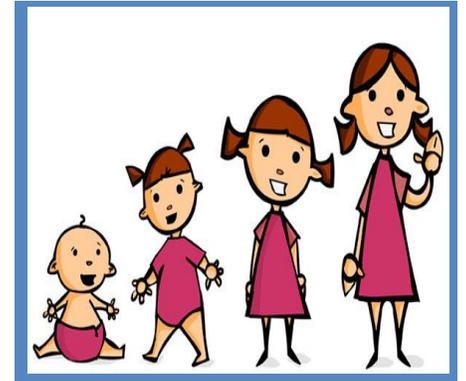




# DETERMINING ELIGIBILITY

## CHILD AND ADULT CARE FOOD PROGRAM (CACFP)



Illinois State Board of Education (ISBE)

*Target Audience: Child Care Centers, Pre-K Programs, Licensed Outside School Hours Programs*



## **Purpose of this training**

Sponsors must have practices in place to ensure eligible children are claimed correctly.



This training will  
cover...

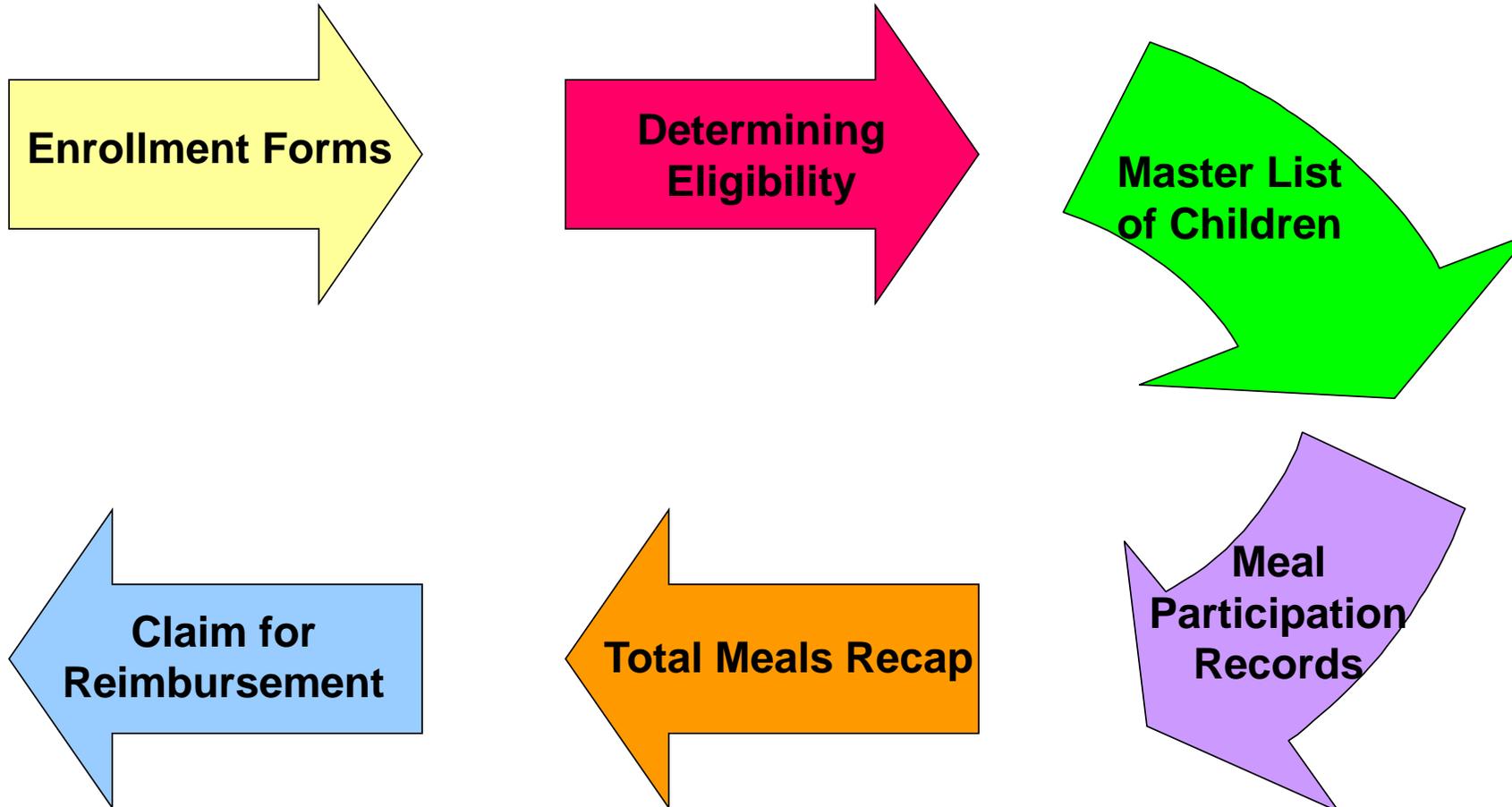


## Eligibility

- ❖ Requirements
- ❖ Parent letter
- ❖ Step-by-step instructions for completion
- ❖ Eligibility types and classifications



## CACFP Monthly Compliance





# Determining Eligibility



ELIGIBLE OR NOT???



