SPONSORING ORGANIZATION NAME	
SPONSORING ORGANIZATION MAILING ADDRESS	
PHONE NUMBER	EMAIL

HOUSEHOLD ELIGIBILITY APPLICATION FOR PROVIDERS REAPPLYING FOR TIER I STATUS BY INCOME OR FOR CLAIMING MEALS FOR CHILDREN RESIDING WITH THE PROVIDER

Dear Day Care Home Provider:

Our records indicate you were determined Tier I status or claimed Tier I reimbursement based on one of the following qualifications:

- Your day care home qualified for **Tier I based on income information submitted on last year's Household Eligibility Application (HEA)**. In order to continue the Tier I status by income you must complete the attached HEA. To be eligible for Tier I status your household income must meet or fall below the Income Eligibility Guidelines or a member of your household must be eligible to receive Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) benefits.

- Your day care home qualified for **Tier I status due to school or census data and you claimed meals for qualifying children** residing in your household while other children were in attendance. In order to continue to claim qualifying children residing in your household, you must complete the enclosed HEA and return it to our office.

- You claimed **Tier I reimbursement for meals served to a qualifying foster child(ren),** residing in your household while other children were in attendance. In order to continue to receive Tier I reimbursement for a foster child(ren) residing in your household, you must complete the enclosed HEA and return it to our office.

Please note that by signing Number 4 on the enclosed HEA for the Illinois *All Kids* Health Insurance, you are stating you do not want your information shared with the Illinois Department of Healthcare and Family Services. If you agree to disclose the application information, it may be used to identify your child(ren) for the health insurance program. If you would like more information on *All Kids*, call toll-free 866/255-5437 or 877/204-1012 (TTY).

Income Eligibility Guidelines
Effective from July 1, 2023, to June 30, 2024

Reduced-Price Meals
185% Federal Poverty Guideline

Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	26,973	2,248	1,124	1,038	519
2	36,482	3,041	1,521	1,404	702
3	45,991	3,833	1,917	1,769	885
4	55,500	4,625	2,313	2,135	1,068
5	65,009	5,418	2,709	2,501	1,251
6	74,518	6,210	3,105	2,867	1,434
7	84,027	7,003	3,502	3,232	1,616
8	93,536	7,795	3,898	3,598	1,799
For each additional family member, add	9,509	793	397	366	183

If you have any questions or need help, please contact your sponsoring organization.

Sincerely,

***NON-DISCRIMINATION STATEMENT**:* In accordance with Federal 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), age, disability, and 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 for program information (e.g., Braille, large print, audiotape, and 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 www.usda.gov/sites/default/files/documents/usda-program-discrimination-complaint-form.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.

PROVIDER INSTRUCTIONS FOR COMPLETING THE HOUSEHOLD ELIGIBILITY APPLICATION

Once properly approved for meal benefits, a Household Eligibility Application (HEA) will remain in effect for 12 months. Complete the Household Eligibility Application (HEA) for one of the following areas.

FOR PROVIDERS UNABLE TO QUALIFY FOR TIER I BY SCHOOL OR CENSUS, APPLYING FOR TIER I STATUS BY INCOME ELIGIBILITY- REFER TO INSTRUCTIONS A AND B.

If anyone (child or adult) in your household **receives Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) or other qualifying benefits**, follow **Instruction A** below. The information will be verified by the sponsor.

Instruction A—Households Receiving SNAP or TANF or other qualifying benefits.

- **Number 1**—List the names of ALL people residing in a provider's household (such as grandparents, other relatives, or friends who live with a provider) and the age(s) of the child(ren) enrolled in a provider's day care home.
- **Number 3**—Record a valid SNAP or TANF case number for any member (child or adult) of this household. The SNAP or TANF case number is on the letter of eligibility for benefits or the case number may be found on a medical card. Do not list an Illinois LINK card number. The SNAP or TANF information provided will require verification by the sponsoring organization. Providing documentation of the benefit is required.
- **Number 4 (OPTIONAL)—***Illinois All Kids Health Insurance Program*.
- **Number 6**—Mark the box that best describes the purpose for the application.
- **Number 7**—Provide a signature of an adult household member and date the application.
- The application is complete.

