4C: Community Coordinated Child Care
155 North Third Street, Suite 300
DeKalb, Illinois 60115
(815) 758-8149 or (800) 848-8727
Fax: (815) 758-5652
www.four-c.org

HOUSEHOLD ELIGIBILITY APPLICATION
FOR PROVIDERS APPLYING FOR TIER I STATUS BY INCOME OR
FOR CLAIMING MEALS FOR CHILDREN RESIDING WITH THE PROVIDER

Dear Day Care Home Provider:

As a participant in the Child and Adult Care Food Program (CACFP), you have been determined as a Tier II day care home. This indicates your day care home is not eligible for the Tier I reimbursement by school or census. You may change your Tier II status to a Tier I status if your household income meets or falls below the Household Eligibility Guidelines – or if a member of your household is eligible to receive Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) benefits. If you have children (under the age of 13 and living in your home), completing an approved application will allow you to claim those children's meals while other children are in attendance. The information you provide on the application will be used to determine your eligibility for meal benefits. The information will be confidential and available to staff in our office directly connected to administering the CACFP. Please contact me at 815-758-8149, ext. 234 or suew@four-c.org with any questions.

Please note that by signing Number 4 on the enclosed HEA for the Illinois *All Kids* Health Insurance, you're 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 877-204-1012 (TTY).

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

Reduced-Price Meals
185% Federal Poverty Guideline

Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	23,606	1,968	984	908	454
2	31,894	2,658	1,329	1,227	614
3	40,182	3,349	1,675	1,546	773
4	48,470	4,040	2,020	1,865	933
5	56,758	4,730	2,365	2,183	1,092
6	65,046	5,421	2,711	2,502	1,251
7	73,334	6,112	3,056	2,821	1,411
8	81,622	6,802	3,401	3,140	1,570
For each additional family member, add	8,288	691	346	319	160

If you have any questions or need help, please contact me at 815-758-8149 x 234.

Sincerely,

Sue Worley

Sue Worley, CACFP Director

Celebrating over 35 Years of Service to Children and Families

CHILD AND ADULT CARE FOOD PROGRAM – HOUSEHOLD ELIGIBILITY APPLICATION FOR DAY CARE HOME PROVIDER

1 LIST EVERYONE IN PROVIDER'S HOUSEHOLD (Children and Adults)

NAME (First, Middle and Last)	Check If No Income	Date of Birth	Ages of Providers Children	**2** FOSTER CHILD Check box for all foster children that are a legal responsibility of DCFS or the court.
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐

3 SNAP or TANF CASE NUMBER
Skip if foster child.
Provide one SNAP or TANF case number for any child or adult in your household. Do NOT use LINK card number. If completed, **skip to Number 6. Do not list foster child.**

Name of Child or Adult: _____

Case Number: _____

4 OPTIONAL—SHARING INFORMATION WITH *ALL KIDS INSURANCE PROGRAM*
May we share your information on this application with *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 *All Kids Insurance Program*.

Sign here: _____

5 HOUSEHOLD MEMBERS WITH INCOME—List only the names of individuals living in the household, their gross income, and how often it is received. If a person has a second job, list that income in the last column. After completing, **go to Number 6.**

NAMES (List only individuals with income)	Earnings from Work (Gross before Deductions)		Income from Welfare, Child Support, Alimony		Income from Retirement, Pensions, SSI, Social Security		Income Received From Savings, Investments, Trust Accounts, and Other Resources	
	How Much?	How Often?	How Much?	How Often?	How Much?	How Often?	How Much?	How Often?
	$ /		$ /		$ /		$ /	
	$ /		$ /		$ /		$ /	
	$ /		$ /		$ /		$ /	
	$ /		$ /		$ /		$ /	
	$ /		$ /		$ /		$ /	

6 Must check only one box.
☐ I am a provider applying to claim my own children and qualify for Tier I status.
☐ I am a provider with no children applying for Tier I status.
☐ I am a Tier I provider based on school or census data applying to claim my own children.

7 Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Number 5 above is completed the adult signing the form must also list the last four digits of his or her social security number or mark the box *I do not have a social security number.*

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 amount of federal funds received will be 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* | *Address of Adult Household Member*

PRIVACY ACT STATEMENT: *The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced-price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program, or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced-price meals, and for administration and enforcement of the Child and Adult Care Food Program. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.*

NON-DISCRIMINATION STATEMENT: 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 (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: 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 your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

SPONSOR REPRESENTATIVE USE ONLY—ELIGIBILITY DETERMINATION — Follow the instructions provided in the Household Income instructions.

Mark one of the boxes below to show how you are going to determine eligibility.

☐ **SNAP/TANF Household**

CONVERSION TABLE

To convert all income to annual income use the following conversion calculations:
Weekly Income x 52
Every 2 Weeks x 26
Twice a Month x 24
Monthly x 12

Income Household

Use the conversion table to convert income to total annual income. Total the number of household members from Section 5.

