



Cumberland Cape Atlantic YMCA 2024-2025 School Aged Child Care Mullica Township Registration Packet

PLEASE
ATTACH
PHOTO

Child's Last Name: _____ First Name: _____

Address: _____

City, State, Zip: _____

Birth Date: ____/____/____ Home Phone: _____

Cell Phone: _____ Male Female Grade Entering Sept. '24 _____

Select your location: Mullica Township School

Select your numbers of days per week: 5 day 4 day 3 day 2 day

Select your program option: AM only PM only AM & PM

Parent Checklist

Parent/Guardian please **initial** next to each item that you are handing in today. No check marks please.

- _____ Completed Registration Form;
Including selecting the program option and your number of days of care per week
- _____ Photo Release (see page 3)
- _____ Signed Medical Information – including insurance carrier, policy and group number
- _____ Expulsion Policy
- _____ Any notes or information to be filed on your child (optional)
- _____ Correct payment and/or deposit amount
- _____ Automatic bank draft form is completed (if using automatic monthly payment option)

Parent Signature

Parent is to sign off that all paperwork is filled out completely.

Parent Signature: _____ Date: _____

Staff Signature

Staff member receiving the paperwork is to sign off that all papers are filled out completely and correct money is remitted.

Staff Signature: _____ Date: _____

Financial Assistance

Third party Rutgers Southern Regional Child Care Resource & Referral (609-365-5027). If denied by Rutgers, Financial Assistance is available through the Y - applications are available at the Member Service Desk and on our website, www.ccaymca.org.

Funds are limited – APPLY EARLY



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FOR SOCIAL RESPONSIBILITY

Cumberland Cape Atlantic YMCA Emergency Contact & Health

Child's Name _____

Parent/Guardian Information

Parent 1 or Legal Guardian Information	Parent 2 or Legal Guardian Information
Last Name: _____	Last Name: _____
First Name: _____	First Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone: _____
Employer: _____	Employer: _____
Email: _____	Email: _____

Joint Custody Information

Has there been a divorce or separation? Yes No

If Yes, who has custody? _____

The joint/non-custodial parent can be contacted in the event of an emergency Yes No

Emergency Contacts (Other than Parent/Guardian) and Authorized Pick Ups

Emergency Contact #1	Emergency Contact #2
Name: _____	Name: _____
Relationship: _____	Relationship: _____
Cell Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone: _____
Address: _____	Address: _____

Medical and Behavior Questions to help us provide the best care possible

Has your child been diagnosed or treated for the following:

- | | | |
|---|------------------------------------|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Special Dietary Needs |
| <input type="checkbox"/> Allergies to Insect Stings | <input type="checkbox"/> Seizures | <input type="checkbox"/> Spectrum Disorder |
| <input type="checkbox"/> Allergy to Poison Ivy | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Other |

Please provide details for any of the above checked boxes:

Signs or symptoms to watch for:

Please list current medications, prescribed or over the counter that your child is currently taking:

-
-

Parent/Guardian Signature: _____

Emergency Medical Information

Insurance Carrier: _____

Policy Number: _____

Group Number: _____



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Cumberland Cape Atlantic YMCA Rules & Authorizations

Before and After Rules

In order for all participants to have the best possible experience, all participants and parents need to be aware of the rules and agree to follow them. If a participant or parent consistently or excessively breaks the rules and chooses not to take part in the program, they negatively impact other participants by jeopardizing their physical or emotional safety. When this happens, all other participants fail to receive the best possible experience.

Rules:

- 1) Treat myself, and others, with Caring, Honesty, Respect, and Responsibility
- 2) Follow direction and instructions from staff
- 3) Keep hands, feet and all other body parts to myself
- 4) Respect all facilities, equipment, and property
- 5) Have FUN!

Consequences:

- 1) Redirection
- 2) Verbal warning or thinking time
- 3) Visit with director and/or call home. Child may speak to parents at that time
- 4) In the event that a second phone call is necessary, the child will be sent home
- 5) In the event of consistent/excessive failure to follow the rules, the child will be sent home and a suspension may be issued
- 6) If a child or parent endangers the physical, mental or emotional health of themselves or others, the child may be immediately suspended or expelled

Parent Signature: _____

Child Signature: _____

Authorizations

My child is in good health and can participate in the normal activities of the program (including Healthy U & Boks) _____ Initial Here

I agree to follow the Payment Policies; if not I will be subject to fees _____ Initial Here

I have received and reviewed a copy of the YMCA Parent Handbook _____ Initial Here

I understand that my child must be physically signed in and out of the program by an authorized **adult** daily _____ Initial Here

I understand that the YMCA is not responsible for lost, stolen or damaged personal articles _____ Initial Here

My child and I have reviewed the Discipline/Behavior & Expulsion Policies and my child will participate in all daily activities _____ Initial Here

I give permission for the Cumberland Cape Atlantic YMCA to:

Seek medical treatment for my child, in my absence, in the event of an emergency _____ Initial Here

Use any photo, voice recordings or videos taken of my child for any and all promotional purposes _____ Initial Here

Allow my child to go on short walks under Y Staff supervision _____ Initial Here

I hereby agree, and accept, responsibility in above initialed items.

Parent Signature _____

Date _____

Licensing Statement

In keeping with New Jersey's child care licensing requirements, we are obligated to provide you, a copy of the informational statement from the Department of Children & Families can be found in the Parent Handbook.

The statement highlights, among other things:

- Your right to observe our center at any time without having to secure permission
- The center's obligation to be licensed and to comply with licensing standards and
- The obligation of all citizens to report suspected child abuse of all forms (physical, sexual, emotional, and neglect) to the State's DCP&P

Name of child: _____

Name of Parent (s)/Guardian (s): _____

I have read and received a copy of the Information to Parents statement prepared by the Bureau of Licensing and DCP&P

Parent Signature _____

Date _____

Cumberland Cape Atlantic YMCA

YMCA Policies

Parent Statement of Understanding

The following information is important for the safety and protection of your child. Please read the information, sign this form, and return the original to the Cumberland Cape Atlantic YMCA (CCA YMCA). A copy will be filed with your child's records.

