Child and Adult Care Food Program
CACFP FY26

Free and Reduced Meal Applications Training

Non-Discrimination Statement

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 Compliant Form which can be obtained online at: USDA Program Nondiscrimination Complaint Form, 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:
U.S. 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.

Welcome In!

- Participants are muted
- Enter your questions into the Q&A, not the chat
- CACFP staff will answer questions in the Q&A

F/R Meal Application

https://cnp.doe.louisiana.gov/Nutrition/Resources

Dropped Date: _____ Re-Entered Date: _____ Transferred Date:_____

CACFP 106 (Rev. 06-26)
FY 2026 FRPM Application

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
MEAL BENEFIT INCOME ELIGIBILITY FORM
FREE AND REDUCED PRICE MEAL (FRPM) APPLICATION FORM (July 1, 2026 – June 30, 2027)

INSTITUTION NAME: _____ FACILITY NAME: _____

PART1. CHILD OR ADULT ENROLLED TO RECEIVE DAY CARE (USE A SEPARATE APPLICATION FOR EACH PARTICIPANT)

Print Name of Participant:	(First, Middle Initial, Last)	Age	DOB (mm/dd/yy)
Foster Child?	Yes _____	No: _____	If participant is in Foster Care, Eligibility is **FREE**. Enter Foster Child's **Personal Income Earned** in Part 2, Section 4 **(If applicable)**
Enter CID # for Child or Adult Care, if applicable :			
Enter FITAP or FDPIR # for Child or Adult Care, if applicable:			
Enter SSI/Medicaid # for Adult Day Care Only			

PART 2. Total Household Gross Income
If you listed a CID/FITAP/FDPIR/SSI/Medicaid case # above, Eligibility is FREE (Skip PART 2.)

A. Name (List everyone in household, including child listed above)	B. Gross income and how often it was received. Examples: $100 / monthly $100 / twice a month $100 / every two weeks $100 / weekly				C. Check if NO income
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement	4. All Other Income	
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑

PART 3: USDA Supplemental Annual Enrollment Information: (This section must be completed annually by an adult household member for all children enrolled at Child Care Centers participating in the USDA Child and Adult Care Food Program.)

Expected Days of participation: _____ Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday

Expected Hours of participation: From____ To ____ or **Before School: From** _____To_____ **Afterschool: From** _____To_____

Expected Meal participation: _____ **Breakfast** _____ **Lunch** _____ **Snack**

PART 4. Adult Signature, Social Security Number, and Contact Information

An adult household member must sign this form. If **Part 3** is completed, the adult signing the form must also list his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on page 2.)

I certify that all information on this form is true and that all income is reported. I understand that the center will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign Here: _____ Print Name:_____ Date: _____

Address:_____ Phone Number:_____

Social Security Number: XXX -XX - __ __ __ __ ❑ I do not have a Social Security Number

Part 5. Participant's ethnic and racial identities (optional)

Mark one ethnic identity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino **Mark one or more racial identities:** ❑ Asian ❑ White ❑ Black or African American ❑ American Indian or Alaskan Native ❑ Native Hawaiian or Other Pacific Islander

For Official Use Only: Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Month, ❑ Twice a month, ❑ Every two weeks, ❑ Week, ❑ Year Household size: _____

Eligibility Determination: _____Free ❑ CID(Food Stamp)/FITAP/FDPIR/SSI/Medicaid Eligible _____Reduced _____Above/ Paid

Extended Categorical Eligibility Validation Attached ____YES ____NO

Determining Official's Signature: _____ Date: _____

Effective July 1, 2026 to June 30, 2027

Free Price Meal Eligibility:

Households with incomes **less than or equal to** these levels are eligible for **free** price meals.	Household Size	Yearly	Monthly	Twice Per Month	Every Two Weeks	Weekly
	1	$20,748	$1,729	$865	$798	$399
	2	$28,132	$2,345	$1,173	$1,082	$541
	3	$35,516	$2,960	$1,480	$1,366	$683
	4	$42,900	$3,575	$1,788	$1,650	$825
	5	$50,284	$4,191	$2,096	$1,934	$967
	6	$57,668	$4,806	$2,403	$2,218	$1,109
	7	$65,052	$5,421	$2,711	$2,502	$1,251
	8	$72,436	$6,037	$3,019	$2,786	$1,393
	Each additional family member add	+ $7,384	+ $616	+ $308	+ $284	+ $142

Reduced Price Meal Eligibility:

Households with incomes **less than or equal to** these levels are eligible for **reduced** price meals.	Household Size	Yearly	Monthly	Twice Per Month	Every Two Weeks	Weekly
	1	$29,526	$2,461	$1,231	$1,136	$568
	2	$40,034	$3,337	$1,669	$1,540	$770
	3	$50,542	$4,212	$2,106	$1,944	$972
	4	$61,050	$5,088	$2,544	$2,349	$1,175
	5	$71,558	$5,964	$2,982	$2,753	$1,377
	6	$82,066	$6,839	$3,420	$3,157	$1,579
	7	$92,574	$7,715	$3,858	$3,561	$1,781
	8	$103,082	$8,591	$4,296	$3,965	$1,983
	Each additional family member add	+ $10,508	+ $876	+ $438	+ $405	+ $203

Date range on the F/R Meal Application changed to align with the date range on the Standards of Eligibility.

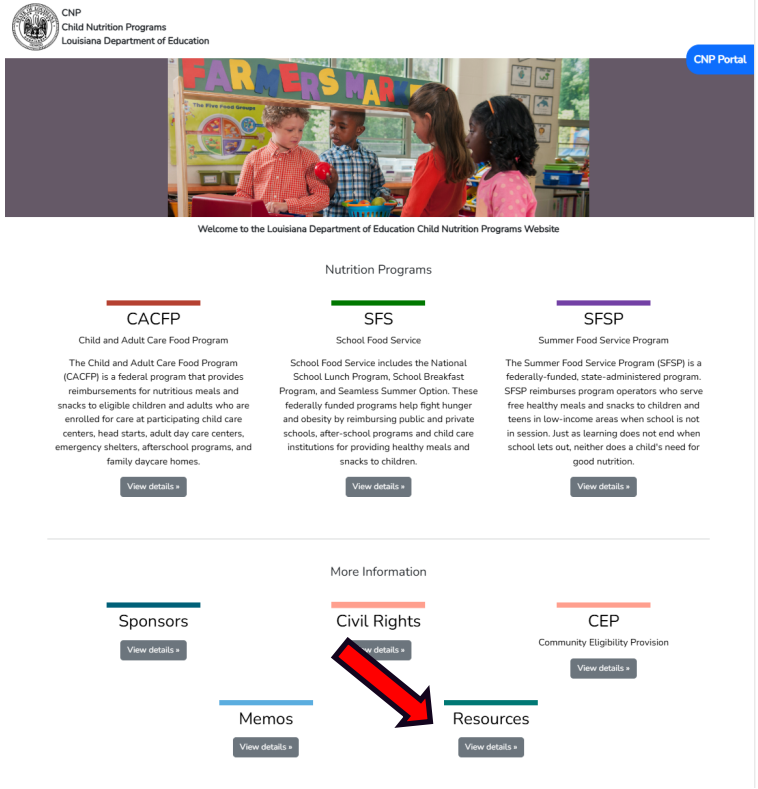
F/R Meal Applications are still valid for a year from the date they are obtained.

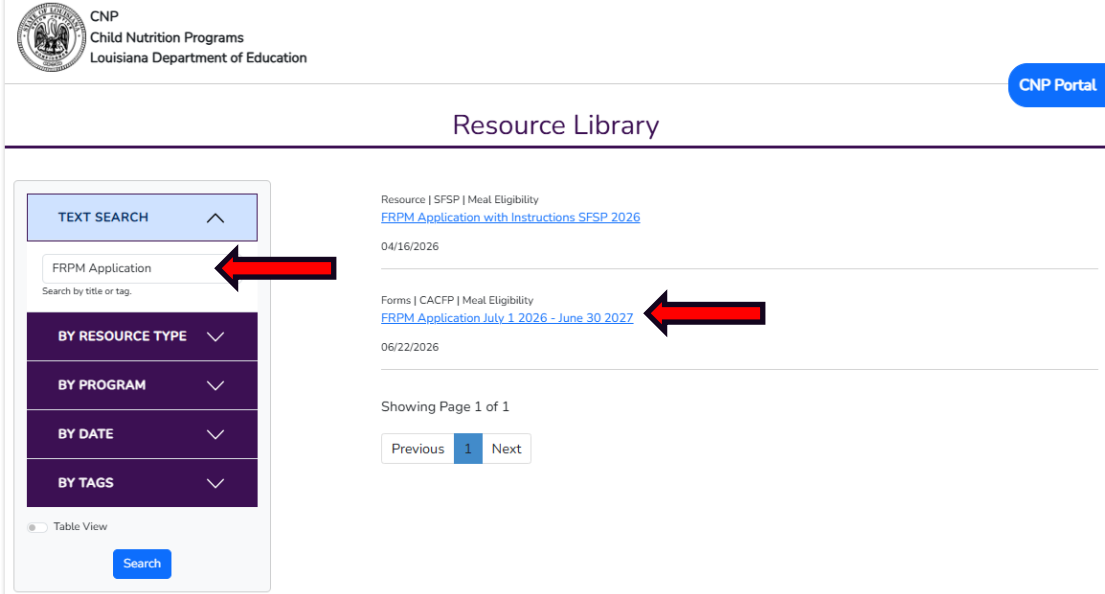
Where Do I Get the Form?

https://cnp.doe.louisiana.gov/Nutrition/Resources

- Sponsors can find the form at our CNP website.
- THE FORMS ARE UPDATED YEARLY DURING THE MONTH OF **JUNE.**
- IT IS THE SPONSOR'S RESPONSIBILITY TO DOWNLOAD AND GIVE THE ENTIRE FORM TO EACH PARENT/GUARDIAN WITH AN **ENROLLED** CHILD.
- There is to be one form for each child enrolled.

