Tennessee Department of Human Services (TDHS)	Child and Adult Care Food Program (CACFP) **INCOME ELIGIBILITY APPLICATION FOR CHILD CARE CENTER PARTICIPANT(S)**	**Form HS-1949** Revised May 2011

PART 1A - NAME OF CHILD CARE CENTER (Enter the name of the child care center):

PART 1B - PARTICIPANT(S) SERVED BY CENTER (Enter the information below for all children from your household that are enrolled for care at the child care center):

Name	Age	Check if Foster Child
		☐
		☐
		☐
		☐

PART 2A - HOUSEHOLDS WHICH ARE CURRENTLY RECEIVING BENEFITS THROUGH THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP), OR FAMILIES FIRST (FF) CASH ASSISTANCE OR FAMILIES FIRST (FF) CHILD CARE ASSISTANCE (If your household is now receiving benefits under one or more of these programs, complete this part, and sign the statement in Part 4 - Do not complete Part 2B.):
ACCENT Case No. for SNAP or FF Cash Assistance:_____ **OR** FF Child Care Assistance Case No.: _____

PART 2B - ALL OTHER HOUSEHOLD MEMBERS (If no information is entered in Part 2A above, complete this part for all household members not identified in Part 1B above and sign the statement in Part 4. Attach additional sheets as necessary)

Names of All Other Household Members	Earnings from Work (Before Deductions)	Child Spport, Alimony or Other Income	Payments Received from Pensions, Retirement, & Social Security
1.	$ per year	$ per year	$ per year
2.	$ per year	$ per year	$ per year
3.	$ per year	$ per year	$ per year
4.	$ per year	$ per year	$ per year

Total Number of Household Members: ____ **Total Yearly Income for Household from All Sources:** $_____ Yearly income is calculated as follows:
Multiply Weekly income by 52, Bi-weekly income (received every two weeks) by 26, Semi-monthly income (received twice a month) by 24, and Monthly income by 12.
Do not round up any numbers.

PART 3 - Medicaid and State Children's Health Insurance Programs --- Please check if you do **not** want the information in this application to be shared with the Medicaid and State Children's Health Insurance Programs: ____ DO NOT WANT APPLICATION INFORMATION TO BE SHARED WITH THE MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAMS.

PART 4 - SIGNATURE (An adult household member must sign the application.) PENALTIES FOR MISREPRESENTATION:
I certify that all of the above information is true and correct. I understand that this information is being given for the receipt of Federal Funds; that institution officials may verify the information on the statement; 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:	Social Security Number (only last four digits):

Street:	City:	State and Zip Code:	Home Telephone:

PART 5 - ETHNIC/RACIAL IDENTITY (**You are not required to answer this question.**): **For Ethnicity**, please check one of the following: ___ Hispanic or Latino ___ Not Hispanic or Latino For Race, please check one or more of the following:
___ American Indian or Alaskan Native ___ Asian ___ Black or African American ___ Native Hawaiian or Other Pacific Islander
___ White. Please see the definitions of Ethnicity and Race on the back of this application.

FOR INSTITUTION USE ONLY: To identify the eligibility classification of the enrolled children identified above, please circle:
Free, Reduced-Price **or** Paid. To identify the basis for classification, please circle: Categorically Eligible **or** Income Eligible

Determining Official Signature: _____ Date: _____

Our Daily Bread Of Tennessee Inc.
ADDENDUM TO ENROLLMENT FORM FOR CHILD CARE

Jaymes Academy, LLC / Angie Phay

Name of Child Care Facility / Director Name

Instructions: This Addendum may be used to meet the enrollment data requirements of the Child and Adult Care Food Program as mandated by the Interim Rule issued on September 1, 2004, by the U.S. Department of Agriculture. The Addendum will be valid for one calendar year from the date of the parent or guardian's signature.

Participant Name: _____ _____
Last First Middle Initial Date of Birth

Enrollment Date: _____ **Special Needs Child** ☐

Normal Days of Care (Circle as Appropriate)

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Normal Hours of Care during School Year: _____ to _____

_____ to _____

Normal Hours of Care during Summer: _____ to _____

_____ to _____

Participant Meals (Circle as Appropriate):

Breakfast AM Supplement Lunch

PM Supplement Supper Evening Supplement

Parent/Guardian Name: _____
Last First Middle Initial

Parent/Guardian Daytime Telephone Number (with Area Code): _____

_____ _____
Signature of Parent/Guardian **Date of Signature**