- **I understand that CCA YMCA staff and volunteers are not allowed to baby-sit or transport children at any time outside the CCA YMCA program.** If a violation is discovered, the Y will take immediate disciplinary action toward staff and/or volunteers.
- **I understand that staff and volunteers are not allowed to initiate contact with members and program participants outside the CCA YMCA, unless necessary in certain limited cases for the smooth operation of a CCA YMCA program. If deemed necessary, contact should be made with the program participant's parent or guardian. Contact includes, but is not limited to, sharing of phone numbers, email addresses, personal websites and/or web logs.** If a violation is discovered, the Y will take immediate disciplinary action toward staff and/or volunteers.
- **I understand that I am not to leave my child* at the CCA YMCA or program site unless a CCA YMCA staff is there to receive and supervise my child. I understand that my child must be escorted to and from the program area by me or another person on my authorized list. Children may not just be dropped off at the door.** *Note: The CCA YMCA's policy is that children under the age of 12 may not be alone in our facilities/program sites.
- **I understand children should not receive excessive gifts (e.g. toys, video games, jewelry) from CCA YMCA staff or volunteers, and I should report this to a supervisor if they do.**
- **I understand that my child will not be allowed to leave the program with an unauthorized person. Any person authorized to pick up my child, including relatives, must be listed with CCA YMCA and must be at least 18 years of age required by the CCA YMCA. Any other alternate pick-up arrangements must be made in writing by a parent/guardian. Phone notification of an alternate pick-up arrangement is only accepted in an emergency.**
- **I understand that should a person arrive to pick up my child who appears to be under the influence of drugs or alcohol, for the child's safety, staff may have no recourse but to contact the police.** Please do not put staff in a position where they have to make this judgment call.
- **I understand that I can help ensure my child's safety by taking an active interest in his or her CCA YMCA experience. I too will monitor volunteer and staff interactions with my child and ask my child specific questions about program activities and volunteer or staff relationships with my child.**
- **I understand that the CCA YMCA is mandated by state law to report any suspected cases of child abuse or neglect to the appropriate authorities for investigation.**
- **I have received a copy of the CCA YMCA Youth Program Handbook and/or Program Policies and Procedures and will keep it for future reference.**

Parent Signature _____

Date _____

Parent Notification of Communications Policy

Families entrust their children to the Cumberland Cape Atlantic YMCA's care for child care, camp, and other youth programs. Our promise to those we serve is to provide a safe environment in which all participants are treated in a caring, honest, respectful and responsible way.

CCA YMCA staff, volunteers, program participants and parents must work together to ensure adherence to this policy.

CCA Staff and Volunteers:

- Will block any personal websites or blogs and mark them as private, denying access to any CCA YMCA program participants
- Will not disclose personal email, telephone, cell phone or website information to any program participants
- Will not attempt to contact any participant via phone, text message email, website or blogs for non-program related business
- Will not use any photos taken for CCA YMCA programs or marketing purposes for personal use
- Will not use cell phones for personal calls during business hours
- Will not use cell phone cameras to take photos of program participants for any reason
- Will notify his/her supervisor immediately if a youth attempts to communicate with an employee via e-mail, instant message, cell phone or social network site

CCA YMCA Program Participants and Their Parents Agree:

- Not to contact any staff via staff's personal telephone/cell phone, text message, email, websites or blogs
- Not to use cell phones during program hours (except for emergency situations)
- They will not use photos, logos or images of the CCA YMCA or its program participants
- Personal photos may only be taken with consent and may not be displayed in any derogatory fashion
- Will not take cell phone photos of staff or program participants while engaged in CCA YMCA programs

Of course, the CCA YMCA does not mean to interfere with anyone's private life, but publicly observable communications, actions or words are not private, and personal expression can have legal consequences, including defamation, copyright infringement and trademark infringement.

Parent Signature _____

Date _____



Department of Children and Families

Office of Licensing

INFORMATION TO PARENTS

Under provisions of the **Manual of Requirements for Child Care Centers (N.J.A.C. 3A:52)**, every licensed child care center in New Jersey must provide to parents of enrolled children written information on parent visitation rights, State licensing requirements, child abuse/neglect reporting requirements and other child care matters. The center must comply with this requirement by reproducing and distributing to parents and staff this written statement, prepared by the Office of Licensing, Child Care & Youth Residential Licensing, in the Department of Children and Families. In keeping with this requirement, the center must secure every parent and staff member's signature attesting to his/her receipt of the information.

Our center is required by the State Child Care Center Licensing law to be licensed by the Office of Licensing (OOL), Child Care & Youth Residential Licensing, in the Department of Children and Families (DCF). A copy of our current license must be posted in a prominent location at our center. Look for it when you're in the center.

To be licensed, our center must comply with the Manual of Requirements for Child Care Centers (the official licensing regulations). The regulations cover such areas as: physical environment/life-safety; staff qualifications, supervision, and staff/child ratios; program activities and equipment; health, food and nutrition; rest and sleep requirements; parent/community participation; administrative and record keeping requirements; and others.

Our center must have on the premises a copy of the Manual of Requirements for Child Care Centers and make it available to interested parents for review. If you would like to review our copy, just ask any staff member. Parents may view a copy of the Manual of Requirements on the DCF website at <http://www.nj.gov/dcf/providers/licensing/laws/CCCmanual.pdf> or obtain a copy by sending a check or money order for \$5 made payable to the "Treasurer, State of New Jersey", and mailing it to: NJDCF, Office of Licensing, Publication Fees, PO Box 657, Trenton, NJ 08646-0657.