Where to Go…


CNP
Child Nutrition Programs
Louisiana Department of Education
CNP Portal
Welcome to the Louisiana Department of Education Child Nutrition Programs Website
Nutrition Programs
CACFP
Child and Adult Care Food Program
The Child and Adult Care Food Program (CACFP) is a federal program that provides reimbursements for nutritious meals and snacks to eligible children and adults who are enrolled for care at participating child care centers, head starts, adult day care centers, emergency shelters, afterschool programs, and family daycare homes.
View details »
SFS
School Food Service
School Food Service includes the National School Lunch Program, School Breakfast Program, and Seamless Summer Option. These federally funded programs help fight hunger and obesity by reimbursing public and private schools, after-school programs and child care institutions for providing healthy meals and snacks to children.
View details »
SFSP
Summer Food Service Program
The Summer Food Service Program (SFSP) is a federally-funded, state-administered program. SFSP reimburses program operators who serve free healthy meals and snacks to children and teens in low-income areas when school is not in session. Just as learning does not end when school lets out, neither does a child's need for good nutrition.
View details »
More Information
Sponsors
View details »
Civil Rights
View details »
CEP
Community Eligibility Provision
View details »
Memos
View details »
Resources
View details »


CNP
Child Nutrition Programs
Louisiana Department of Education
CNP Portal
Resource Library
TEXT SEARCH
FRPM Application
Search by title or tag.
BY RESOURCE TYPE
BY PROGRAM
BY DATE
BY TAGS
Table View
Search
Resource | SFSP | Meal Eligibility
FRPM Application with Instructions SFSP 2026
04/16/2026
Forms | CACFP | Meal Eligibility
FRPM Application July 1 2026 - June 30 2027
06/22/2026
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Dropped Date: _____ Re-Entered Date: _____ Transferred Date:_____

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INSTITUTION NAME: _____ FACILITY NAME: _____

PART1. CHILD OR ADULT ENROLLED TO RECEIVE DAY CARE (USE A SEPARATE APPLICATION FOR EACH PARTICIPANT)

Print Name of Participant:	(First, Middle Initial, Last)	Age	DOB (mm/dd/yy)
Foster Child?	Yes _____	No: _____	If participant is in Foster Care, Eligibility is FREE.
Enter CID # for Child or Adult Care, if applicable :			Enter Foster Child's Personal Income Earned in Part 2, Section 4 (If applicable)
Enter FITAP or FDPIR # for Child or Adult Care, if applicable:			
Enter SSI/Medicaid # for Adult Day Care Only			

PART 2. Total Household Gross Income
If you listed a CID/FITAP/FDPIR/SSI/Medicaid case # above, Eligibility is FREE (Skip PART 2.)

A. Name (List everyone in household, including child listed above)	B. Gross income and how often it was received. Examples: $100 / monthly $100 / twice a month $100 / every two weeks $100 / weekly				C. Check if NO income
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement	4. All Other Income	
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑

PART 3: USDA Supplemental Annual Enrollment Information: (This section must be completed annually by an adult household member for all children enrolled at Child Care Centers participating in the USDA Child and Adult Care Food Program.)

Expected Days of participation: _____ **Monday** _____ **Tuesday** _____ **Wednesday** _____ **Thursday** _____ **Friday**

Expected Hours of participation: From____ **To** ____ **or Before School: From** ____**To**____ **Afterschool: From** ____**To**____

Expected Meal participation: _____ **Breakfast** _____ **Lunch** _____ **Snack**

PART 4. Adult Signature, Social Security Number, and Contact Information

An adult household member must sign this form. If **Part 3** is completed, the adult signing the form must also list his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on page 2.)

I certify that all information on this form is true and that all income is reported. I understand that the center will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign Here: _____ Print Name:_____ Date: _____

Address:_____ Phone Number:_____

Social Security Number: XXX -XX - __ __ __ __ ❑ I do not have a Social Security Number

Part 5. Participant's ethnic and racial identities (optional)

Mark one ethnic identity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino **Mark one or more racial identities:** ❑ Asian ❑ White ❑ Black or African American ❑ American Indian or Alaskan Native ❑ Native Hawaiian or Other Pacific Islander

For Official Use Only: Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Month, ❑ Twice a month, ❑ Every two weeks, ❑ Week, ❑ Year Household size: _____

Eligibility Determination: _____Free ❑ CID(Food Stamp)/FITAP/FDPIR/SSI/Medicaid Eligible _____Reduced _____Above/ Paid

Extended Categorical Eligibility Validation Attached ____YES ____NO

Determining Official's Signature: _____ Date: _____

THIS FORM CHANGES YEARLY

This document determines the meal reimbursement rate for each participant.

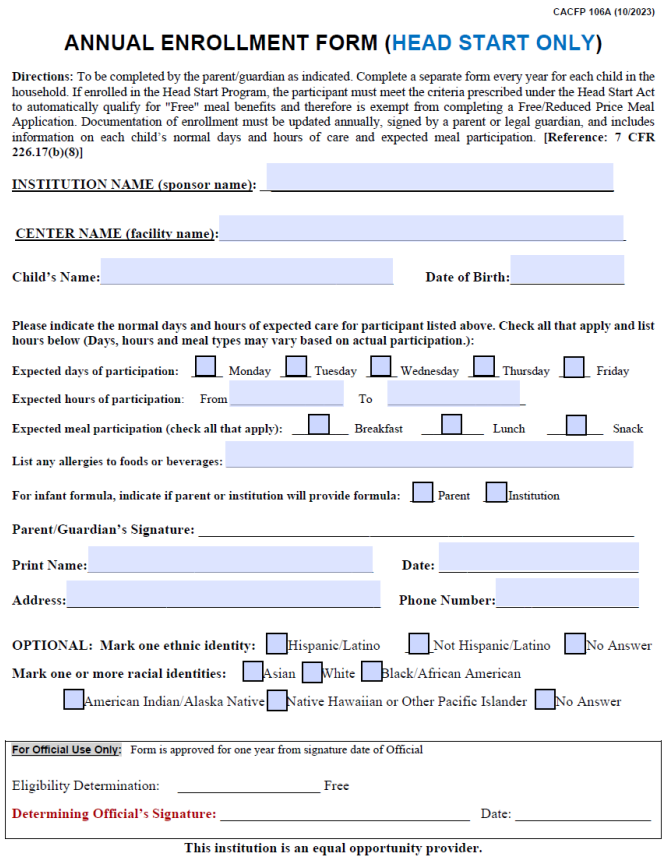
The same form is used for childcare and adult day care participants.

This form is valid from July 1,2026 - June 30, 2027.

A new form is be completed by parent and validated by Institution or sponsor yearly.

At-Risk afterschool meals and Shelter programs do not require this form.

Annual Enrollment Forms (Head Starts Only)



CACFP 106A (10/2023)

ANNUAL ENROLLMENT FORM (HEAD START ONLY)

Directions: To be completed by the parent/guardian as indicated. Complete a separate form every year for each child in the household. If enrolled in the Head Start Program, the participant must meet the criteria prescribed under the Head Start Act to automatically qualify for "Free" meal benefits and therefore is exempt from completing a Free/Reduced Price Meal Application. Documentation of enrollment must be updated annually, signed by a parent or legal guardian, and includes information on each child's normal days and hours of care and expected meal participation. **[Reference: 7 CFR 226.17(b)(8)]**

INSTITUTION NAME (sponsor name): _____

CENTER NAME (facility name): _____

Child's Name: _____ **Date of Birth:** _____

Please indicate the normal days and hours of expected care for participant listed above. Check all that apply and list hours below (Days, hours and meal types may vary based on actual participation.):

Expected days of participation: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Expected hours of participation: From _____ To _____

Expected meal participation (check all that apply): ☐ Breakfast ☐ Lunch ☐ Snack

List any allergies to foods or beverages: _____

For infant formula, indicate if parent or institution will provide formula: ☐ Parent ☐ Institution

Parent/Guardian's Signature: _____

Print Name: _____ **Date:** _____

Address: _____ **Phone Number:** _____

OPTIONAL: Mark one ethnic identity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ No Answer

Mark one or more racial identities: ☐ Asian ☐ White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ No Answer

For Official Use Only: Form is approved for one year from signature date of Official

Eligibility Determination: _____ Free

Determining Official's Signature: _____ Date: _____

This institution is an equal opportunity provider.

Head Start programs may use the FRPM application or their own form, only if all the information contained on this form is documented for each enrolled participants.

This form may be accessed through: https://cnp.doe.louisiana.gov/Nutrition/Resources

Free and Reduced Meal Applications Eligibility Determination

There are two ways eligibility is decided:

1. Automatically classified as Free:

- The participant is a recipient of SNAP, in a temporary shelter (FITAP) or on an Indian reservation(FDPIR) .
- The **ADULT** participant is a recipient of Medicaid/SSI.
- The participant is a foster child.