Total Household Annual Income $_____

Total Household Size _____

☐ Approved to Claim Foster Child's meals at Tier I Rate

☐ Approved Tier I Status/ Claim Providers Own Children (if applicable)

☐ Denied

Signature of Representative: _____

Date

**Effective Date of Application:* _____

**Effective Date may be made retroactive back to the first day the provider participates in the CACFP as long as it occurs in the same month in which the provider's eligibility is certified.*

Provider Name (please print): _____ Month & Year: _____

Family Child Care "Net Income Worksheet"

This worksheet is intended to be used to help family child care providers calculate their net income to determine if they are eligible for the Tier I reimbursement rate for meals and snacks. The worksheet should not be used by providers to fill out their IRS Schedule C tax form. The calculation of yearly net income on the tax forms involves many other business expenses not listed on this worksheet. Listed below are the most common reoccuring monthly expenses most providers are likely to incur. Providers who want to learn more about all allowable business deductions should consult the books at the end of this worksheet.

Monthly Income RECEIVED in the month listed above:
List child's last name and indicate the total $ received in the month:

_____	$ _____	
_____	_____	
_____	_____	
_____	_____	$ _____ (A)

Monthly Expenses PAID in the month listed above:

Utilities (gas, electric, water, garbage)	$ _____			
Mortgage interest	_____			
Apartment/house rent	_____			
Household supplies (paper products, etc)	_____			
Other items	_____			
Total	$ _____			
Multiply by the time-space percentage *		x	_____ %	_____
Car mileage (enter the number of miles driven in the last month in which the primary purpose was for the business)				
Multiply the total by $.575 (2020 standard mileage rate)				
Total business miles _____ x $.575				_____
Monthly payments to day care assistants				_____

Yearly Expenses

Property tax	$ _____			
House/renter's insurance	_____			
Total	$ _____			
Multiply by the time-space percentage		x	_____ %	
Yearly business expense			_____ divided by 12 mths	_____
Day care liability insurance			_____ divided by 12 mths	_____

Yearly Expenses continued...

House depreciation $ _____

Purchase price of home _____

Minus value of land at time of purchase _____

Plus home improvements after purchase _____
(do not include home repairs)

Total (basis of home) $ _____

Multiply by the time-space percentage x _____ %

Business use of home _____

Divide business basis by 30 years _____
(This equals the yearly house depreciation expense)

Divide above number by 12 months $ _____
(This equals the monthly house depreciation expense)

Furniture/appliance depreciation

Total fair market value of furniture/appliances as of
the month the business began _____

Multiply by the time-space percentage x _____ %

Business basis of items _____

Divide business basis by 7 years _____
(This equals the yearly furniture/appliance depreciation expense)

Divide above number by 12 months _____
(This equals the monthly furniture/appliance depreciation expense)

Total monthly expenses $ _____ (B)

Monthly Net Income (Subtract B from A) $ _____

Note: A monthly net income that results in a negative number (loss) must be reported as $0.00 on the Household Income Eligibility Application for Day Care Home Provider.

* Time-space percentage: The time-space % is used to determine the business portion of many household expenses. The formula to calculate this number is:

$$\frac{\text{\# hours home is used for business in a week}}{\text{168 hours in a week}} \times \frac{\text{\# square feet home is regularly used for business}}{\text{total \# of square feet in home}} = \text{time-space \%}$$

A provider who works 10 hours a day, 5 days a week would have a time-space % of 30%. Most providers use all of the rooms in their home for their business on a regular basis. A typical provider would therefore have a time-space of around 30-35%.

Prepared by Tom Copeland. For more information, see *The Basic Guide to Family Child Care Record Keeping* for a listing of over 750 business deductions. Consult the annual Family Child Care Workbook for specific instructions on how to fill out your federal tax forms. Both books are available from Redleaf Press at 1.800.423.8309.

4-C: Community Coordinated Child Care is not engaged in rendering tax advice. If you require this type of assistance, please consult a tax professional to represent you.

PROVIDER INSTRUCTIONS FOR COMPLETING THE HOUSEHOLD ELIGIBILITY APPLICATION

Once properly approved for meal benefits, a Household Eligibility Application (HEA) will remain in effect for 12 months. Complete the Household Eligibility Application (HEA) for one of the following areas.

FOR PROVIDERS UNABLE TO QUALIFY FOR TIER I BY SCHOOL OR CENSUS, APPLYING FOR TIER I STATUS BY INCOME ELIGIBILITY- REFER TO INSTRUCTIONS A AND B.

If anyone (child or adult) in your household **receives Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) or other qualifying benefits**, follow **Instruction A** below. The information will be verified by the sponsor.

Instruction A—Households Receiving SNAP or TANF or other qualifying benefits.