We encourage parents to discuss with us any questions or concerns about the policies and program of the center or the meaning, application or alleged violations of the Manual of Requirements for Child Care Centers. We will be happy to arrange a convenient opportunity for you to review and discuss these matters with us. If you suspect our center may be in violation of licensing requirements, you are entitled to report them to the Office of Licensing toll free at 1 (877) 667-9845. Of course, we would appreciate your bringing these concerns to our attention, too.

Our center must have a policy concerning the release of children to parents or people authorized by parents to be responsible for the child. Please discuss with us your plans for your child's departure from the center.

Our center must have a policy about administering medicine and health care procedures and the management of communicable diseases. Please talk to us about these policies so we can work together to keep our children healthy.

Our center must have a policy concerning the expulsion of children from enrollment at the center. Please review this policy so we can work together to keep your child in our center.

Parents are entitled to review the center's copy of the OOL's Inspection/Violation Reports on the center, which are available soon after every State licensing inspection of our center. If there is a licensing complaint investigation, you are also entitled to review the OOL's Complaint Investigation Summary Report, as well as any letters of enforcement or other actions taken against the center during the current licensing period. Let us know if you wish to review them and we will make them



available for your review or you can view them online at <https://childcareexplorer.njccis.com/portal/>.

Our center must cooperate with all DCF inspections/investigations. DCF staff may interview both staff members and children.

Our center must post its written statement of philosophy on child discipline in a prominent location and make a copy of it available to parents upon request. We encourage you to review it and to discuss with us any questions you may have about it.

Our center must post a listing or diagram of those rooms and areas approved by the OOL for the children's use. Please talk to us if you have any questions about the center's space.

Our center must offer parents of enrolled children ample opportunity to assist the center in complying with licensing requirements; and to participate in and observe the activities of the center. Parents wishing to participate in the activities or operations of the center should discuss their interest with the center director, who can advise them of what opportunities are available.

Parents of enrolled children may visit our center at any time without having to secure prior approval from the director or any staff member. Please feel free to do so when you can. We welcome visits from our parents.

Our center must inform parents in advance of every field trip, outing, or special event away from the center, and must obtain prior written consent from parents before taking a child on each such trip.

Our center is required to provide reasonable accommodations for children and/or parents with disabilities and to comply with the New Jersey Law Against Discrimination (LAD), P.L. 1945, c. 169 (N.J.S.A. 10:5-1 et seq.), and the Americans with Disabilities Act (ADA), P.L. 101-336 (42 U.S.C. 12101 et seq.). Anyone who believes the center is not in compliance with these laws may contact the Division on Civil Rights in the New Jersey Department of Law and Public Safety for information about filing an LAD claim at (609) 292-4605 (TTY users may dial 711 to reach the New Jersey Relay Operator and ask for (609) 292-7701), or may contact the United States Department of Justice for information about filing an ADA claim at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Our center is required, at least annually, to review the Consumer Product Safety Commission (CPSC), unsafe children's products list, ensure that items on the list are not at the center, and make the list accessible to staff and parents and/or provide parents with the CPSC website at <https://www.cpsc.gov/Recalls>. Internet access may be available at your local library. For more information call the CPSC at (800) 638-2772.

Anyone who has reasonable cause to believe that an enrolled child has been or is being subjected to any form of hitting, corporal punishment, abusive language, ridicule, harsh, humiliating or frightening treatment, or any other kind of child abuse, neglect, or exploitation by any adult, whether working at the center or not, is required by State law to report the concern immediately to the State Central Registry Hotline, toll free at (877) NJ ABUSE/(877) 652-2873. Such reports may be made anonymously. Parents may secure information about child abuse and neglect by contacting: DCF, Office of Communications and Legislation at (609) 292- 0422 or go to www.state.nj.us/dcf/.



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Cumberland Cape Atlantic YMCA
1159 E. Landis Avenue, Vineland, NJ 08360
www.ccaymca.org • 856-691-0030

EXPULSION POLICY

NAME OF CENTER: _____

Unfortunately, there are sometimes reasons we have to expel a child from our program either on a short term or permanent basis. We want you to know we will do everything possible to work with the family of the child(ren) in order to prevent this policy from being enforced.

The following are reasons we may have to expel or suspend a child from this center:

IMMEDIATE CAUSES FOR EXPULSION:

- The child is at risk of causing serious injury to other children or himself/herself.
- Parent threatens physical or intimidating actions toward staff members.
- Parent exhibits verbal abuse to staff in front of enrolled children

PARENTAL ACTIONS FOR CHILD'S EXPULSION:

- Failure to pay/habitual lateness in payments.
- Failure to complete required forms including the child's immunization records.
- Habitual tardiness when picking up your child.
- Verbal abuse to staff.
- Other (explain)

CHILD'S ACTIONS FOR EXPULSION:

- Failure of child to adjust after a reasonable amount of time.
- Uncontrollable tantrums/ angry outbursts.
- Ongoing physical or verbal abuse to staff or other children.
- Excessive biting.
- Other (explain)

SCHEDULE OF EXPULSION:

If after the remedial actions above have not worked, the child's parent/guardian will be advised verbally and in writing about the child's or parent's behavior warranting an expulsion. An expulsion action is meant to be a period of time so that the parent/ guardian may work on the child's behavior or to come to an agreement with the center. The parent/guardian will be informed regarding the length of the expulsion period and the expected behavioral changes required in order for the child or parent to return to the center. The parent/guardian will be given a specific expulsion date that allows the parent sufficient time to seek alternate child care (approximately one to two weeks' notice depending on risk to other children's welfare or safety). Failure of the child/parent to satisfy the terms of the plan may result in permanent expulsion from the center.