## Eligibility Documentation

- **REQUIRED FOR:**

- Child Care Centers
- Pre-K Programs
- Outside School Hours Programs

- **EXEMPT FOR:**

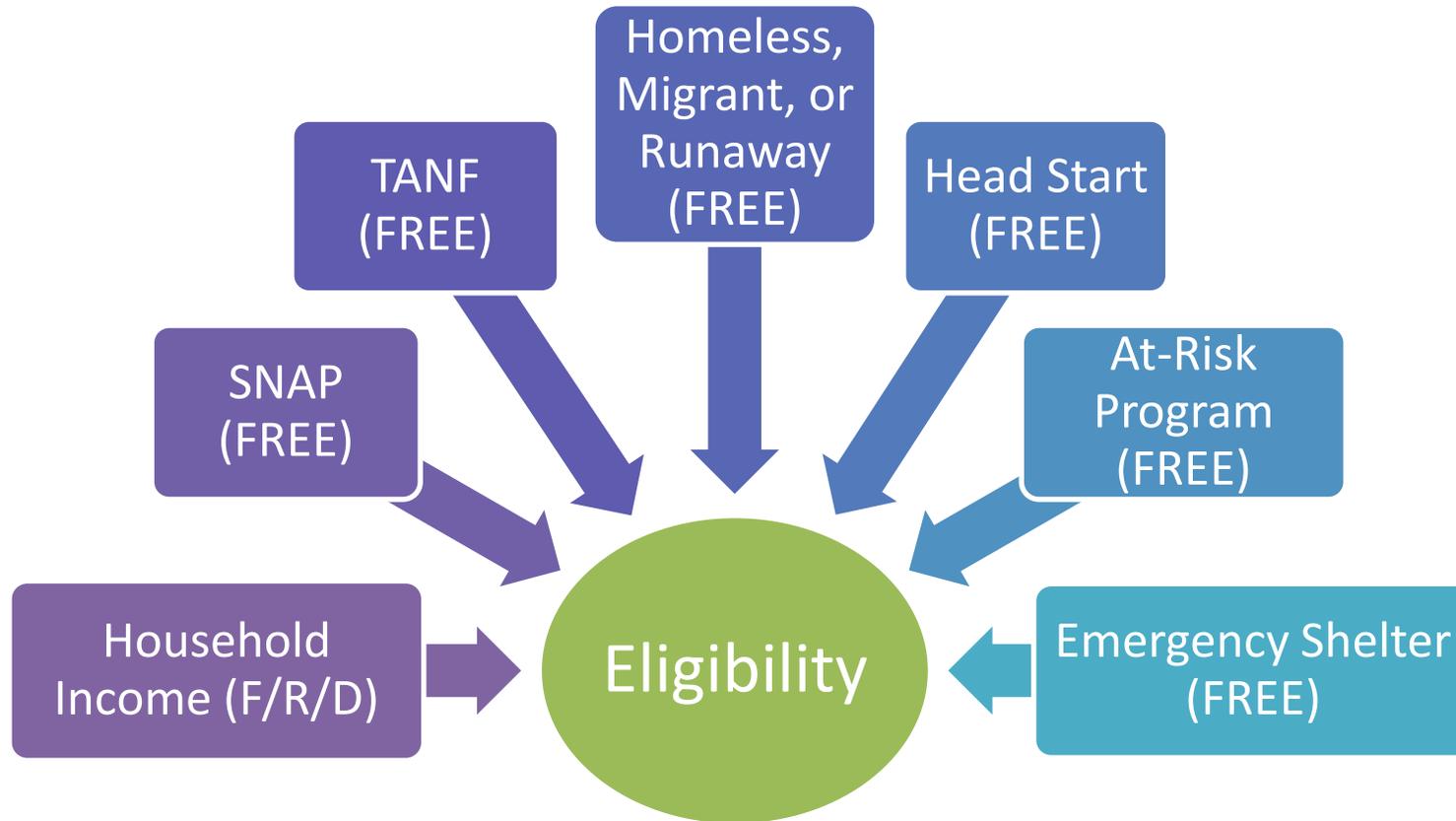
- At-Risk After School Programs
- Head Start and Even Start Programs
- Emergency Shelters





## Determining Eligibility

Eligibility documentation will determine the rate of reimbursement your organization will receive:





## How is Eligibility Determined?

1. Household Income
2. Foster Child(ren)
3. SNAP and TANF
  - Electronic Direct Certification (DC)
  - Extension of DC





# 1) Determining Eligibility: Household Income





## PARENT LETTER FOR CHILD CARE CENTERS July 1, 2019 Through June 30, 2020

Parent or Guardian:

This child care center participates in the USDA Child and Adult Care Food Program (CACFP) and receives Federal funds to provide healthy meals and snacks to all of the enrolled children. The amount of reimbursement the center receives is based on the information you provide on the attached Household Eligibility Application. Part of the USDA requirement is to ask you to complete the application. If your income is equal to or less than the income listed in the chart below for your household size, the center will receive a higher level of reimbursement. Read the attached instructions carefully and fill out all required information. We cannot approve an application that is not complete. Please return the completed application back to our center as soon as possible.

If a member of your family (child or adult) receives Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) benefits; or you care for a foster child that is the legal responsibility of the State through DCFS or the court, these children are eligible for meal benefits regardless of your household income.

If your income(s) is over the income guidelines listed below, you are not required to complete this application; however, it would be helpful if you would write your child's name on the application and return it to our center. Please notify us, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the income eligibility standards.

### Income Eligibility Guidelines Effective from July 1, 2019 to June 30, 2020

#### Reduced-Price Meals 185% Federal Poverty Guideline

Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	23,107	1,926	963	889	445
2	31,284	2,607	1,304	1,204	602
3	39,461	3,289	1,645	1,518	759
4	47,638	3,970	1,985	1,833	917
5	55,815	4,652	2,326	2,147	1,074
6	63,992	5,333	2,667	2,462	1,231
7	72,169	6,015	3,008	2,776	1,388
8	80,346	6,696	3,348	3,091	1,546
For each additional family member, add	8,177	682	341	315	158

The information you provide on the application will be used to determine your child's eligibility for meal benefits. The information will be kept confidential and only available to staff directly connected with administering the CACFP.

By signing the section on the application 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 877/201-0012 (TTY).

If you have any questions or need help, please contact our center.

The USDA Household Income Eligibility Guidelines are listed for families who do not receive TANF or SNAP benefits. If a household's income falls within or below the listed guidelines, they should contact their child care center or day care center provider for the benefits of the program. They may be required to complete an application and provide income, TANF, or SNAP information.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and 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 (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: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), 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 a 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; or (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov). This institution may not discriminate on the basis of race, color, national origin, sex, or disability in its programs and activities. This institution may not discriminate on the basis of race, color, national origin, sex, or disability in its programs and activities. This institution may not discriminate on the basis of race, color, national origin, sex, or disability in its programs and activities.

ISBE 69-49 Parent Letter – Centers (5/19)

Parent  
Letter  
(ISBE 69-49)



## Household Eligibility Application (HEA)

## ISBE Form 69-88

### HOUSEHOLD ELIGIBILITY APPLICATION FOR CHILD CARE CENTERS CHILD AND ADULT CARE FOOD PROGRAM

1. All Household Members		2.	3.
NAMES OF ALL HOUSEHOLD MEMBERS First, Middle Initial, Last	Ages of Children at Center	FOSTER CHILD	
		Foster children are a legal responsibility of DCFS or court. If all are foster children, skip to Section 6.	
		SNAP OR TANF CASE NUMBER Skip to Part 6 if you list a SNAP or TANF case number. At least one SNAP/TANF must be provided below.	
		<input type="checkbox"/>	

**4. Homeless, Migrant, or Runaway**

Homeless  Migrant  Runaway  Head Start

Signature of Homeless Liaison, Migrant Coordinator, or Head Start Director \_\_\_\_\_ Date \_\_\_\_\_

**5. Total Household Gross Income (before deductions) You must tell us how much and how often.**

GROSS INCOME AND HOW OFTEN IT WAS RECEIVED (Example: \$100/month; \$100 twice a month; \$100/every other week; \$100/week)

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT WAS RECEIVED (Example: \$100/month; \$100 twice a month; \$100/every other week; \$100/week)							
	Earnings From Work (Before Deductions)		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp., Unemployment, SSI, etc. (All other income)	
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?
i.	\$		\$		\$		\$	
ii.	\$		\$		\$		\$	
iii.	\$		\$		\$		\$	
iv.	\$		\$		\$		\$	
v.	\$		\$		\$		\$	

**6. Signature and Social Security Number (Adult must sign)**

An adult household member must sign the application. If Section 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.

