COLORADO
Department of Public Health & Environment

CHILD AND ADULT CARE FOOD PROGRAM
2023-2024 Provider Income Eligibility Form (IEF)
For Family Child Care Home Sponsors

(A) Names and ages of children in your household for whom application is made

Name	Age
______________________	________
______________________	________
______________________	________

❑ Supplemental Nutrition Assistance Program (SNAP)*, previously known as Food Stamp — **Case Number:**__________________

❑ Temporary Assistance for Needy Families (TANF) — **Case Number:**__________________

❑ Food Distribution Program on Indian Reservations (FDPIR)* — **Case Number:**__________________

**If any member of the household receives benefits under SNAP (Food Stamps), TANF, or Food Distribution Program on Indian Reservations (FDPIR) complete sections (A) &(E) ONLY.*
A Quest card or a Social Security Number is not an accepted number for SNAP, TANF, or FDPIR. Please see the instructions.

Other Source Categorically Eligible programs allow automatic eligibility at the Free rate in the CACFP when the institution obtains documentation from the corresponding agency and verifies children are enrolled in one of the programs listed below. If applicable, please check one of the boxes.

❑ One or more child listed above is a foster child who is the responsibility of the State or was placed by the court.

❑ One or more child listed above is an Even Start, Early Head Start (EHS), or Head Start enrolled child or pregnant mother (enrolled in EHA), who is categorically eligible for free meals and therefore is not required to complete an IEF. However, one of the following documents from the Head Start program must be on file: 1) An approved Head Start or Even Start application; 2) A statement of Head Start or Even Start enrollment; or 3) A list of participants from the Even Start or Head Start official listing the Even Start, Early Head Start or Head Star child's or pregnant mother's name. 4) For the Even Start documentation from the Even Start official that confirms the child has not entered Kindergarten.

❑ If one or more child listed above is a homeless, migrant, or runaway child, the sponsor must obtain documentation verifying the status of the child from the director of the homeless shelter, Migrant Education Program Coordinator, or an official of the Runaway and Homeless Youth program.

(B) Net Child Care Income

Child Care Expenses:

Business costs (auto, building, utility and other expenses, etc.)	$	________.00
Cost of food for day care children (less own children)	+	________.00
TOTAL CHILD CARE EXPENSES	=	$________.00

CHILD CARE INCOME:

Gross day care fees (money from parents of day care children)*	$	________.00
CACFP reimbursement (less own children)*	+	________.00
TOTAL CHILD CARE INCOME	=	$________.00
TOTAL CHILD CARE EXPENSES	-	$________.00
NET CHILD CARE INCOME	=	$________00

***If less than zero, count as zero**

☐ Weekly ☐ Month ☐ Annually

Number of children in your care:

Part-time: ____________ **Full-time:** ____________

(C) Total Household Income for MONTH OR YEAR

Household Members not listed in (A) (Provider)	Gross Salary and Wages	All Other Income	To be completed by Sponsor
	$	$	$
	$	$	$
	$	$	$
	$	$	$
	$	$	$
	$	$	$
		Total*	$________

TOTAL NUMBER IN HOUSEHOLD:__________
(Include children from section (A) in this number.)

(D) SOCIAL SECURITY NUMBER X X X – X X – ☐☐☐☐

If the adult household member completing this form does not provide a SNAP, TANF, or FDPIR number in Section A, the person completing this form must provide the last 4 digits of their Social Security Number (SSN).

Check this box if the adult household member signing this form does not have a Social Security Number. ☐

(E) SIGNATURE: I certify that all of the information in this form is true and correct. I understand that this information is being given in connection with the receipt of Federal funds. Sponsor officials may request documentation, and deliberate misrepresentation may be subject to prosecution under applicable State and Federal Criminal Statutes.

______________________________ ____________ ______________________________
Signature of Provider or Adult Household Member Date Address

______________________________ ______________________________
Printed Name ______________________ City State Zip

______________________ (________)
County Telephone Number

*Note: Your Sponsor may not approve this form unless it is complete and has been signed and dated.

FOR FCCH SPONSOR USE ONLY

☐ **Eligible based on area for Tier I rate** for all enrolled child care children. Provider is income eligible and may claim own children at Tier I rates (no documentation necessary).

☐ **Eligible based on income for Tier I rate** for all enrolled child care children. Provider is income eligible and may claim own children at Tier I rates (documentation on file).

☐ **Ineligible**

Signature of Sponsor's Authorized Representative:______________________________

	Month		Year	
Date:				

This form expires 12 months after the month in which it is received and approved by the FCCH Sponsor.
Example: If the determination date is July 2023, the form is valid from July 1, 2023 through July 31, 2024. **The Sponsor may use the date the provider signs the income eligibility form OR the date the Sponsor's official makes the determination, and signs and dates the income eligibility form. The same approval method selected must be used for all forms approved by the Sponsor.**

Nondiscrimination Statement **Revised May 2022**

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 (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, 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: Mail: US Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or fax: (833) 256-1665 or (202) 690-7442; or email: program.intake@usda.gov This institution is an equal opportunity provider.