If they do not have an SSN, check the **I do not have an SSN** box. An SSN 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.