North Carolina Department of Health and Human Services
Division of Child and Family Well-Being, Community Nutrition Services Section
Child and Adult Care Food Program

INFANT AND CHILD INCOME ELIGIBILITY APPLICATION

INSTITUTION NAME: EC Canada + Associates, Inc. FACILITY NAME: Milestones School of Achievement, 227 AGREEMENT#: 6417

1. PARTICIPANT'S NAME & DATE OF BIRTH:

First Name	Last Name	Date of Birth	First Name	Last Name	Date of Birth

2. SNAP, TANF or FDPIR case number:

SNAP #_____ **TANF#:** _____ **FDPIR #** _____

If you have provided the case number; DO NOT complete #3 and #4. **Skip to complete #5 and #6.**

3. Is this application for a:
Foster Infant/Child? ☐ Yes ☐ No Homeless Infant/Child? ☐ Yes ☐ No Infant/Child from a migrant family? ☐ Yes ☐ No

4. HOUSEHOLD MEMBERS MONTHLY INCOME:

Names of All Other Household Members	Monthly Wages / Salaries	Monthly Social Security	Monthly Public Assistance / Child Support	Monthly Retirement Pensions	Other Monthly Income
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$

5. ETHNIC IDENTITY: (Check one). ☐ Hispanic or Latino ☐ Not Hispanic or Latino

RACE (Check one or more): ☐ White ☐ Black or African American ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

6. **SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER:** I certify that all of the above information is true and correct; that the application is being made in connection with the receipt of federal funds, that Program officials may verify the information on the application; and that deliberate misrepresentation of any of the information on the application may subject me to prosecution under applicable State and Federal criminal statutes.

_____ _____
Signature of Adult Household Member (Required) Date

Check if no SSN ☐
_____
Last Four Digits of Social Security Number
(Required **only** if qualifying by income)

_____ _____
Printed Name Home Telephone # Work Telephone #

_____
Address City Zip Code

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 infant/child for free or reduced-price meals. You must include the last four digits of the social security number or check the "no SSN" box of the adult household member who signs the application if qualifying by income. The last four digits of the social security number is not required when you apply on behalf of a foster infant/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 for your infant/child 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 your infant/child is eligible for free or reduced-price meals and for administration and enforcement of the Program.

To be completed by Institution/Sponsor

TOTAL HOUSEHOLD SIZE _____ TOTAL HOUSEHOLD MONTHLY INCOME $ _____

Approved: ☐ Free ☐ Reduced-Price ☐ Denied

Reason for denial: ☐ Income too high ☐ Incomplete application ☐ Other: _____

Withdrew on (Date): _____

For state use only:
Verified by: _____ Date: _____
Verified classification:
☐ Free ☐ Reduced-Price ☐ Denied
Reason for classification change: _____

_____
Signature of Eligibility Official (Individual at the Institution Level) – Required **Date – Required**

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Infant and Child Enrollment Form

INSTITUTION NAME: EC Canada + Associates, Inc. FACILITY NAME: Milestones School of Achievement 227 AGREEMENT#: 6417

Dear Parent/Guardian,

This center/program receives funding from the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). CACFP needs proof of enrollment for all infants and children. Please complete the table below for each infant and/or child in your family enrolled at this center/program. Be sure to sign and date in the space below.

The information below must be completed by the parent or guardian.

Infant/Child's First Name	Infant/Child's Last Name	Date of Birth	Normal/Typical Hours of Care	Normal/Typical Days of Care (Circle all that apply)	Meals Normally Eaten (Circle all that apply)
			7 to 6	M T W TH F Sat Sun	B AM L PM S LPM
			____ to ____	M T W Th F Sat Sun	B AM L PM S LPM
			____ to ____	M T W Th F Sat Sun	B AM L PM S LPM
			____ to ____	M T W Th F Sat Sun	B AM L PM S LPM
			____ to ____	M T W Th F Sat Sun	B AM L PM S LPM

Normal/Typical Hours of Care: Write in each infant/child's usual arrival and departure time. Indicate a.m. or p.m.

Normal Days of Care: Circle the days of the week each infant/child is usually in attendance at the facility.
(M-Monday; T-Tuesday; W-Wednesday; Th- Thursday; F-Friday; Sat-Saturday; Sun-Sunday)

Meals Normally Eaten – Circle the meals each infant/child usually eats at the facility.
(B-Breakfast; AM-AM Snack; L-Lunch; PM-PM Snack; S-Supper; LPM-Late PM/Evening Snack)

Parent/Guardian Signature:_____ **Date:** _____

Print Name: _____

Address: _____

City:_____ State:_____ Zip Code: _____

Home Telephone Number: ( )_____ Work Telephone Number: ( ) _____

For Facility/Provider Use Only:
Signature of Facility Representative/Provider:_____ Date: _____
Date each infant/child withdrew:_____

For State Use Only: Complete:_____ Incomplete_____ Reason:_____ Verified by:_____ Date:_____

This institution is an equal opportunity provider.