If no one in your household receives SNAP or TANF benefits and **you want to apply for the higher reimbursement for your day care operation based on your household income, follow Instruction B.**
It is <u>not</u> necessary to complete income information if SNAP or TANF information was provided above in Instruction A or if all the children residing with the provider are documented foster children (refer to Instruction D). The information will be verified by the sponsor.

Instruction B—Households Reporting Income

- **Number 1**— List the names of ALL people residing in a provider's household (such as grandparents, other relatives, or friends who live with a provider) and the age(s) of the child(ren) enrolled in a provider's day care home. (Foster child(ren) may be included on the HEA)
- **Number 4 (OPTIONAL)** — *Illinois All Kids Health Insurance Program*.
- **Number 5**—List total gross income (before deductions), not take-home pay; and the frequency, how often the money is received, for each household member for the last month. If the income last month was not the usual amount normally receive, a projected amount may be provided that represents the gross income.
    - For ONLY the self-employed, list average monthly income after expenses. This is for a business, farm, or rental property.
    - If receiving Military Privatized Housing Initiative pay or receive combat pay, do not include these allowances as income.
- **Number 6**—Mark the box that best describes the purpose for the application.
- **Number 7**—The provider must sign and date the application.
- **Also,** provide the last four digits of the social security number of the provider signing the application. Refusal to provide the last four digits of the social security number will result in the application not being approved. If the adult does not have a social security number, mark the box, *I do not have a social security number*.
- The application is complete. Documentation must be provided to support all information (foster child documentation if applicable, check stubs, W-2's 1040 Schedule C, etc...)
- The sponsoring organization will verify the information contained on the HEA.

FOR PROVIDERS APPROVED TIER 1 STATUS BY SCHOOL OR CENSUS WANTING TO CLAIM CHILDREN, TO INCLUDE FOSTER CHILDREN WHEN OUTSIDE CHILDREN ARE PRESENT:

If you have been approved **Tier I status by School or Census Data and would like to claim qualifying children, including foster children, residing with you when outside qualifying children are present,** you must complete a HEA in order to claim the qualifying children, including foster children residing with you. Refer to **Instruction C**. The application may be verified by the sponsor.

Instruction C—Provider approved Tier I status by School or Census and would like to claim children residing with the provider. Follow the instructions provided in **Instruction B, Numbers 1 through 7**. The sponsoring organization may verify the information.

FOR PROVIDERS IDENTIFIED AS TIER II STATUS WANTING TO CLAIM FOSTER CHILDREN WHEN OUTSIDE CHILDREN ARE PRESENT:

A foster child(ren) residing with you is(are) eligible for Tier I reimbursement for eligible meals, when outside qualifying children are present, regardless of you tier status (Tier I or Tier II) when a HEA is submitted by the provider. The eligibility for the foster child does not transfer to the household. In order to document a child as a foster child, legal document from DCFS or the DCFS appointed representative must be submitted for each foster child with the Household Eligibility Application. In lieu of a document a provide may request DCFS or its representative to complete form 50-73 (Homeless, Runaway, Migrant, Head Start, and Foster Child Certification Form) that can be found on the following ISBE website: https://www.isbe.net/Documents/50-73_hmls_cert_mm.pdf#search=form%2050%2D73.

Instruction D—For the foster child(ren) residing in a providers home, please provide the following information on the HEA:

- **Number 1**—List the name(s) and age(s) of the foster child(ren) residing in the provider's day care home.
- **Number 2**—Check the box(es) indicating the child(ren) is a foster child(ren).
- **Number 4 (OPTIONAL)**— *Illinois All Kids Health Insurance Program*.
- **Number 6**—Mark the box that best describes the purpose for the application
- **Number 7**—Provide a signature of the provider and date the application.
- The application is complete.

