KY Child and Adult Care Food Program Income Application

2013-2014 Child Care Centers

Complete this form in order for this center to qualify for reimbursement for meals served to your child(ren).

1. **CHILD INFORMATION** (print) 2. **PROGRAM BENEFITS**

	Name of Child	Birthdate	SNAP#	K-TAP#	If kinship or foster care, check here.
1.	_____	_____	_____	_____	☐
2.	_____	_____	_____	_____	☐
3.	_____	_____	_____	_____	☐

3. **HOUSEHOLD MEMBERS AND MONTHLY INCOME**: If you gave a SNAP or K-TAP case number, go to Part 4.

NAMES OF HOUSEHOLD MEMBERS Including Children Not Listed Above LAST FIRST	GROSS MONTHLY Income From Work (Before Deductions)	MONTHLY Income From Welfare Payments, Child Support, Alimony	MONTHLY Income from Pensions Retirement Social Security	Any Other MONTHLY Income
1. _____	$_____	$_____	$_____	$_____
2. _____	$_____	$_____	$_____	$_____
3. _____	$_____	$_____	$_____	$_____
4. _____	$_____	$_____	$_____	$_____
5. _____	$_____	$_____	$_____	$_____

4. SIGNATURE AND SOCIAL SECURITY NUMBER: I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

X_____

Signature of Adult Household Member

X_____ X_____

Last four digits Social Security Number* **Date**

Printed Name _____Home Telephone No. _____Work Telephone No._____

Street/Apt.No._____City/State/Zip_____

5. Participant's ethnic and racial identities (optional) Mark one ethnic identity: ____Hispanic or Latino _____ Not Hispanic or Latino
Mark one or more racial identities: _____ Asian _____White _____Black or African American _____American Indian or Alaska Native
_____ Native Hawaiian or Other Pacific Islander

FOR SPONSOR USE ONLY. DO NOT WRITE BELOW THIS LINE.

MONTHLY INCOME CONVERSION – WEEKLY X 52

☐ SNAP/K-TAP Household

☐ Foster/Kinship Care

☐ Income Household:

Total Household Monthly Income: _____

Household Size: _____

EVERY 2 WEEKS X 26

Application approved for:

TWICE A MONTH X 24

☐ Free Meals

☐ Reduced Price Meals

☐ Paid

_____ _____ _____ _____

Signature of Determining Official Date W/D Date Re-enter Date