\_\_\_\_\_ X X X - X X - \_\_\_\_  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 center will get federal funds 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 \_\_\_\_\_

**7. Contact Information (Optional)**

Work Telephone Number (Include Area Code) \_\_\_\_\_ Home Telephone Number (Include Area Code) \_\_\_\_\_ Home Address (Number, Street, City, State, ZIP Code) \_\_\_\_\_

**8. Children's Racial and Ethnic Identities (Optional)**

Mark one ethnic identity:  Hispanic/Latino  Not Hispanic/Latino

Mark one or more racial identities:  Asian  Black or African American  Native Hawaiian or Other Pacific Islander  White  American Indian or Alaska Native

**9. Optional - Sharing Information With All Kids Insurance Program**

May we share your information on this application with the 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 the All Kids Insurance Program.

Date: \_\_\_\_\_ Sign here: \_\_\_\_\_

**CHILD CARE REPRESENTATIVE USE ONLY**  
Eligibility Determination - Complete Sections A and B Below

**SECTION A** Annual Income Conversion Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12 Convert income only if different frequencies of pay are reported.

TOTAL INCOME \$ \_\_\_\_\_ Per:  Week  Every 2 Weeks  Twice a Month  Month  Year NUMBER IN HOUSEHOLD: \_\_\_\_\_

Free based on:  foster child  migrant  SNAP or TANF  runaway  household's income  homeless  Head Start

Reduced based on:  household's income

Denied - Reason:  income too high  incomplete application  Non-qualifying SNAP/TANF

**SECTION B** Signature of Determining Official: \_\_\_\_\_ Date: \_\_\_\_\_

Use your "Mouse" or "Tab" key to move through the fields and check boxes. After completing last field, save document to hard drive to make future updates or click print button.



## Determining Eligibility → Household Income

- Parent/Guardian responsibilities:
  - Section 1: Names of ALL household members
  - Section 5: Names of ALL household members with income
  - Section 6: Last 4 of SSN **or** check “I do not have a SSN” AND signature of the adult household member

<b>1. All Household Members</b>		<b>2.</b>		<b>3.</b>					
<b>NAMES OF ALL HOUSEHOLD MEMBERS</b> First, Middle Initial, Last		Ages of Children at Center	<b>FOSTER CHILD</b> Foster children are a legal responsibility of DCFS or court. If all are foster children, skip to Section 6	<b>SNAP OR TANF CASE NUMBER</b> Skip to Part 6 if you list a SNAP or TANF case number. At least one SNAP/TANF must be provided below.					
			<input type="checkbox"/>						
			<input type="checkbox"/>						
			<input type="checkbox"/>						
			<input type="checkbox"/>						
			<input type="checkbox"/>						
			<input type="checkbox"/>						
<b>4. Homeless, Migrant, or Runaway</b>									
<input type="checkbox"/> Homeless <input type="checkbox"/> Migrant <input type="checkbox"/> Runaway <input type="checkbox"/> Head Start									
<small>Secretary of Homeless, Migrant, Runaway, or Head Start Director</small> _____ <small>Title</small> _____									
<b>5. Total Household Gross Income (before deductions) You must tell us how much and how often.</b>									
<small>GROSS INCOME AND HOW OFTEN IT WAS RECEIVED (Example: \$100/month; \$100 twice a month; \$100 every other week; \$100/week)</small>									
<b>NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)</b>	<b>Earnings From Work (Before Deductions)</b>		<b>Welfare, Child Support, Alimony</b>		<b>Pensions, Retirement, Social Security</b>		<b>Worker's Comp., Unemployment, SSI, etc. (All other income)</b>		
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?	
i.	\$		\$		\$		\$		
ii.	\$		\$		\$		\$		
iii.	\$		\$		\$		\$		
iv.	\$		\$		\$		\$		
v.	\$		\$		\$		\$		
<b>6. Signature and Social Security Number (Adult must sign)</b>									
<small>An adult household member must sign the application. If Section 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.</small>									
				X X X - X X			<input type="checkbox"/> I do not have a Social Security Number.		
				<small>Social Security Number</small>					
<small>I certify all information on this application is true and all income is reported. I understand the center will get federal funds 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.</small>									
Date		Printed Name of Adult Household Member			Signature of Adult Household Member				



## Determining Eligibility → Household Income

### Sponsor Responsibilities:

- Complete Section A
  - Total Income & how often
  - Number in household
  - Designation of category and indicate how determined
- Complete Section B
  - Signature of Determining Official
  - Date when application was approved

CHILD CARE REPRESENTATIVE USE ONLY	
Eligibility Determination - Complete Sections A and B Below	
<b>SECTION A</b>	Annual Income Conversion: Weekly X 52, Every 2 Weeks X 26, Twice a Month X 24, Once a Month X 12. <small>Convert income only if different frequency of payment</small>
TOTAL INCOME \$ _____ Per: <input type="checkbox"/> Week <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Month <input type="checkbox"/> Year	NUMBER IN HOUSEHOLD: _____
<input type="checkbox"/> Free based on: <input type="checkbox"/> foster child <input type="checkbox"/> SNAP or TANF <input type="checkbox"/> homeless	<input type="checkbox"/> Reduced based on: <input type="checkbox"/> household's income
<input type="checkbox"/> migrant <input type="checkbox"/> runaway <input type="checkbox"/> household's income <input type="checkbox"/> Head Start	<input type="checkbox"/> Denied — Reason: <input type="checkbox"/> income too high <input type="checkbox"/> incomplete application <input type="checkbox"/> Non-qualifying SNAP/TANF
<b>SECTION B</b>	Signature of Determining Official: _____ Date: _____



## Income Conversion

### When income is reported on a Household Eligibility Application (HEA):

- If only one income is reported OR all income is at the same frequency (weekly, every 2 weeks, etc.) **DO NOT CONVERT.** Add the income amounts and compare to the Income Eligibility Guidelines Chart.
- If different income frequencies, **all income must be annualized.** Do not round converted income.
- Conversion figures:
  - Weekly X 52
  - Every 2 weeks X 26
  - Twice per month X 24
  - Monthly X 12





## Determining Eligibility for Household Income → Use this Income Eligibility Guidelines Chart

### FISCAL YEAR 2021 INCOME ELIGIBILITY GUIDELINES

The United States Department of Agriculture has issued the following income guidelines for the period July 1, 2020, through June 30, 2021:

This chart is updated and posted on the CACFP Website annually on July 1st

Income Eligibility Guidelines											
Household Size	Free Meals 130% Federal Poverty Guideline					Household Size	Reduced-Price Meals 185% Federal Poverty Guideline				
	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly		Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	16,588	1,383	692	638	319	1	23,606	1,968	984	908	454
2	22,412	1,868	934	862	431	2	31,894	2,658	1,329	1,227	614
3	28,236	2,353	1,177	1,086	543	3	40,182	3,349	1,675	1,546	773
4	34,060	2,839	1,420	1,310	655	4	48,470	4,040	2,020	1,865	933
5	39,884	3,324	1,662	1,534	767	5	56,758	4,730	2,365	2,183	1,092
6	45,708	3,809	1,905	1,758	879	6	65,046	5,421	2,711	2,502	1,251
7	51,532	4,295	2,148	1,982	991	7	73,334	6,112	3,056	2,821	1,411
8	57,356	4,780	2,390	2,206	1,103	8	81,622	6,802	3,401	3,140	1,570
For each additional family member, add	5,824	486	243	224	112	For each additional family member, add	8,288	691	346	319	160

**Example 1: Household of 4 with income of \$1,390 Twice Per Month**  
- Eligible for FREE because their total income is less than \$1,420

**Example 2: Household of 2 with income of \$600 Weekly**  
- Eligible for REDUCED because their total income is between \$432 - \$614



**Let's practice by  
looking at some  
Household  
Eligibility  
Applications  
(HEA)**





## APPLICATION 1

### 1. Is this application complete?



### 2. What is the eligibility of this HEA?

**HOUSEHOLD ELIGIBILITY APPLICATION FOR CHILD CARE CENTERS  
CHILD AND ADULT CARE FOOD PROGRAM**

1. All Household Members		2.		3.	
NAMES OF ALL HOUSEHOLD MEMBERS <small>First, Middle Initial, Last</small>	Ages of Children at Center	FOSTER CHILD <small>Foster children are a legal responsibility of DCFS or court. If all are foster children, skip to Section 6</small>		SNAP OR TANF CASE NUMBER <small>Skip to Part 6 if you file a SNAP or TANF case number. At least one SNAP/TANF must be provided below.</small>	
Donald Duck		<input type="checkbox"/>			
Daisy Duck		<input type="checkbox"/>			
Huey Duck	6	<input type="checkbox"/>			
Dewey Duck	4	<input type="checkbox"/>			
Louie Duck	2	<input type="checkbox"/>			
		<input type="checkbox"/>			

4. Homeless, Migrant, or Runaway  
 Homeless    Migrant    Runaway    Head Start  
 Signature of Homeless Liaison, Migrant Coordinator, or Head Start Director \_\_\_\_\_ Date \_\_\_\_\_

5. Total Household Gross Income (before deductions) You must tell us how much and how often.

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT WAS RECEIVED (Example: \$100/month; \$100 twice a month; \$100 every other week; \$100/week)							
	Earnings From Work (Before Deductions)		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp., Unemployment, SSI, etc. (All other income)	
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?
i. Donald	\$ 600	2 weeks	\$		\$		\$	
ii. Daisy	\$ 400	2 weeks	\$		\$		\$	
iii.	\$		\$		\$		\$	
iv.	\$		\$		\$		\$	
v.	\$		\$		\$		\$	

6. Signature and Social Security Number (Adult must sign)  
 An adult household member must sign the application. If Section 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.  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 center will get federal funds 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.

7/12/20xx \_\_\_\_\_       D Duck        
 Date Printed Name of Adult Household Member Signature of Adult Household Member



**Step 1:**  
How many are in the household?

**5**

**Step 2:**  
What is their total income & frequency?

**\$1,000**

**Every 2 weeks**  
(600 + 400)

CHILD CARE A

1. All Household Members		2.	
NAMES OF ALL HOUSEHOLD MEMBERS First, Middle Initial, Last		Ages of Children at Center	Foster or DCFS a
Donald Duck			
Daisy Duck			
Huey Duck		6	
Dewey Duck		4	
Louie Duck		2	

4. Homeless, Migrant, or Runaway  
 Homeless  Migrant  Runaway  Head Start

5. Total Household Gross Income (before deductions) You must list

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT IS	
	Earnings from Work (Before Deductions)	
	Amount	How often?
1. Donald	\$ 600	2 weeks
2. Daisy	\$ 400	2 weeks

**Step 3:** Grab your Income Eligibility Guidelines Chart  
Look at the Household Size and Income Frequency.

Income Eligibility Guidelines  
Effective from July 1, 2020, to June 30, 2021

Household Size	Free Meals 130% Federal Poverty Guideline					Household Size	Reduced-Price Meals 185% Federal Poverty Guideline				
	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly		Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	16,588	1,383	692	338	319	1	23,606	1,968	984	908	454
2	22,412	1,868	934	462	431	2	31,894	2,658	1,329	1,227	614
3	28,236	2,353	1,177	586	543	3	40,182	3,349	1,675	1,546	773
4	34,060	2,839	1,420	710	655	4	48,470	4,040	2,020	1,865	933
5	39,884	3,324	1,663	834	767	5	56,758	4,730	2,365	2,183	1,092
6	45,708	3,809	1,905	958	879	6	65,046	5,421	2,711	2,502	1,251
7	51,532	4,295	2,148	1,082	991	7	73,334	6,112	3,056	2,821	1,411
8	57,356	4,780	2,390	1,206	1,103	8	81,622	6,802	3,401	3,140	1,570
For each additional family member, add	5,824	486	243	224	112	For each additional family member, add	8,288	691	346	319	160

**ANSWER →**

CHILD CARE REPRESENTATIVE USE ONLY  
Eligibility Determination - Complete Sections A and B Below

SECTION A Annual Income Conversion Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12 Convert income only if different frequencies of pay are reported

TOTAL INCOME \$ 1000 Per:  Week  Every 2 Weeks  Twice a Month  Month  Year NUMBER IN HOUSEHOLD: 5

Free based on:  
 foster child  migrant  
 SNAP or TANF  runaway  
 homeless  household's income  Head Start

Reduced based on:  
 household's income

Denied — Reason:  
 income too high  
 incomplete application  
 Non-qualifying SNAP/TANF

SECTION B Signature of Determining Official: K Nesler Date: 7/13/20xx



## APPLICATION 2

### 1. Is this application complete?



### 2. What is the eligibility of this HEA?

**HOUSEHOLD ELIGIBILITY APPLICATION FOR CHILD CARE CENTERS  
CHILD AND ADULT CARE FOOD PROGRAM**

1. All Household Members		2.		3.	
NAMES OF ALL HOUSEHOLD MEMBERS <small>First, Middle Initial, Last</small>	Ages of Children at Center	FOSTER CHILD <small>Foster children are a legal responsibility of DCFS or court. If all are foster children, skip to Section 6</small>		SNAP OR TANF CASE NUMBER <small>Skip to Part 6 if you list a SNAP or TANF case number. At least one SNAP/TANF must be provided below.</small>	
John Smith		<input type="checkbox"/>			
Mary Smith		<input type="checkbox"/>			
Suzy Smith	3	<input type="checkbox"/>			
		<input type="checkbox"/>			
		<input type="checkbox"/>			
		<input type="checkbox"/>			