Effective July 1, 2026 to June 30, 2027

Free Price Meal Eligibility:						
Households with incomes **less than or equal to** these levels are eligible for **free** price meals.	Household Size	Yearly	Monthly	Twice Per Month	Every Two Weeks	Weekly
	1	$20,748	$1,729	$865	$798	$399
	2	$28,132	$2,345	$1,173	$1,082	$541
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	8	$72,436	$6,037	$3,019	$2,786	$1,393
	Each additional family member add	+ $7,384	+ $616	+ $308	+ $284	+ $142
Reduced Price Meal Eligibility:						
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	8	$103,082	$8,591	$4,296	$3,965	$1,983
	Each additional family member add	+ $10,508	+ $876	+ $438	+ $405	+ $203

2. By calculation based on the current Standards of Eligibility Form CACFP 108 which will determine the participant's free, reduced or above/paid eligibility status.

Free and Reduced Meal Applications

Dropped Date: _____ Re-Entered Date: _____ Transferred Date:_____

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FY 2026 FRPM Application

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Print Name of Participant:	(First, Middle Initial, Last)	Age	DOB (mm/dd/yy)
Foster Child?	Yes _____	No: _____	If participant is in Foster Care, Eligibility is FREE.
Enter CID # for Child or Adult Care, if applicable :			Enter Foster Child's **Personal Income Earned** in Part 2, Section 4 **(If applicable)**
Enter FITAP or FDPIR # for Child or Adult Care, if applicable:			
Enter SSI/Medicaid # for Adult Day Care Only			

PART 2. Total Household Gross Income
If you listed a CID/FITAP/FDPIR/SSI/Medicaid case # above, Eligibility is FREE (Skip PART 2.)

A. Name (List everyone in household, including child listed above)	B. Gross income and how often it was received Examples: $100 / monthly $100 / twice a month $100 / every two weeks $100 / weekly				C. Check if NO income
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	$ /	$ /	$ /	$ /	❑
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	$ /	$ /	$ /	$ /	❑
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Sign Here: _____ Print Name:_____ Date: _____

Address:_____ Phone Number:_____

Social Security Number: XXX -XX - __ __ __ __ ❑ I do not have a Social Security Number

Part 5. Participant's ethnic and racial identities (optional)

Mark one ethnic identity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino **Mark one or more racial identities:** ❑ Asian ❑ White ❑ Black or African American ❑ American Indian or Alaskan Native ❑ Native Hawaiian or Other Pacific Islander

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Eligibility Determination: _____Free ❑ CID(Food Stamp)/FITAP/FDPIR/SSI/Medicaid Eligible _____Reduced _____Above/ Paid

Extended Categorical Eligibility Validation Attached ____YES ____NO

Determining Official's Signature: _____ Date: _____

Enter the institution and facility name.

CID=Child Identification Number -this is where the SNAP Card number is placed. It is a 9-digit number that begins with two zeroes.

The parent must complete Part 1: Legal name of the participant and Date of birth must be provided.

Free and Reduced Meal Applications

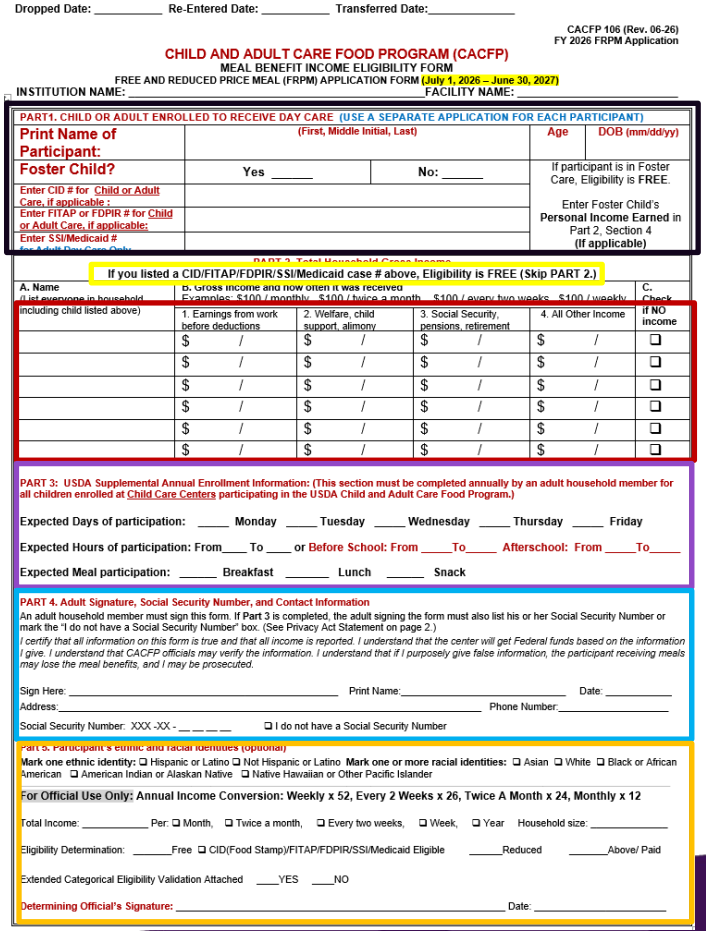
PART 1: Parent completes legal name, age, DOB, CID, FITAP, FDPIR #.

PART 2: Must be completed for all participants not categorically eligible and determined as “free”.

PART 2: A complete list of EVERYONE in the household -with complete names (no initials, nicknames, abbreviations)

PART 2: The total gross income from all sources and how often the income is received -monthly, weekly, etc. Is placed

FOR OFFICE USE ONLY:
The institution completes this info.



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	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑

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Social Security Number: XXX -XX - __ __ __ __ ❑ I do not have a Social Security Number

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Mark one ethnic identity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino **Mark one or more racial identities:** ❑ Asian ❑ White ❑ Black or African American ❑ American Indian or Alaskan Native ❑ Native Hawaiian or Other Pacific Islander

For Official Use Only: Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Month, ❑ Twice a month, ❑ Every two weeks, ❑ Week, ❑ Year Household size: _____

Eligibility Determination: _____Free ❑ CID(Food Stamp)/FITAP/FDPIR/SSI/Medicaid Eligible _____Reduced _____Above/ Paid

Extended Categorical Eligibility Validation Attached ___YES ___NO

Determining Official's Signature: _____ Date: _____

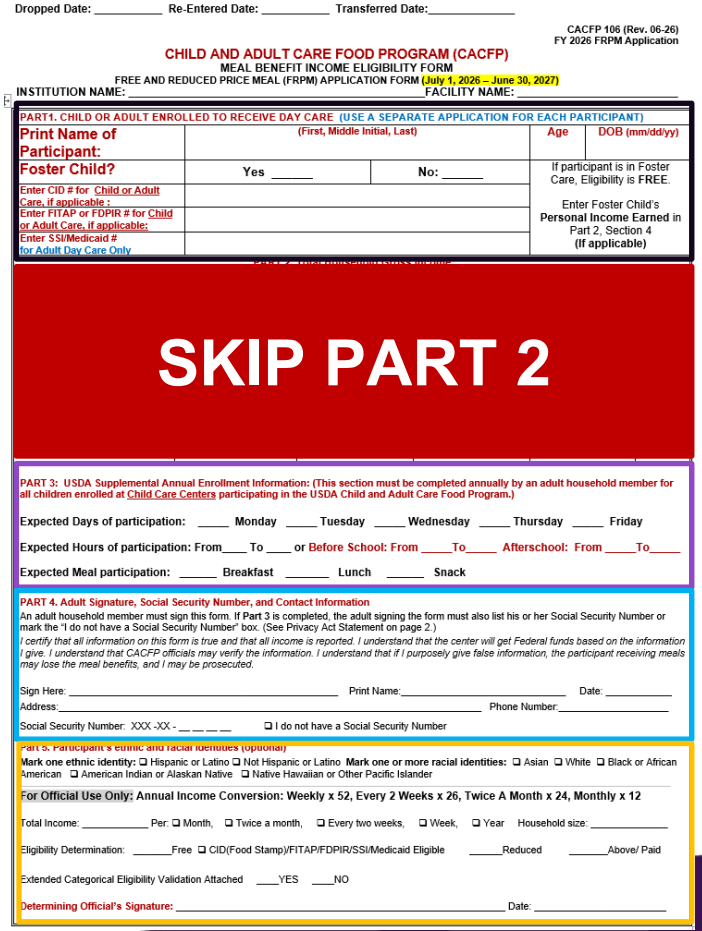
PART 3: The parent or guardian must indicate normal days/hours of care and meal types.

PART 4: The parent or guardian must sign, enter the last 4 digits of SS# or mark “no SS”.

PART 5: Optional racial/ethnic identity.

Free and Reduced Meal Applications

PART 1: Parent completes legal name, age, DOB, CID, FITAP, FDPIR #.



Dropped Date: _____ Re-Entered Date: _____ Transferred Date:_____

CACFP 106 (Rev. 06-26)
FY 2026 FRPM Application

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
MEAL BENEFIT INCOME ELIGIBILITY FORM
FREE AND REDUCED PRICE MEAL (FRPM) APPLICATION FORM (July 1, 2026 – June 30, 2027)

INSTITUTION NAME: _____ FACILITY NAME: _____

PART1. CHILD OR ADULT ENROLLED TO RECEIVE DAY CARE (USE A SEPARATE APPLICATION FOR EACH PARTICIPANT)

Print Name of Participant:	(First, Middle Initial, Last)	Age	DOB (mm/dd/yy)
Foster Child?	Yes _____	No: _____	If participant is in Foster Care, Eligibility is FREE.
Enter CID # for Child or Adult Care, if applicable :			Enter Foster Child's Personal Income Earned in Part 2, Section 4 (If applicable)
Enter FITAP or FDPIR # for Child or Adult Care, if applicable:			
Enter SSI/Medicaid # for Adult Day Care Only			

SKIP PART 2

PART 3: USDA Supplemental Annual Enrollment Information: (This section must be completed annually by an adult household member for all children enrolled at Child Care Centers participating in the USDA Child and Adult Care Food Program.)

Expected Days of participation: _____ Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday

Expected Hours of participation: From____ To ____ or Before School: From ____To_____ Afterschool: From ____To____

Expected Meal participation: _____ Breakfast _____ Lunch _____ Snack

PART 4. Adult Signature, Social Security Number, and Contact Information

An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on page 2.)

I certify that all information on this form is true and that all income is reported. I understand that the center will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign Here: _____ Print Name:_____ Date: _____

Address:_____ Phone Number:_____

Social Security Number: XXX -XX - __ __ __ __ ❑ I do not have a Social Security Number

Part 5. Participant's ethnic and racial identities (optional)

Mark one ethnic identity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino **Mark one or more racial identities:** ❑ Asian ❑ White ❑ Black or African American ❑ American Indian or Alaskan Native ❑ Native Hawaiian or Other Pacific Islander

For Official Use Only: Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Month, ❑ Twice a month, ❑ Every two weeks, ❑ Week, ❑ Year Household size: _____

Eligibility Determination: _____Free ❑ CID(Food Stamp)/FITAP/FDPIR/SSI/Medicaid Eligible _____Reduced _____Above/ Paid

Extended Categorical Eligibility Validation Attached ____YES ____NO

Determining Official's Signature: _____ Date: _____

FOR OFFICE USE ONLY:
The institution completes this info.

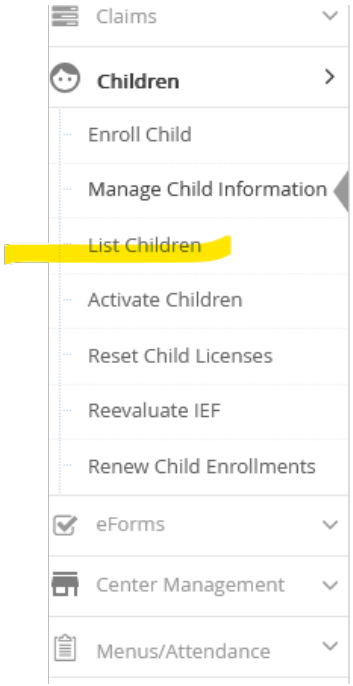
PART 3: The parent or guardian must indicate normal days/hours of care and meal types.

PART 4: The parent or guardian must sign the form. A SS# is not necessary for foster children.

PART 5: Optional racial/ethnic identity.

Free and Reduced Meal Applications from KIDKARE

- To print the FRP Meal Application for a single child or a few children, navigate to the child's page and click 'Enrollment/IEF Form' under the picture area.
- This will print the form with the Sponsor and Center Name, Participant Name, Age, Date of Birth, Parent/Guardian Name, Address. If you have the CID number in, Kidkare it will print on this form as well.
- If the child is not a foster child or does not qualify based on SNAP, the income portion of the form will still need to be completed by the parent. SSN and Signature will need to be completed by parent/guardian on all forms.
- To print the forms **for many or all children,** run the following report. you will have the opportunity to select all participants or choose the ones you want to print form for.
- Reports, Children, Child EIF/Child Enrollment Report (for completion by parent)



These options will print the FRPM Application, Standards of Eligibility, and the Letter to Parent. You should be giving the parents/participants ALL this information.

Standards of Eligibility Form

CACFP 108

THIS FORM CHANGES YEARLY

There are two charts:

The top section determines **free eligibility.** The bottom section determines **reduced eligibility.**

Amounts are based upon family size and frequency of gross income -yearly, monthly, etc.

Free Price Meal Eligibility:						
Households with incomes **less than or equal to** these levels are eligible for **free** price meals.	Household Size	Yearly	Monthly	Twice Per Month	Every Two Weeks	Weekly
	1	$20,748	$1,729	$865	$798	$399
	2	$28,132	$2,345	$1,173	$1,082	$541
	3	$35,516	$2,960	$1,480	$1,366	$683
	4	$42,900	$3,575	$1,788	$1,650	$825
	5	$50,284	$4,191	$2,096	$1,934	$967
	6	$57,668	$4,806	$2,403	$2,218	$1,109
	7	$65,052	$5,421	$2,711	$2,502	$1,251
	8	$72,436	$6,037	$3,019	$2,786	$1,393
	Each additional family member add	+ $7,384	+ $616	+ $308	+ $284	+ $142
Reduced Price Meal Eligibility:						
Households with incomes **less than or equal to** these levels are eligible for **reduced** price meals.	Household Size	Yearly	Monthly	Twice Per Month	Every Two Weeks	Weekly
	1	$29,526	$2,461	$1,231	$1,136	$568
	2	$40,034	$3,337	$1,669	$1,540	$770
	3	$50,542	$4,212	$2,106	$1,944	$972
	4	$61,050	$5,088	$2,544	$2,349	$1,175
	5	$71,558	$5,964	$2,982	$2,753	$1,377
	6	$82,066	$6,839	$3,420	$3,157	$1,579
	7	$92,574	$7,715	$3,858	$3,561	$1,781
	8	$103,082	$8,591	$4,296	$3,965	$1,983
	Each additional family member add	+ $10,508	+ $876	+ $438	+ $405	+ $203

Eligibility Determination Example

The household size is three (3). If the income received is $200 every two weeks, $150 every week, and $100 a month the total annual income = $14,200

$200 x 26 =	$ 5,200 per year
$150 x 52 =	$ 7,800 per year
$100 x 12 =	$ 1,200 per year
Total Annual Income =	**$14,200** qualifies for Free Eligibility Status

✓Household size is the total number of people currently living in the home as their primary address and are identified in Part 2 Section A of the FRPM Application (not visiting guests/relatives).

✓Check the appropriate Eligibility Determination on the FRPM Application

Extended Categorical Eligibility

Extended Categorical Eligibility Validation Attached ✔ YES ___NO

Determining Official's Signature: _____ Date: _____

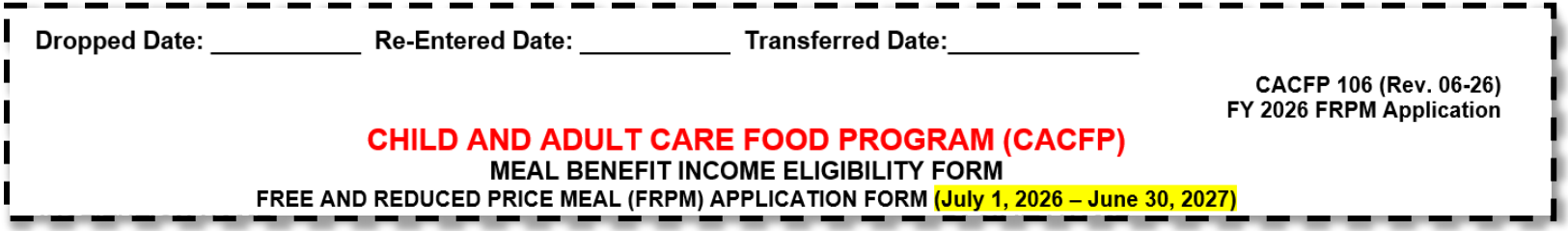
The Determining Official makes a copy of the FRPM Application for the participant already receiving Categorically Free benefits and attaches it to the FRPM Application of the participant requesting Extended Categorical Eligibility.

"Yes" is checked on the application.

The addresses on both applications must match.

Enrollment Status Changes

Enrollment status is to be properly documented each fiscal year -October to September.
At the top of the FRPM Application is a section that requires a date for enrollment changes:



Dropped Date: _____ Re-Entered Date: _____ Transferred Date:_____

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FREE AND REDUCED PRICE MEAL (FRPM) APPLICATION FORM (July 1, 2026 – June 30, 2027)

Dropped Date: The date an enrolled participant withdraws enrollment from the institution.

Re-Entered Date: The date a dropped participant returns (re -enrolls) to the institution.

Transferred Date: The date an enrolled participant transferred to another approved facility of the sponsor/institution.

Application Sponsor/Institutions Determining Official

*This person **takes responsibility** for verifying the completeness of the application and eligibility of the participant using the information provided on the FRPM application.*

For Official Use Only: Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Month, ❑ Twice a month, ❑ Every two weeks, ❑ Week, ❑ Year Household size: _____

Eligibility Determination: _____Free ❑ CID(Food Stamp)/FITAP/FDPIR/SSI/Medicaid Eligible _____Reduced _____Above/ Paid

Extended Categorical Eligibility Validation Attached ____YES ____NO

Determining Official's Signature: _____ Date: _____

Determining Officials should be aware that " Household" is defined as a group of related or nonrelated people living together as one economic unit .

The Determining Official must:

✓**Enter the total gross income from all sources** , the income frequency, and the household size. Then determine the eligibility category of the participant based on the Standards of Eligibility form, CACFP 108.

✓**Convert multiple income data** to annual income using the Annual Income Conversions provided in this section.

✓**Decide the eligibility determination** based on the total income frequency or total annual household Income and household size.

WHAT TO DO IF...

What Do I Do If a Parent Marks NO Income?

Ask if there is any supplemental income.

What Do I Do If the Parent Refuses to Sign?

Write on the form "Parent Refused" and the child will be classified as **above.**

POINTS TO REMEMBER:

- One form per enrolled person at your center.
- The forms change each year.
- All parts of the form must be completed.
- The forms must be signed and dated by the designated official.
- The forms are to be completed by the parent.
- Do not count anyone on your Meal Count Attendance Form without one.

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