A CHILD WILL NOT BE EXPELLED IF A PARENT/GUARDIAN:

- Made a complaint to the Office of Licensing regarding a center's alleged violations of the licensing requirements.
- Reported abuse or neglect occurring at the center.
- Questioned the center regarding policies and procedures.
- Without giving the parent sufficient time to make other child care arrangements.

PROACTIVE ACTIONS THAT CAN BE TAKEN IN ORDER TO PREVENT EXPULSION:

- Try to redirect child from negative behavior.
- Reassess classroom environment, appropriateness of activities, supervision.
- Always use positive methods and language while disciplining children.
- Praise appropriate behaviors.
- Consistently apply consequences for rules.
- Give the child verbal warnings.
- Give the child time to regain control.
- Document the child's disruptive behavior and maintain confidentiality.
- Give the parent/guardian written copies of the disruptive behavior that might lead to expulsion.
- Schedule a conference including the director, classroom staff, and parent/guardian to discuss how to promote positive behaviors.
- Give the parent literature of other resources regarding methods of improving behavior.
- Recommend an evaluation by professional consultation on premises.
- Recommend an evaluation by local school district study team.

2025 NEW JERSEY CHILD AND ADULT CARE FOOD PROGRAM ELIGIBILITY APPLICATION

NAME(S) & AGE(S) OF ENROLLED PARTICIPANT(S)																																																																										
	(Name)	(Age)																																																																								
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<p><i>OPTIONAL: RACIAL/ETHNIC IDENTITY OF PARTICIPANT</i></p> <p>Check one ETHNIC identity:</p> <p><input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino</p> <p style="text-align: center;">Mark one or more RACIAL identity (ies):</p> <p><input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American</p> <p><input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White</p> <p style="text-align: center;">Enrollment Information</p>																																																																										
<p><i>Check () each day the above participant is enrolled for care, the hours of care each day, and the meal type(s) served:</i></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">DAYS OF CARE:</th> <th style="width: 10%;">MON</th> <th style="width: 10%;">TUES</th> <th style="width: 10%;">WED</th> <th style="width: 10%;">THURS</th> <th style="width: 10%;">FRI</th> <th style="width: 10%;">SAT</th> <th style="width: 10%;">SUN</th> </tr> </thead> <tbody> <tr> <td>HOURS OF CARE:</td> <td style="text-align: center;">-</td> <td style="text-align: center;">-</td> <td style="text-align: center;">-</td> <td style="text-align: center;">-</td> <td style="text-align: center;">-</td> <td style="text-align: center;">-</td> <td style="text-align: center;">-</td> </tr> <tr> <td>Swing / Rotating Shifts: (If Applicable)</td> <td style="text-align: center;">-</td> <td style="text-align: center;">-</td> <td style="text-align: center;">-</td> <td style="text-align: center;">-</td> <td style="text-align: center;">-</td> <td style="text-align: center;">-</td> <td style="text-align: center;">-</td> </tr> </tbody> </table> <table style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th style="width: 10%;">MEAL TYPES SERVED:</th> <th style="width: 15%;">BREAKFAST</th> <th style="width: 15%;">A.M. SUPPLEMENT</th> <th style="width: 15%;">LUNCH</th> <th style="width: 15%;">P.M. SUPPLEMENT</th> <th style="width: 15%;">SUPPER</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>				DAYS OF CARE:	MON	TUES	WED	THURS	FRI	SAT	SUN	HOURS OF CARE:	-	-	-	-	-	-	-	Swing / Rotating Shifts: (If Applicable)	-	-	-	-	-	-	-	MEAL TYPES SERVED:	BREAKFAST	A.M. SUPPLEMENT	LUNCH	P.M. SUPPLEMENT	SUPPER																																									
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<p>OPTION 1A: BENEFICIARIES of Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FPIR)</p> <p>If you are now receiving SNAP, TANF or FPIR for this child, complete <u>one</u> of the following numbers:</p> <p>SNAP CASE # _____ OR TANF CASE # _____ OR FPIR CASE # _____</p>																																																																										
<p>OPTION 1B: FOSTER CHILD</p> <p>If you are applying for a foster child, check the box and list any personal income which has been identified by specific category such as clothing, school fees, allowances, etc.:</p> <p>FOSTER CHILD <input type="checkbox"/> INCOME \$ _____</p>																																																																										
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<p>OPTION 2: BENEFICIARIES of SNAP, FPIR, SSI or Medicaid</p> <p>If you are now receiving SNAP, SSI, FPIR or Medicaid complete one of the following numbers:</p> <p>SNAP CASE # _____ OR FPIR CASE # _____ OR SSI CASE # _____ OR MEDICAID CASE # _____</p>																																																																										
<p>OPTION 3: HOUSEHOLD ELIGIBILITY - COMPLETE IF YOU DID NOT COMPLETE OPTION 1A, OPTION 1B, OR OPTION 2</p> <p><i>Complete the following information: Household Members, Social Security Numbers and Income.</i></p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th rowspan="2" style="width: 30%;">NAMES OF ALL OTHER HOUSEHOLD MEMBERS: (Related and Unrelated)</th> <th colspan="5" style="text-align: center;">MONTHLY INCOME (Complete One Or More - Before Deductions)</th> </tr> <tr> <th style="width: 10%;">Monthly (Gross Earnings) Wages/Salary</th> <th style="width: 15%;">MONTHLY SOCIAL SECURITY PENSIONS / RETIREMENT</th> <th style="width: 15%;">MONTHLY UNEMPLOYMENT WORKER'S COMPENSATION</th> <th style="width: 15%;">MONTHLY WELFARE, CHILD SUPPORT, ALIMONY</th> <th style="width: 15%;">Monthly Any Other Income</th> </tr> </thead> <tbody> <tr><td>1</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td></tr> <tr><td>2</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td></tr> <tr><td>3</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td></tr> <tr><td>4</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td></tr> <tr><td>5</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td></tr> <tr><td>6</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td></tr> <tr><td>7</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td></tr> <tr><td>8</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td></tr> <tr><td>9</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td></tr> <tr><td>10</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td><td style="text-align: center;">\$</td></tr> </tbody> </table> <p>TOTAL NUMBER IN HOUSEHOLD (INCLUDE ENROLLED PARTICIPANT): _____</p> <p>TOTAL GROSS HOUSEHOLD INCOME: _____</p>				NAMES OF ALL OTHER HOUSEHOLD MEMBERS: (Related and Unrelated)	MONTHLY INCOME (Complete One Or More - Before Deductions)					Monthly (Gross Earnings) Wages/Salary	MONTHLY SOCIAL SECURITY PENSIONS / RETIREMENT	MONTHLY UNEMPLOYMENT WORKER'S COMPENSATION	MONTHLY WELFARE, CHILD SUPPORT, ALIMONY	Monthly Any Other Income	1	\$	\$	\$	\$	\$	2	\$	\$	\$	\$	\$	3	\$	\$	\$	\$	\$	4	\$	\$	\$	\$	\$	5	\$	\$	\$	\$	\$	6	\$	\$	\$	\$	\$	7	\$	\$	\$	\$	\$	8	\$	\$	\$	\$	\$	9	\$	\$	\$	\$	\$	10	\$	\$	\$	\$	\$
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<p>ADULT HOUSEHOLD MEMBER SIGNATURE and LAST FOUR DIGITS of SOCIAL SECURITY NUMBER: (See Privacy Act Statement below)</p> <p>An Adult Household Member must sign and date this form, and list the last four (4) digits of his or her Social Security Number.</p> <p>If you do not have a social security number, mark the box - <input type="checkbox"/> "I do not have a Social Security Number."</p>																																																																										
<p>PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the Food Stamp, TANF, SSI, or Medicaid Number of the enrolled participant is correct, or that all income is reported. I understand that this information is being given for the receipt of Federal funds issued to the day care center based on the information I provide. I understand that CACFP officials may verify this information, and that deliberate misrepresentation may result in the participant losing meal benefits, and I may be prosecuted under the applicable State and Federal laws. <i>An Adult Household Member must complete the following:</i></p> <p>Signature: _____ Address: _____</p> <p>Print Name: _____ City: _____ State: _____ Zip Code: _____</p> <p>Date: _____ Phone Number: _____</p> <p>Last four (4) digits of Social Security Number: * * * - * * - _____ <input type="checkbox"/> I do not have a Social Security Number</p>																																																																										
<p>PRIVACY ACT STATEMENT: The National School Lunch Act requires that, unless the participants' Case Number is provided, you must include the Social Security Number of the adult household member signing the application or indicate that the household member does not have a Social Security Number. Provision of a Social Security Number is not mandatory, but if a Social Security Number is not given or an indication is not made that the signer does not have such a number, the participant cannot be determined eligible for free or reduced priced menus. The Social Security Numbers may be used to identify you for verifying the correctness of information stated on the application. These verifications may include audits, and investigations and may include contacting employers to determine income, contacting a Food Stamp or TANF office to determine current certification for receipt of Food Stamps or TANF benefits, contacting the State Employment Security office to determine the amount of benefits received and checking the documentation produced by household members to verify 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. These acts must be told to all household members whose Social Security Numbers are reported on this form.</p>																																																																										
<p>Determination: Free: _____ Reduced: _____ Paid: _____</p> <p>Signature of Determining Official: _____</p> <p>_____ Date: _____</p>		<p>TOTAL MONTHLY INCOME \$ _____</p> <p><i>Conversion factors to figure monthly income: Weekly x 4.33 Twice a month x 2 Every 2 weeks x 2.15</i></p>																																																																								

**2024-2025 CHILD AND ADULT CARE FOOD PROGRAM LETTER
TO PARENT/PARTICIPANT**

Dear Parent/Participant:

Our agency depends on Child and Adult Care Food Program funds to provide meals at no separate charge to all participants. Complete information is necessary in order to receive the maximum funds available through the United States Department of Agriculture. The information will serve as documentation that our enrolled participants are eligible for the Child and Adult Care Food Program. You may complete and submit one CACFP eligibility application for all participants from the same household that are enrolled for care with our agency.

Household members include everyone in your household (such as grandparents, other relatives, or friends who live with you) who share income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you. Once properly categorized for free or reduced price benefits, whether through income or by providing a current SNAP, FDPIR, or TANF case number (SNAP, FDPIR, SSI, or Medicaid case number for Adult Day Care Participants), you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within those eligibility standards.

The income that you report must be the total gross income received by all members of your household.

The "Eligibility Income Scale" for reduced-price meals is included in this letter for your information. If your income is less than or equal to these reduced- priced standards, the participant is eligible for free or reduced-price meals from the Child and Adult Care Food Program, which means increased reimbursement for our center and increased nutritional benefits for the participant.

Please complete, sign and return the form so that our center may receive maximum reimbursement. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. This form will be placed in our files and treated as confidential information. Your cooperation is vital and appreciated.

In accordance with federal civil rights 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), disability, age, or 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 to obtain program information (e.g., Braille, large print, audiotape, 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: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.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: 1. U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250; or 2. Fax (833) 256-1665 or (202) 690-7442; or 3. Email: program.intake@usda.gov

(Name of Day Care Center)

(Day Care Center Phone Number)

New Jersey Department of Agriculture Child and Adult Care Food Program

Phone Number 609-984-1250

TO APPLY, YOU MUST COMPLETE ONE OF THREE OPTIONS.

- List the Name of the participant (First and Last Names).
- Complete the Days, Hours of Care, and the meal types served to the enrolled participant. (One time requirement for Adult Day Care participants)

Option 1A or 1B - CHILD CARE PARTICIPANTS ONLY:

If you receive SNAP, TANF, or FDPIR benefits for the participant, list the SNAP, TANF or FDPIR Case Number and Sign and Date the form.