**4. Homeless, Migrant, or Runaway**

Homeless    Migrant    Runaway    Head Start

\_\_\_\_\_  
Signature of Homeless Liaison, Migrant Coordinator, or Head Start Director

\_\_\_\_\_  
Date

**5. Total Household Gross Income (before deductions) You must tell us how much and how often.**

NAMES <small>(LIST ALL HOUSEHOLD MEMBERS WITH INCOME)</small>	GROSS INCOME AND HOW OFTEN IT WAS RECEIVED (Example: \$100/month; \$100 twice a month; \$100 every other week; \$100/week)							
	Earnings From Work (Before Deductions)		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp., Unemployment, SSI, etc. (All other income)	
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?
i. John Smith	\$ 450	week	\$		\$		\$	
ii. Mary Smith	\$ 1000	month	\$		\$		\$	
iii.	\$		\$		\$		\$	
iv.	\$		\$		\$		\$	
v.	\$		\$		\$		\$	

**6. Signature and Social Security Number (Adult must sign)**

An adult household member must sign the application, if Section 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.

X X X - X X - 0 1 0 1    I do not have a Social Security Number.

Social Security Number

*I certify all information on this application is true and all income is reported. I understand the State Board of Education, or Office of Inspector General, may verify this information on the applicable state and federal laws.*

7/5/20xx   John Smith   John Smith

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



**Step 1:**  
How many are in the household?  
**3**

**Step 2:**  
What is their total income & frequency?

**\$35,400 Annually**

$\$450 \times 52 = \$23,400$

$\$1,000 \times 12 = \$12,000$

<b>1. All Household Members</b>		<b>2.</b>
NAMES OF ALL HOUSEHOLD MEMBERS First, Middle Initial, Last		Ages of Children at Center Foster Child DCFS or
John Smith		
Mary Smith		
Suzy Smith	3	
<b>4. Homeless, Migrant, or Runaway</b>		
<input type="checkbox"/> Homeless <input type="checkbox"/> Migrant <input type="checkbox"/> Runaway <input type="checkbox"/> Head Start		
<b>5. Total Household Gross Income (before deductions) You must t</b>		
NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT W	
	Earnings From Work (Before Deductions)	
	Amount	How often?
i. John Smith	\$ 450	week
ii. Mary Smith	\$ 1000	month

**Step 3:** Grab your Income Eligibility Guidelines Chart  
Look at the Household Size and Income Frequency.

Income Eligibility Guidelines Effective from July 1, 2020, to June 30, 2021											
Household Size	Free Meals 130% Federal Poverty Guideline					Household Size	Reduced-Price Meals 185% Federal Poverty Guideline				
	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly		Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	1,588	1,383	692	638	319	1	2,306	1,968	984	908	454
2	2,412	1,868	934	862	431	2	3,494	2,658	1,329	1,227	614
<b>3</b>	<b>3,418</b>	2,353	1,177	1,086	543	<b>3</b>	<b>40,182</b>	3,349	1,675	1,546	773
4	34,500	2,839	1,420	1,310	655	4	48,470	4,040	2,020	1,865	933
5	39,884	3,324	1,662	1,534	767	5	56,758	4,730	2,365	2,183	1,092
6	45,708	3,809	1,905	1,758	879	6	65,046	5,421	2,711	2,502	1,251
7	51,532	4,295	2,148	1,982	991	7	73,334	6,112	3,056	2,821	1,411
8	57,356	4,780	2,390	2,206	1,103	8	81,622	6,802	3,401	3,140	1,570
For each additional family member, add	5,824	486	243	224	112	For each additional family member, add	8,288	691	346	319	160

**ANSWER →**

<b>SECTION A</b>	Annual Income Conversion: Weekly X 52   Every 2 Weeks X 26   Twice a Month X 24   Once a Month X 12	Convert: indicate only if different frequencies of pay are reported.
TOTAL INCOME \$	35,400	Per: <input type="checkbox"/> Week <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Month <input checked="" type="checkbox"/> Year
<input type="checkbox"/> Free based on: <ul style="list-style-type: none"> <li><input type="checkbox"/> foster child</li> <li><input type="checkbox"/> SNAP or TANF</li> <li><input type="checkbox"/> homeless</li> <li><input type="checkbox"/> migrant</li> <li><input type="checkbox"/> runaway</li> <li><input type="checkbox"/> household's income</li> <li><input type="checkbox"/> Head Start</li> </ul>		<input checked="" type="checkbox"/> Reduced based on: <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> household's income</li> </ul>
<input type="checkbox"/> Denied -- Reason: <ul style="list-style-type: none"> <li><input type="checkbox"/> income too high</li> <li><input type="checkbox"/> incomplete application</li> <li><input type="checkbox"/> non-qualifying SNAP/TANF</li> </ul>		NUMBER IN HOUSEHOLD: <b>3</b> $450 \times 52 = 23,400$ $1000 \times 12 = 12,000$
<b>SECTION B</b>	Signature of Determining Official: <i>K. Wodak</i>	Date: <b>7/5/2022</b>



## APPLICATION 3

### 1. Is this application complete?



### 2. What is the eligibility of this HEA?

**HOUSEHOLD ELIGIBILITY APPLICATION FOR CHILD CARE CENTERS  
CHILD AND ADULT CARE FOOD PROGRAM**

1. All Household Members		2.	3.	
NAMES OF ALL HOUSEHOLD MEMBERS <small>First, Middle Initial, Last</small>	Ages of Children at Center	FOSTER CHILD <small>Foster children are a legal responsibility of DCFS or court. If all are foster children, skip to Section 5.</small>	SNAP OR TANF CASE NUMBER <small>Skip to Part 6 if you list a SNAP or TANF case number. At least one SNAP/TANF must be provided below.</small>	
Jim Johnson		<input type="checkbox"/>		
Billy Johnson	1	<input type="checkbox"/>		
		<input type="checkbox"/>		

**4. Homeless, Migrant, or Runaway**

Homeless    Migrant    Runaway    Head Start

Signature of Homeless Liaison, Migrant Coordinator, or Head Start Director \_\_\_\_\_ Date \_\_\_\_\_

**5. Total Household Gross Income (before deductions) You must tell us how much and how often.**

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT WAS RECEIVED (Example: \$100/month, \$100 twice a month, \$100 every other week, \$100/week)							
	Earnings From Work (Before Deductions)		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp., Unemployment, SSI, etc. (All other income)	
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?
i. Jim Johnson	\$ 934	2/month	\$		\$		\$	
ii.	\$		\$		\$		\$	
iii.	\$		\$		\$		\$	
iv.	\$		\$		\$		\$	
v.	\$		\$		\$		\$	

**6. Signature and Social Security Number (Adult must sign)**

An adult household member must sign the application. If Section 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.