- **Number 1**—List the names of ALL people residing in a provider's household (such as grandparents, other relatives, or friends who live with a provider) and the age(s) of the child(ren) enrolled in a provider's day care home.
- **Number 3**—Record a valid SNAP or TANF case number for any member (child or adult) of this household. The SNAP or TANF case number is on the letter of eligibility for benefits or the case number may be found on a medical card. Do not list an Illinois LINK card number. The SNAP or TANF information provided will require verification by the sponsoring organization. Providing documentation of the benefit is required.
- **Number 4 (OPTIONAL)**—*Illinois All Kids Health Insurance Program.*
- **Number 6**—Mark the box that best describes the purpose for the application.
- **Number 7**—Provide a signature of an adult household member and date the application.
- The application is complete.

If no one in your household receives SNAP or TANF benefits and **you want to apply for the higher reimbursement for your day care operation based on your household income, follow Instruction B.**
It is not necessary to complete income information if SNAP or TANF information was provided above in Instruction A or if all the children residing with the provider are documented foster children (refer to Instruction D). The information will be verified by the sponsor.

Instruction B—Households Reporting Income

- **Number 1**— List the names of ALL people residing in a provider's household (such as grandparents, other relatives, or friends who live with a provider) and the age(s) of the child(ren) enrolled in a provider's day care home. (Foster child(ren) may be included on the HEA)
- **Number 4 (OPTIONAL)** — *Illinois All Kids Health Insurance Program.*
- **Number 5**—List total gross income (before deductions), not take-home pay; and the frequency, how often the money is received, for each household member for the last month. If the income last month was not the usual amount normally receive, a projected amount may be provided that represents the gross income.
    - For ONLY the self-employed, list average monthly income after expenses. This is for a business, farm, or rental property.
    - If receiving Military Privatized Housing Initiative pay or receive combat pay, do not include these allowances as income.
- **Number 6**—Mark the box that best describes the purpose for the application.
- **Number 7**—The provider must sign and date the application.
- **Also,** provide the last four digits of the social security number of the provider signing the application. Refusal to provide the last four digits of the social security number will result in the application not being approved. If the adult does not have a social security number, mark the box, *I do not have a social security number.*
- The application is complete. Documentation must be provided to support all information (foster child documentation if applicable, check stubs, W-2's 1040 Schedule C, etc...)
- The sponsoring organization will verify the information contained on the HEA.

FOR PROVIDERS APPROVED TIER 1 STATUS BY SCHOOL OR CENSUS WANTING TO CLAIM CHILDREN, TO INCLUDE FOSTER CHILDREN WHEN OUTSIDE CHILDREN ARE PRESENT:

If you have been approved **Tier I status by School or Census Data and would like to claim qualifying children, including foster children, residing with you when outside qualifying children are present,** you must complete a HEA in order to claim the qualifying children, including foster children residing with you. Refer to **Instruction C**. The application may be verified by the sponsor.

Instruction C—Provider approved Tier I status by School or Census and would like to claim children residing with the provider. Follow the instructions provided in **Instruction B, Numbers 1 through 7**. The sponsoring organization may verify the information.

FOR PROVIDERS IDENTIFIED AS TIER II STATUS WANTING TO CLAIM FOSTER CHILDREN WHEN OUTSIDE CHILDREN ARE PRESENT:

A foster child(ren) residing with you is(are) eligible for Tier I reimbursement for eligible meals, when outside qualifying children are present, regardless of you tier status (Tier I or Tier II) when a HEA is submitted by the provider. The eligibility for the foster child does not transfer to the household. In order to document a child as a foster child, legal document from DCFS or the DCFS appointed representative must be submitted for each foster child with the Household Eligibility Application. In lieu of a document a provide may request DCFS or its representative to complete form 50-73 (Homeless, Runaway, Migrant, Head Start, and Foster Child Certification Form) that can be found on the following ISBE website: https://www.isbe.net/Documents/50-73_hmls_cert_mm.pdf#search=form%2050%2D73.

Instruction D—For the foster child(ren) residing in a providers home, please provide the following information on the HEA:

- **Number 1**—List the name(s) and age(s) of the foster child(ren) residing in the provider's day care home.
- **Number 2**—Check the box(es) indicating the child(ren) is a foster child(ren).
- **Number 4 (OPTIONAL)**— *Illinois All Kids Health Insurance Program.*
- **Number 6**—Mark the box that best describes the purpose for the application
- **Number 7**—Provide a signature of the provider and date the application.
- The application is complete.

The All Kids program offers many Illinois children comprehensive healthcare that includes doctor visits, hospital stays, prescription drugs, vision care, dental care and medical devices like eyeglasses and asthma inhalers.

Some families pay monthly premiums for the coverage, but rates for middle-income families are significantly lower than they are on the private market. For example, a family of four that earns between $50,700 and $77,112 a year pays a $40 monthly premium per child, and a $10 co-pay per physician visit. Fill out the application today.

All Kids Hotline 1-866-ALL-KIDS (1-866-255-5437)
TTY: 1-877-204-1012