If you are applying for a Foster Child who is under the legal responsibility of the welfare agency or court, Check the Box and Sign and Date the form.

A FOSTER CHILD'S PERSONAL USE INCOME is defined as follows:

- Funds received from a welfare agency, which can be identified for personal use of the child. Where funds provided by the welfare agency are specified by agency, i.e., funds for shelter and care; special needs funds; and funds for personal needs such as clothing, school fees, allowances, etc., only those funds that can be identified as personal use funds shall be considered as income.
- Money received in hand from any source. This includes, but is not limited to, funds received from trust accounts, monies provided by the child's family for personal use and earnings from employment other than occasional or part-time (e.g., paper routes, baby-sitting).

Option 2 – ADULT CARE PARTICIPANTS ONLY

If you receive SNAP, FDPIR, SSI or Medicaid benefits for the participant, indicate the SNAP, FDPIR, SSI or Medicaid Case Number and Sign and Date the form.

Option 3 – CHILD CARE AND ADULT PARTICIPANTS:

If you do not receive SNAP, TANF, FDPIR, SSI or Medicaid benefits for the participant, you must complete:

- Names of all (Related or Unrelated) household members
- List the household income (Monthly Gross Earnings) for each household member.
- Total number in household (#1 + #3 above).
- Total the gross income of all household members.
- Sign, Print and complete the full address of the Adult Household Member signing the application.
- Date the form and complete the telephone number of Adult Household Member signing the application.
- List the last four (4) digits of the social security number for the Adult Household Member signing the application or indicate that the Adult Household Member signing the application does not possess a social security number.

**ELIGIBILITY INCOME SCALE
Effective From July 1, 2024 to June 30, 2025**

HOUSEHOLD SIZE	REDUCED		
	ANNUAL	MONTHLY	WEEKLY
1	\$19,579 - \$27,861	\$1,633 - \$2,322	\$ 378 - \$ 536
2	\$26,573 - \$37,814	\$2,216 - \$3,152	\$ 512 \$ 728
3	\$33,567 - \$47,767	\$2,799 - \$3,981	\$ 647 - \$ 919
4	\$40,561 - \$57,720	\$3,381 - \$4,810	\$ 781 - \$1,110
5	\$47,555 - \$67,673	\$3,964 - \$5,640	\$ 916 - \$1,302
6	\$54,549 - \$77,626	\$4,547 - \$6,469	\$1, 050 - \$1,493
7	\$61,543 - \$87,579	\$5,130 - \$7,299	\$1,185 - \$1,685
8	\$68,537 - \$97,532	\$5,713 - \$8,128	\$1,319 - \$1,876
Each Additional Family Member	+9,953	+830	+192

2025 PROGRAMA DE ALIMENTACIÓN DE NIÑOS Y ADULTOS

FORMULARIO DE ELIGIBILIDAD

NOMBRE(S) Y EDAD(ES) DEL PARTICIPANTE(S):

	(Nombre)	(Edad)	(Nombre)	(Edad)
--	----------	--------	----------	--------

OPCIONAL: IDENTIDAD RACIAL/ÉTNICA DEL PARTICIPANTE

Marque una o más identidades raciales:

<input type="checkbox"/> Amerindio o nativo de Alaska <input type="checkbox"/> Hispano o Latino <input type="checkbox"/> Ni Hispano ni Latino	<input type="checkbox"/> Asiático <input type="checkbox"/> Nativo de Hawái u otras islas del Pacífico	<input type="checkbox"/> Negro o afroamericano <input type="checkbox"/> Blanco
---	--	---

Información de Matriculación

Marque () por cada día que el participante es matriculado, horas, y el tipo de comida servida:

LOS DÍAS DEL CUIDADO:	LUNES	MARTES	MIÉRCOLES	JUEVES	VIERNES	SABADO	DOMINGO
LAS HORAS DEL CUIDADO:	-	-	-	-	-	-	-
Turno Alternativo (Si es Pertinente)	-	-	-	-	-	-	-
TIPO DE COMIDA SERVIDA:	DESAYUNO	SUPLEMENTO DE MAÑANA	ALMUERZO	SUPLEMENTO DE TARDE	CENA		

PARTICIPANTES DEL PROGRAMA DE LOS NIÑOS SOLAMENTE

OPCIÓN 1A: BENEFICIOS de Programa Asistencia Para Nutrición Suplementaria (SNAP, o Cupones para alimentos), Asistencia Provisional para Familias Necesitadas (TANF), o Programa de Distribución de Alimentos en Reservas Indígenas (FDPIR).

Si está recibiendo SNAP, TANF o FDPIR para su hijo, anota UNO de los números del caso:

Número de caso de SNAP: _____ 0 Número de caso de TANF: _____ 0 Número de caso de FDPIR: _____

OPCIÓN 1B: HIJO DE CRIANZA (BAJO TUTELA LEGAL DE UNA AGENCIA DE BENEFICENCIA O EL TRIBUNAL)

Si está aplicando para un hijo de crianza, marque la caja abajo. Por favor, escribe el monto de ingresos para "uso personal" (como por ejemplo ropa, honorario de la escuela, etc.) que el niño recibió el mes pasado.

HIJO DE CRIANZA INGRESOS \$ _____

PARTICIPANTES DEL PROGRAMA DE LOS ADULTOS SOLAMENTE

OPCIÓN 2: BENEFICIOS de Programa Asistencia Para Nutrición Suplementaria (SNAP, o cupones para alimentos), Programa de Distribución de Alimentos en Reservas Indígenas (FDPIR), Ingreso de Seguro Social (SSI) o Beneficios de Medicaid.

Si está recibiendo SNAP, FDPIR, ingreso de seguro social, o Medicaid, anota UNO de los números del caso:

Número de caso de SNAP: _____ 0 de FDPIR: _____ 0 de SSI _____ 0 de Medicaid _____

OPCIÓN 3: ELIGIBILIDAD DE LA UNIDAD FAMILIAR - COMPLETE ESTA PARTE SI NO COMPLETÓ OPCIÓN 1A, OPCIÓN 1B, OR OPCIÓN 2

Anota la siguiente información: Miembros de la unidad familiar, número de seguro social, e ingresos mensuales:

NOMBRES DE LOS MIEMBROS DE LA UNIDAD FAMILIAR: (Pariente o Sin Parentesco)	INGRESO MENSUAL (Anota una columna o más – antes de las deducciones)				
	INGRESOS (MENSUALES) PORT RABAJO	MENSUALES SEGURO SOCIAL PENSIONES JUBILACIÓN	MENSUALES COMPENSACIÓN POR DESEMPLEO	MENSUALES ASISTENCIA SOCIAL PENSIÓN PARA HIJOS PENSIÓN ALIMENTICIA	INGRESOS POR UN SEGUNDO TRABAJO O CUALQUIER OTRO INGRESO MENSUAL
1	\$	\$	\$	\$	\$
2	\$	\$	\$	\$	\$
3	\$	\$	\$	\$	\$
4	\$	\$	\$	\$	\$
5	\$	\$	\$	\$	\$
6	\$	\$	\$	\$	\$
7	\$	\$	\$	\$	\$
8	\$	\$	\$	\$	\$
9	\$	\$	\$	\$	\$
10	\$	\$	\$	\$	\$

NUMERO ACTUAL DE MIEMBROS EN LA UNIDAD FAMILIAR: (INCLUYENDO EL PARTICIPANTE): _____

INGRESO ACTUAL (TOTAL): _____ \$ _____

FIRMA DE ADULTO y LOS ULTIMOS CUATRO DIGITOS DE NUMERO DE SEGURO SOCIAL: (Lee la Declaración de Privacidad abajo)

Un miembro adulto de la unidad familiar debe firmar y poner la fecha abajo. También anota los últimos cuatro dígitos del número de seguro social. Si usted no tiene un número de seguro social, marque la caja "No tengo un número de seguro social".

LAS CONSECUENCIAS DE MALA REPRESENTACIÓN: Yo certifico que toda la información en esta solicitud es verdadera y que toda la información de cupones para alimentos, ingresos de seguro social, numero de Medicaid, e ingresos es verdadera y que declaré todos los ingresos. Comprendo que el centro del proveedor recibirá fondos federales con base en la información que yo declare. Entiendo que los funcionarios del programa CACFP pueden verificar la información. Entiendo que si doy información falsa a propósito, el participante que recibe las comidas podría perder sus beneficios de comidas y a mí se me podría procesar judicialmente.

Un Miembro Adulto de la Unidad Familiar debe firmar esta parte:

Firma: _____ Dirección: _____

Nombre (en letra de imprenta): _____ Ciudad/Pueblo: _____ Estado: _____ Código Postal: _____

Fecha: _____ Numero de Teléfono: _____

Los últimos cuatro (4) dígitos de seguro social: * * * - * * - No tengo número de Seguro Social

Declaración de Privacidad: La ley de almuerzos escolares Richard B. Russell National School Lunch Act ordena que se proporcione la información que se pide en esta solicitud. No tiene que darnos la información, pero si no lo hace, no podemos aprobar las comidas gratuitas o a precios reducidos para el participante. Usted tiene que incluir los últimos cuatro dígitos del número de Seguro Social del miembro adulto de la unidad familiar que firme la solicitud. El número de Seguro Social no se requiere si usted provee un numero de caso de los programas Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR), o bien otro número de identificación del FDPIR para el participante, y tampoco si indica que el miembro adulto de la unidad familiar que firma so solicitud no tiene un número de Seguro Social. Usaremos su información para decidir si el participante reúne los requisitos para recibir comidas gratuitas o a precios reducidos, así como para administrar y hacer cumplir el programa.

NO LLENE ESTA PARTE. ES SOLO PARA USO OFICIAL.
TO BE COMPLETED BY DAY CARE AGENCY ONLY – DO NOT WRITE BELOW THIS LINE

Determination: Free: _____ Reduced: _____ Paid: _____	TOTAL MONTHLY INCOME \$ _____
Signature of Determining Official: _____	<i>Conversion factors to figure monthly income: Weekly x 4.33 Twice a month x 2 Every 2 weeks x 2.15</i>
Date: _____	

2024-2025 PROGRAMA DE ALIMENTACIÓN DE NIÑOS Y ADULTOS CARTA A LOS PAPAS/PARTICIPANTES

Estimados Padres/Participante:

Nuestra agencia es dependiente en el Programa de Alimentación de Niños y Adultos para poder ofrecer comidas gratuitas o a precios reducidos a nuestros participantes. Es necesario completar toda la información para recibir el reembolso máximo del Departamento de Agricultura de los EE.UU (USDA). Usted puede completar la aplicación para todos los participantes que son miembros de la unidad familiar.

Miembros de la unidad familiar incluye todos que viven en la casa (como abuelos, familia, o amigos) que comparten los ingresos y gastos. Debe incluirse a usted y a todos los niños que viven en la casa. También puede incluir hijos de crianza (bajo tutela legal de una agencia) que viven con usted. Ya que sea apropiadamente clasificado para los beneficios gratuitos o reducidos por la cantidad de ingresos que declaro o por el número de caso de SNAP, FDPIR, o TANF (SNAP, FDPIR, SSI o Medicaid para los participantes adultos), su elegibilidad continuará por 12 meses. Si la cantidad de ingresos baja durante el año, deber notificarnos para que podemos hacer los propios cambios.

Los ingresos que usted declaró deben ser los ingresos brutos recibidos por todas las personas en su hogar.

El "Cuadro de Ingreso de Elegibilidad Federal" para la comida a un costo reducido está incluido en la parte abajo para su información. Si su ingreso es menor o igual a los estándares abajo, su hijo estará elegible para la Programa de Alimentación de Niños y Adultos, y nuestro centro pueda recibir más fondos para comprar comida más nutritiva para los niños.

Por favor, llene y firma la solicitud para que podemos recibir el reembolso máximo para nuestro centro. No podemos aprobar una aplicación incompleta, así que lee las instrucciones con cuidado y llene toda la información requerida. La solicitud es confidencial y va a quedarse en nuestros archivos.

De acuerdo con la ley federal de derechos civiles y las normas y políticas de derechos civiles del Departamento de Agricultura de los Estados Unidos (USDA), esta entidad está prohibida de discriminar por motivos de raza, color, origen nacional, sexo (incluyendo identidad de género y orientación sexual), discapacidad, edad, o represalia o retorsión por actividades previas de derechos civiles.

La información sobre el programa puede estar disponible en otros idiomas que no sean el inglés. Las personas con discapacidades que requieren medios alternos de comunicación para obtener la información del programa (por ejemplo, Braille, letra grande, cinta de audio, lenguaje de señas americano (ASL), etc.) deben comunicarse con la agencia local o estatal responsable de administrar el programa o con el Centro TARGET del USDA al (202) 720-2600 (voz y TTY) o comuníquese con el USDA a través del Servicio Federal de Retransmisión al (800) 877-8339.

Para presentar una queja por discriminación en el programa, el reclamante debe llenar un formulario AD-3027, formulario de queja por discriminación en el programa del USDA, el cual puede obtenerse en línea en: <https://www.fns.usda.gov/sites/default/files/resource-files/usdaprogram-discrimination-complaint-form-spanish.pdf>, de cualquier oficina de USDA, llamando al (866) 632-9992, o escribiendo una carta dirigida a USDA. La carta debe contener el nombre del demandante, la dirección, el número de teléfono y una descripción escrita de la acción discriminatoria alegada con suficiente detalle para informar al Subsecretario de Derechos Civiles (ASCR) sobre la naturaleza y fecha de una presunta violación de derechos civiles. El formulario AD-3027 completado o la carta debe presentarse a USDA por: **1. Correo:** U.S. Department of Agriculture, Office of the Secretary for Civil Rights, 1400 Independence Avenue, Sw Washington, D.C. 20250-9410; or **2. Fax:** (833) 256-1665 o (202) 690-7442; o **3. Correo electrónico:** program.intake@usda.gov

(Nombre del Centro Del Proveedor)

(Numero de Telefono)

New Jersey Department of Agriculture Child and Adult Care Food Program

Phone Number 609-984-1250

PARA APLICAR, LLENE UNA DE LAS TRES OPCIONES SIGUIENTES:

1. Liste el nombre y apellido del participante.
2. Liste los días, las horas y el tipo de comida servida.

Opción 1A o 1B - PARTICIPANTES QUE SON NIÑOS:

Liste el número de caso si recibe beneficios de los programas SNAP (cupones para alimentos), FDPIR o "TANF" para su hijo. Liste la fecha y firme la solicitud.

Si está aplicando para un hijo de crianza (bajo tutela legal de una agencia de beneficencia o el tribunal), marque la caja, liste la fecha y firme la solicitud.

Opción 2 – PARTICIPANTES QUE SON ADULTOS:

Si está recibiendo SNAP (cupones para alimentos), FDPIR, ingreso de seguro social, o beneficios de Medicaid, liste el número de caso y la fecha. Firme la solicitud.

Opción 3 – PARTICIPANTES QUE SON NIÑOS Y ADULTOS:

Si no está recibiendo SNAP (cupones de alimentos), TANF, FDPIR, ingreso de seguro social o beneficios de Medicaid, liste:

3. Nombres de todo los miembros de la unidad familiar que está viviendo en el mismo hogar.
4. Los ingresos brutos para cada miembro.
5. El número actual de los miembros de la unidad familiar. (#1 + #3 arriba).
6. Ingreso actual de los miembros de la unidad familiar (bruto).
7. Firme, poner la fecha, y liste los últimos cuatro números del seguro social para el miembro adulto que está firmando la solicitud. Si el miembro no tiene seguro social, marque la caja que dice "No tengo número de seguro social".
8. Liste el nombre del miembro adulto firmando la aplicación.
9. Liste la dirección y número de teléfono del miembro adulto que está firmando la solicitud.

**Cuadro de Ingreso de Elegibilidad Federal
Efectivo de 1 de Julio, 2024 hasta el 30 de Junio, 2025**

TAMANO DEL HOGAR	REDUCIDO		
	ANUAL	MENSUAL	SEMENAL
1	\$19,579 - \$27,861	\$1,633 - \$2,322	\$ 378 - \$ 536
2	\$26,573 - \$37,814	\$2,216 - \$3,152	\$ 512 - \$ 728
3	\$33,567 - \$47,767	\$2,799 - \$3,981	\$ 647 - \$ 919
4	\$40,561 - \$57,720	\$3,381 - \$4,810	\$ 781 - \$1,110
5	\$47,555 - \$67,673	\$3,964 - \$5,640	\$ 916 - \$1,302
6	\$54,549 - \$77,626	\$4,547 - \$6,469	\$1,050 - \$1,493
7	\$61,543 - \$87,579	\$5,130 - \$7,299	\$1,185 - \$1,685
8	\$68,537 - \$97,532	\$5,713 - \$8,128	\$1,319 - \$1,876
Para cada miembro del hogar adicional agregue:	+9,953	+830	+192