X X X - X X - 2 2 2 1    I do not have a Social Security Number.  
Social Security Number

I certify all information on this application is true and all income is reported. I understand the center will get federal funds 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.

7/20/20xx   Jim Johnson  
Date   Printed Name of Adult Household Member   Signature of Adult Household Member

**7. Contact Information (Optional)**



**Step 1:**  
How many are in the household?

**2**

**Step 2:**  
What is their total income & frequency?

**\$934**

**Twice per month**

**1. All Household Members**

NAMES OF ALL HOUSEHOLD MEMBERS First, Middle Initial, Last	Age of Child at Center	Foster or DPS or
Jim Johnson		
Billy Johnson	1	

**4. Homeless, Migrant, or Runaway**  
 Homeless  Migrant  Runaway  Head Start

**5. Total Household Gross Income (before deductions) You must be**

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT PAID	
	Amount	How often?
Jim Johnson	\$ 934	2/month

**Step 3:** Grab your Income Eligibility Guidelines Chart  
Look at the Household Size and Income Frequency.

**Income Eligibility Guidelines**  
Effective from July 1, 2020, to June 30, 2021

Household Size	Free Meals 130% Federal Poverty Guideline					Household Size	Reduced-Price Meals 185% Federal Poverty Guideline				
	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly		Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	16,588	1,383	692	638	319	1	23,606	1,968	984	908	454
2			934	862	431	2	31,894	2,658	1,329	1,227	614
3	28,236	2,353	1,177	1,086	543	3	40,182	3,349	1,675	1,546	773
4	34,060	2,839	1,420	1,310	655	4	48,470	4,040	2,020	1,865	933
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8	57,356	4,780	2,390	2,206	1,103	8	81,622	6,802	3,401	3,140	1,570
For each additional family member, add	5,824	486	243	224	112	For each additional family member, add	8,288	691	346	319	160

**ANSWER →**

**Eligibility Determination - Complete Sections A and B Below**

**SECTION A Annual Income Conversion** Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12 Convert income only if different frequencies of pay are reported.

TOTAL INCOME \$ **934** Per:  Week  Every 2 Weeks  Twice a Month  Month  Year **NUMBER IN HOUSEHOLD: 2**

Free based on:  
 foster child  migrant  SNAP or TANF  runaway  household's income  Head Start  homeless

Reduced based on:  
 household's income

Denied — Reason:  
 income too high  incomplete application  Non-qualifying SNAP/TANF

**SECTION B** Signature of Determining Official: **K. Nodler** Date: **7/21/20xx**



## Incomplete Applications

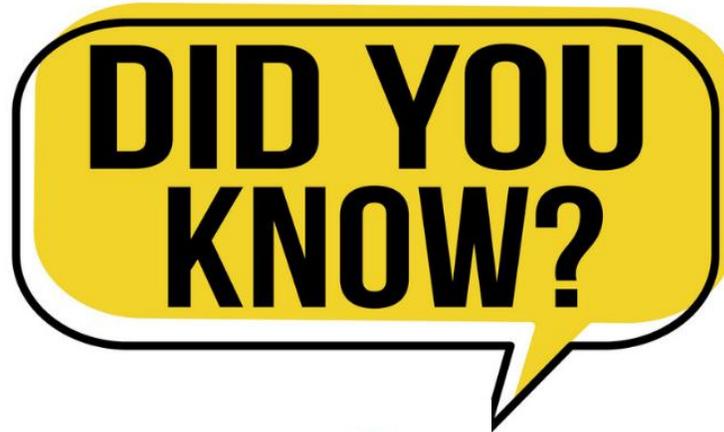
- The determining official cannot process an incomplete HEA.
  - Return the HEA to the household to obtain missing information.
    - If adult member signature is missing, HEA must be returned to obtain a signature.
    - Faxed/Scanned HEA may be acceptable.
  - Contact household and note missing information on the HEA.
  - All changes should be initialed and dated.
    - ISBE recommends using a different color ink to document.
  - An incomplete application is **PAID** until corrected.





It is **NOT** required for a household to complete a HEA.

No HEA = PAID



It is **REQUIRED** for a household to complete an Enrollment Form.

No Enrollment Form = No meals claimed



## 2) Determining Eligibility: Foster child





## Household Eligibility Application (HEA)- FOSTER CHILD

- A foster child is a child whose care and placement is the responsibility of the State, or who is formally placed by a court with a caretaker household through which the State retains legal custody of the child.
- A foster child is categorically eligible for **FREE MEALS** and may be included as a member of the foster family if the foster family chooses to also apply for benefits for other children.
  - Including children in foster care as household members may help other children in the household qualify for benefits.
- If non-foster children are not eligible for free or reduced priced meal benefits, an eligible foster child will still receive free benefits.



## Determining Eligibility – Foster Child

- **Parent/Guardian responsibilities:**
  - Section 1: Names of ALL household members
  - Section 2: Check box if Foster Child
  - Section 5 (*depends*): If non-foster children attend the facility, must complete household income
  - Section 6: Signature
    - If non-foster children attend the facility, must have either Last 4 of SSN **or** check “I do not have a SSN”

**1. All Household Members**

**NAMES OF ALL HOUSEHOLD MEMBERS**  
First, Middle Initial, Last

Ages of Children at Center

**2. FOSTER CHILD**  
Foster children are a legal responsibility of DCFS or court. If all are foster children, skip to Section 6

**3. SNAP OR TANF CASE NUMBER** Skip to Part 6 if you list a SNAP or TANF case number. At least one SNAP/TANF must be provided below.

**4. Homeless, Migrant, or Runaway**

Homeless  Migrant  Runaway  Head Start

**5. Total Household Gross Income (before deductions) You must tell us how much and how often.**

GROSS INCOME AND HOW OFTEN IT WAS RECEIVED (Example: \$100/month; \$100 twice a month; \$100/every other week; \$100/week)

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	Earnings From Work (Before Deductions)		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp., Unemployment, SSI, etc. (All other income)	
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?
i.	\$		\$		\$		\$	
ii.	\$		\$		\$		\$	
iii.	\$		\$		\$		\$	
iv.	\$		\$		\$		\$	
v.	\$		\$		\$		\$	

**6. Signature and Social Security Number (Adult must sign)**

An adult household member must sign the application. If Section 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.

X 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 center will get federal funds 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 \_\_\_\_\_



## Determining Eligibility – Foster Child

### Sponsor Responsibilities:

- Complete Section A
  - **Foster Only**: Check box for free and foster child
  - **Non-Foster children**: determine eligibility based on income & HH size & document eligibility (F, R, D)
- Complete Section B
  - Signature of Determining Official
  - Date when application was approved

**CHILD CARE REPRESENTATIVE USE ONLY**  
Eligibility Determination - Complete Sections A and B Below

<b>SECTION A</b>	Annual Income Conversion	Weekly X 52	Every 2 Weeks X 26	Twice a Month X 24	Once a Month X 12	Convert income only if different frequencies of pay are reported.	
TOTAL INCOME \$	Per:	<input type="checkbox"/> Week	<input type="checkbox"/> Every 2 Weeks	<input type="checkbox"/> Twice a Month	<input type="checkbox"/> Month	<input type="checkbox"/> Year	NUMBER IN HOUSEHOLD: _____
<input type="checkbox"/> <b>Free based on:</b> <input type="checkbox"/> foster child <input type="checkbox"/> SNAP or TANF <input type="checkbox"/> homeless		<input type="checkbox"/> <b>Reduced based on:</b> <input type="checkbox"/> household's income <input type="checkbox"/> migrant <input type="checkbox"/> runaway <input type="checkbox"/> household's income <input type="checkbox"/> Head Start		<input type="checkbox"/> <b>Denied — Reason:</b> <input type="checkbox"/> income too high <input type="checkbox"/> incomplete application <input type="checkbox"/> Non-qualifying SNAP/TANF			
<b>SECTION B</b>							
Signature of Determining Official: _____						Date: _____	



## Determining Eligibility

### Foster Child-Categorically Eligible Using Other Documentation

- A foster child may be certified categorically eligible for free meals if you receive one of these documents:
  - DCFS or local agency papers indicating the status of the child as a foster child whose care and placement is the responsibility of the State
- OR**
- Official court documents stating that the foster child has been placed within a caretaker household



### 3) Determining Eligibility: SNAP/TANF Benefits





## Determining Eligibility – SNAP/TANF Benefits

- Parent/Guardian responsibilities:
  - **Section 1:** Names of ALL household members
  - **Section 3:** 9 digit SNAP or TANF number of a household member of the household
    - HEAs cannot be accepted with Medicaid numbers. Persons receiving Medicaid benefits only that are NOT directly certified for meal benefits- must complete an income application.
  - **Section 6:** Signature

1. All Household Members		2. FOSTER CHILD		3. SNAP OR TANF CASE NUMBER	
NAMES OF ALL HOUSEHOLD MEMBERS First, Middle Initial, Last		Ages of Children at Center	FOSTER CHILD Foster children are a legal responsibility of DCFS or court. If all are foster children, skip to Section 6	SNAP OR TANF CASE NUMBER Skip to Part 6 if you list a SNAP or TANF case number. At least one SNAP/TANF must be provided below.	
			<input type="checkbox"/>		
			<input type="checkbox"/>		
			<input type="checkbox"/>		
			<input type="checkbox"/>		
			<input type="checkbox"/>		
			<input type="checkbox"/>		

4. Homeless, Migrant, or Runaway  
 Homeless  Migrant  Runaway  Head Start  
 Signature of Homeless Liaison, Migrant Coordinator, or Head Start Director \_\_\_\_\_ Date \_\_\_\_\_

5. Total Household Gross Income (before deductions) You must tell us how much and how often.

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT WAS RECEIVED (Example: \$100/month; \$100 twice a month; \$100 every other week; \$100/week)							
	Earnings From Work (Before Deductions)		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp., Unemployment SSI, etc. (All other income)	
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?
i.	\$		\$		\$		\$	
ii.	\$		\$		\$		\$	
iii.	\$		\$		\$		\$	
iv.	\$		\$		\$		\$	
v.	\$		\$		\$		\$	

6. Signature and Social Security Number (Adult must sign)  
 An adult household member must sign the application. If Section 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.  
 X X X X - X X -       I do not have a Social Security Number.  
 Social Security Number

I certify all information on this application is true and all income is reported. I understand the center will get federal funds 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



# Determining Eligibility – SNAP/TANF Benefits

## Sponsor Responsibilities:

- Complete Section A
  - Check box for free
  - Check box for SNAP/TANF
  
- Complete Section B
  - Signature of Determining Official
  - Date when application was approved

CHILD CARE REPRESENTATIVE USE ONLY			
Eligibility Determination - Complete Sections A and B Below			
<b>SECTION A</b>	Annual Income Conversion	Weekly X 52    Every 2 Weeks X 26    Twice a Month X 24    Once a Month X 12	<i>Convert income only if different frequencies of pay are reported.</i>
TOTAL INCOME \$	Per:	<input type="checkbox"/> Week <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Month <input type="checkbox"/> Year	NUMBER IN HOUSEHOLD: <input type="text"/>
<input type="checkbox"/> Free based on:	<input type="checkbox"/> migrant	<input type="checkbox"/> Reduced based on:	<input type="checkbox"/> Denied — Reason:
<input type="checkbox"/> foster child	<input type="checkbox"/> household's income	<input type="checkbox"/> household's income	<input type="checkbox"/> income too high
<input type="checkbox"/> SNAP or TANF	<input type="checkbox"/> household's income	<input type="checkbox"/> Head Start	<input type="checkbox"/> incomplete application
<input type="checkbox"/> homeless			<input type="checkbox"/> Non-qualifying SNAP/TANF
<b>SECTION B</b>	Signature of Determining Official: _____		Date: _____



## Determining Eligibility by Electronic Direct Certification



## Benefits of Electronic Direct Certification

- Sponsors can search children who may receive SNAP, TANF, Income-Eligible Medicaid or Foster to determine **FREE** eligibility
- One less form for the household to fill out. If there is a match, no HEA is needed
- Reduces the risk for human error
- Benefits can be extended from a child listed on the DC report to other children living in the same household
  - **EXCEPTION** → Foster children benefits cannot be extended to non-foster living in the household



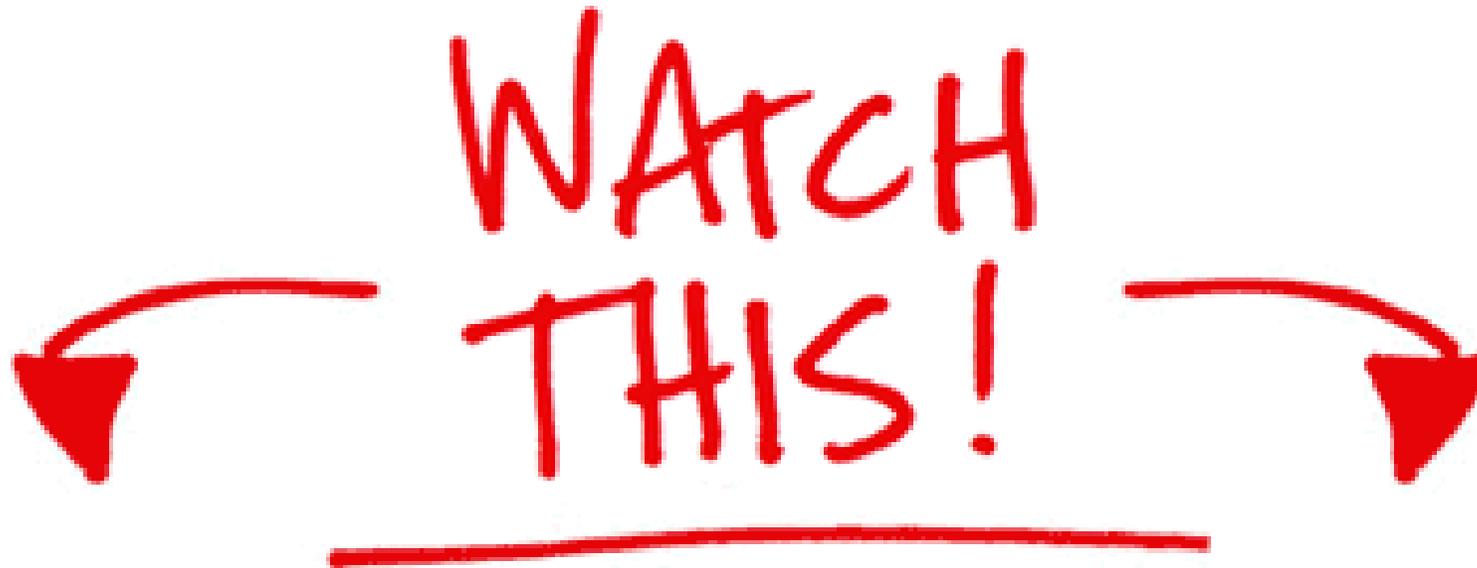


## More about Electronic Direct Certification

- Key information:
  - Do NOT use the Direct Certification process to verify SNAP or TANF numbers submitted on an HEA.
  - Must keep information confidential!!
  - May only be used to identify children for free meal benefits.
  - For the children identified through the Electronic Direct Certification System, make sure to print the report:
    - DC report identifies SNAP, TANF, Income-Eligible Medicaid and Foster
    - **Good for 12 months only!!**
  - Distribute HEA to children who were NOT identified free through the Direct Certification process.



**To learn more....**



**“How to do Electronic Direct Certification in WINS”**

**Webinar**



## CATEGORICAL ELIGIBLE

Children automatically eligible for free meals based on the following criteria:

- A child who is a member of a household that receives benefits from Assistance Programs (SNAP and TANF) listed on the HEA
- All children listed on the DC Report
- A child is documented as:
  - Homeless, runaway, or migrant
  - A foster child
  - Enrolled in a federally-funded Head Start or Even Start program





## Other unique scenarios you may be faced



- Child Living with One Parent, Other Relative(s), or Friends
- Joint Custody
- Any other unique scenarios – contact ISBE



- Pick a month for your annual paperwork renewal (Enrollment Forms and Household Eligibility Application)
- Look up your enrolled children in the Electronic Direct Certification system. If they are on the DC Report, give the household the following:
  - Enrollment Form (ISBE 67-98)
- The children who are NOT on the DC Report, give the household the following:
  - Parent Letter (ISBE form 69-49)
  - Household Eligibility Application (ISBE form 69-88)
  - Enrollment Form (ISBE 67-98)
- Maintain paperwork in an organized binder by section
  - Direct Certification (DC) Reports
  - Household Eligibility Applications by Free, Reduced and Paid/Denied
  - Enrollment Forms



## Recordkeeping

- All forms must be kept for 3 years plus the current year.
- If audit findings have not been resolved, the forms must be kept as long as necessary to resolve the issues raised by the audit.





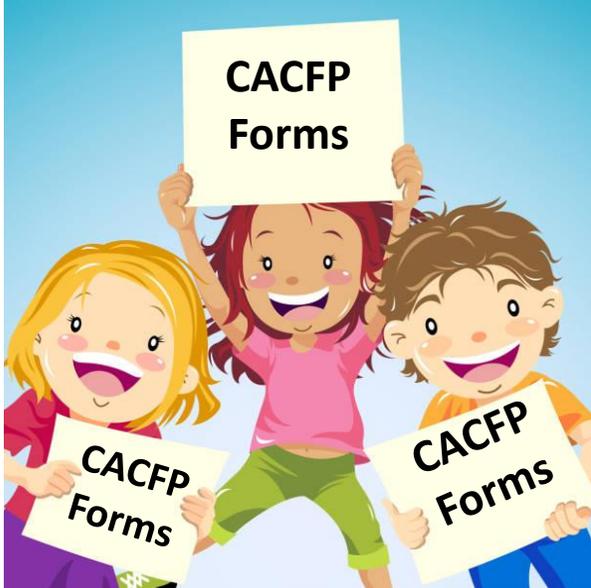
## Common errors found with Eligibility during an ISBE audit

- HEA is missing information
- Outdated forms
- Approved incorrectly
- Meal classifications are based on old income guidelines
- Not using the correct income conversions
- Total number in household is incorrect
- Sponsor has not completed the bottom section





## Where to find the forms and documents you need to stay current each year



Home > Nutrition > Child and Adult Care Food Program > Child and Adult Care Food Program (CACFP) Forms and Documents

NUTRITION  
Child and Adult Care Food Program  
Child and Adult Care Food Program (CACFP) Forms and Documents

### NUTRITION CHILD AND ADULT CARE FOOD PROGRAM (CACFP) FORMS AND DOCUMENTS

[CACFP ADMINISTRATIVE HANDBOOK](#)

#### Enrollment and Household Eligibility Information

- Enrollment and Eligibility Instructions
- Enrollment Form
- Household Eligibility Application
- Parent Letter
- Electronic Direct Certification Guidance
- Income Eligibility Guidelines
- USDA Eligibility Manual

#### Recordkeeping

- Master List
- Master List for Emergency Shelters
- Master List for Head Start and Even Start



## **Don't Forget....**

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**Every July 1<sup>st</sup> the following forms are updated annually:**

- Parent Letter
- Household Eligibility Application
- Income Eligibility Guidelines





## SUMMARY



1. Enrollment forms are required  
(Child Care Centers, Head Start/Even Start Programs, Pre-K Programs and Licensed Outside School Hours Programs)
2. Eligibility
  - Free → HEA, DC Report, Extension of Benefits, Foster Child Documentation, Master List for Head Start/Even Start and Master List for Emergency Shelter
  - Reduced → HEA
  - Paid/Denied → No HEA required. Must have an enrollment form on file in order to claim
3. Electronic Direct Certification
4. Double check forms for completeness
5. Sponsor needs to sign and date forms
6. Create/maintain master list as needed



## **Nutrition Department**

**Illinois State Board of Education**

**[www.isbe.net/nutrition](http://www.isbe.net/nutrition)**

**[cnp@isbe.net](mailto:cnp@isbe.net)**

**800-545-7892**

thank  
you!