Meal Benefit Form for Providers

Complete, sign, and return this form to your day care home (DCH) sponsor.

If you need assistance completing this form, call: 562-463-1427

Enter name of DCH provider: _____

Are you applying for eligibility as a Tier I home? ☐ Yes ☐ No

Are your child(ren) enrolled for care in your home? ☐ Yes ☐ No

Are you applying for Tier I meal benefits for your own child(ren)? ☐ Yes ☐ No

1. Child Information:

Enter the name(s) of all children from your household enrolled in your care. Indicate foster child with either yes or no.

Last Name	First Name	Birthdate	Foster Child*

*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.

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, indicate which program, and enter the program case number.

Last Name, First Name	Program:	Case Number:

3. Income Eligibility (Not required if you reported a case number in Part 2):

Does any person in the household receive income? ☐ Yes ☐ No

List Gross Income and how often it is received (e.g., weekly, every two weeks, twice a month, monthly, or annually). 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.

Household members' names (List all household members not listed in Part 1.)	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 plus other household members listed in Part 3): _____

4. Signature and Certification

Penalties for Misrepresentation: I certify that all 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 Parent or Guardian

Date

Signature of Parent or Guardian

Phone Number

Last Four Digits of Social Security Number (SSN)

No SSN ☐

Address

City, State, Zip

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.

Racial/Ethnic Identity (Optional)

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.

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (select one or more)

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Income Eligibility Scale
Effective from July 1, 2025, through June 30, 2026

Day Care Home Tier I Scale

Household size	Annual	Monthly	Twice per month	Every two weeks	Weekly
1	$28,953	$2,413	$1,207	$1,114	$557
2	$39,128	$3,261	$1,631	$1,505	$753
3	$49,303	$4,109	$2,055	$1,897	$949
4	$59,478	$4,957	$2,479	$2,288	$1,144
5	$69,653	$5,805	$2,903	$2,679	$1,340
6	$79,828	$6,653	$3,327	$3,071	$1,536
7	$90,003	$7,501	$3,751	$3,462	$1,731
8	$100,178	$8,349	$4,175	$3,853	$1,927
For each additional family member, add	$10,175	$848	$424	$392	$196

Day Care Home Sponsor Use Only

Indicate all that apply: ☐ Tier I ☐ Tier II

Enter total gross income: _____ Frequency income is received: _____

(Annual Income Conversion: Weekly multiplied by 52, every 2 weeks multiplied by 26, twice a month multiplied by 24, monthly multiplied by 12). Convert income if multiple income frequencies are listed for the household.

Indicate Categorical Eligibility:

☐ CalFresh ☐ FDPIR

☐ CalWORKs ☐ Foster

Child(ren) eligible for Tier II High (Reimbursed at Tier I rate or Tier II Low).

Indicate High or Low: ☐ High ☐ Low

Provider's own child(ren) eligible for Tier I reimbursement: ☐

This form must be signed and dated by the agency's official.

Printed Name of Agency Official:

_____

Signature of Agency Official: Date:

_____ _____

Instructions for Completing the Meal Benefits Form for Providers

If you need help, please call: _____

Name of DCH Provider:

a. Enter your name.

b. Indicate whether or not you are applying for eligibility as a Tier I home by marking Yes or No.

c. Indicate if your child(ren) is/are enrolled for care in your home by circling Yes or No.

d. Indicate if you are applying for Tier I meal benefits for your own child(ren) by marking Yes or No.

Part 1—Child Information:

a. Enter the name(s) of your child(ren) enrolled in care and their birthdate(s).
b. Indicate if your child is a foster child by writing Yes or No.

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. Enter the benefit recipient's name. Only one benefit recipient is needed.
b. Indicate the program: CalFresh, CalWORKs, or FDPIR.
c. Enter the CalFresh, CalWORKs, or FDPIR case number.
d. 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. Indicate if any person in the household receives income by marking Yes or No.

b. Enter 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 parent or grandparent, etc.) if they are part of your household.

c. Enter 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.

d. 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.

e. Enter the total number of household members. Count the children in Part 1 and the household members in Part 3.

f. Go to Part 4.

Income to Report

Earnings from work, child support, alimony:

Wages, salaries, or tips

Strike benefits

Unemployment compensation

Net income from self-employment

Public assistance payments

Alimony or child support payments

Pensions, retirement, Social Security:

Pensions

Supplemental security income

Retirement income

Veteran's payment

Social Security

Other monthly income:

Disability benefits

Cash withdrawn from savings

Interest dividends

Income from estates, trusts, or 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. Enter 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 or indicate **No SSN**. 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.

Ethnicity:

a. **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.

b. **Not Hispanic or Latino.**

Race: Select one or more.

a. **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.

b. **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.

c. **Black or African American:** A person having origins in any of the black racial groups of Africa.

d. **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

e. **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

U.S. Department of Agriculture (USDA) Nondiscrimination Statement

In accordance with federal civil rights law and USDA civil rights regulations and policies, the USDA, its agencies, offices, 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, audiotape, 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 https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint 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. Email: program.intake@usda.gov

This institution is an equal opportunity provider.

If the provider believes that they may be over income based on the income guideline above, please complete a Decline Participation Form for each child.

Angels Child Care Food Program
13200 Crossroads Pkwy N #155
City Of Industry, CA 91746
562-463-1427 Office

Declining Participation in the Child and Adult Care Food Program

All facilities participating in the Child and Adult Care Food Program (CACFP) are required to offer meals/snacks to enrolled participants in their care according to Title 7, *Code of Federal Regulations*, Part 226 and applicable state laws.

As the participant or parent/guardian, you choose to decline the agency's meals/snacks and will furnish all food for yourself or the enrolled participant. Return this form to the child/adult care agency.

Child(ren) Name _____

Reason for Declining Participation in the CACFP

- ☐ **Over Income**
- ☐ **Declining to Complete MBF**
- ☐ **Other**

_____

_____

_____

Participant's or Parent/Guardian's Print Name _____

Participant's or Parent/Guardian's Signature _____ **Date** _____

For Agency Use Only

ACCFP Representative's Signature _____ **Date** _____

Keep a Copy in Participant's File