CHILD AND ADULT CARE FOOD PROGRAM – HOUSEHOLD ELIGIBILITY APPLICATION FOR DAY CARE HOME PROVIDER

1 LIST EVERYONE IN PROVIDER'S HOUSEHOLD (Children and Adults)

NAME (First, Middle and Last)	Check If No Income	Date of Birth	Ages of Provid-ers Children	**2 FOSTER CHILD** Check box for all foster children that are a legal responsibility of DCFS or the court.
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐

3 SNAP or TANF CASE NUMBER
Skip if foster child.
Provide one SNAP or TANF case number for any child or adult in your household. Do NOT use LINK card number. If completed, **skip to Number 6. Do not list foster child.**

Name of Child or Adult: _____

SNAP or TANF Number (9 digits)

_ _ _ _ _ _ _ _ _

WIC Number _ _

4 OPTIONAL—SHARING INFORMATION WITH *ALL KIDS INSURANCE PROGRAM*
May we share your information on this application with *All Kids Insurance Program*, the complete health insurance program for every child in Illinois? If yes, do not sign below.

☐ No, I do not want my information from this application shared with *All Kids Insurance Program*.

Sign here:

5 HOUSEHOLD MEMBERS WITH INCOME—List only the names of individuals living in the household, their gross income, and how often it is received. If a person has a second job, list that income in the last column. After completing, **go to Number 6.**

NAMES (List only individuals with income)	**Earnings from Work** (Gross before Deductions)		**Income from Welfare, Child Support, Alimony**		**Income from Retirement, Pensions, SSI, Social Security**		**Income Received From Savings, Investments, Trust Accounts, and Other Resources**	
	How Much?	How Often?	How Much?	How Often?	How Much?	How Often?	How Much?	How Often?
	$ /		$ /		$ /		$ /	
	$ /		$ /		$ /		$ /	
	$ /		$ /		$ /		$ /	
	$ /		$ /		$ /		$ /	
	$ /		$ /		$ /		$ /	

6 Must check only one box.
☐ I am a provider applying to claim my own children and qualify for Tier I status.
☐ I am a provider with no children applying for Tier I status.
☐ I am a Tier I provider based on school or census data applying to claim my own children.

7 Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Number 5 above is completed the adult signing the form must also list the last four digits of his or her social security number or mark the box *I do not have a social security number*.

X X X - X X - _____
_____ _____ _____
Social Security Number

☐ I **do not** have a social security number.

I certify all information on this application is true and all income is reported. I understand the amount of federal funds received will be based on the information I give. I understand the institution, Illinois State Board of Education, or Office of Inspector General, may verify this information on the application. Deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Date	*Printed Name of Adult Household Member*	*Signature of Adult Household Member*	*Address of Adult Household Member*

***PRIVACY ACT STATEMENT**: 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 child for free or reduced-price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster 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 or other FDPIR identifier for your child 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 child is eligible for free or reduced-price meals, and for administration and enforcement of the Child and Adult Care Food Program. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.*

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SPONSOR REPRESENTATIVE USE ONLY—ELIGIBILITY DETERMINATION — Follow the instructions provided in the Household Income instructions.

Mark one of the boxes below to show how you are going to determine eligibility.

☐ **SNAP/TANF Household**

Income Household

Use the conversion table to convert income to total annual income. Total the number of household members from Section 5.

Total Household Annual Income $_____

Total Household Size _____

CONVERSION TABLE

To convert all income to annual income use the following conversion calculations:
Weekly Income x 52 Every 2 Weeks x 26 Twice a Month x 24 Monthly x 12

☐ Approved to Claim Foster Child's meals at Tier I Rate
☐ Approved Tier I Status/Claim Providers Own Children (if applicable)
☐ Denied

Signature of Representative: _____

Date

Effective Date of Application: _____
**Effective Date may be made retroactive back to the first day the provider participates in the CACFP as long as it occurs in the same month in which the provider's eligibility is certified.*

Print
Reset Form

Return to: