



STATE OF MAINE
DEPARTMENT OF EDUCATION
23 STATE HOUSE STATION
AUGUSTA, ME 04333-0023

JANET T. MILLS
GOVERNOR

A. PENDER MAKIN
COMMISSIONER

TIER II - Family Child Care Providers
July 1, 2025 to June 30, 2026

Dear Parent:

The Day Care Home in which you are enrolling your child participates in the U.S. Department of Agriculture's Child and Adult Care Food Program. This means your Child Care Provider must serve meals and snacks to your child that meet or exceed the nutritional requirements set forth by the U.S. Government. In return for meeting these requirements, the Provider receives payment from the USDA based on the income levels of the families being served.

You are not required to complete this form, but if you choose to do so, your provider may receive a higher reimbursement for the meals served to your child. If you do complete the form, you have the option of returning it directly to your provider or to the provider's sponsor. If you would like to submit your form directly to the sponsor, return the completed form to:

Sponsor Name: _____

Address: _____

Phone Number: _____

_____ Initial here if you consent to allowing your provider, _____,
(Provider's Full Name)

to collect your form and submit it to the sponsor. Your provider will not review your form.

Please do not return the completed form to the Department of Education.

Instructions for attached application:

1. Enter the name and age of the child for whom you are making application.
2. If the child for whom you are making application is a member of a household that receives SNAP (Supplemental Nutrition Assistance Program - formerly known as Food Stamps), TANF (Temporary Assistance for Needy Families), or benefits under the Food Distribution Program on Indian Reservations (FDPIR), you may give the SNAP, TANF, or FDPIR case number in "Part I" and then skip to instruction # 6.
3. Include the name of each person living in the "household." A "household" is any group of persons who live together and share living expenses. These persons may or may not all be related to each other.
4. The last four (4) digits of the Social Security number of the household member or guardian who signs the application. If this person does not have a Social Security Number, the word "NONE" must be entered in the allotted space.
5. List the total income before deductions, from all sources, for all persons living in the household

6. The signature, address, and telephone number of the person completing the application. The date the form was signed must also be included.

A form will not be considered “complete” unless the applicable information listed above is provided. The person who signs the form must understand that if the household income section of the form is left blank, that person is certifying that the household has zero income. The CACFP sponsor will then consider your child to be in that category of eligibility which qualifies the provider to receive the highest level of payment for the meals and supplements your child will receive.

The following chart shows the upper income level for the ‘Tier I’ category for the period **July 1, 2025, to June 30, 2026**. If the total income for your household size is equal to or less than the amount shown, the provider serving your child will be able to receive the Tier I, or highest, level of reimbursement for meals or supplements served to your child.

Eligibility Scale for “Reduced-Price” Meals

Family Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	28,953	2,413	1,207	1,114	557
2	39,128	3,261	1,631	1,505	753
3	49,303	4,109	2,055	1,897	949
4	59,478	4,957	2,479	2,288	1,144
5	69,653	5,805	2,903	2,679	1,340
6	79,828	6,653	3,327	3,071	1,536
7	90,003	7,501	3,751	3,462	1,731
8	100,178	8,349	4,175	3,853	1,927
Each Additional Family Member	10,175	848	424	392	196

If a member of the household becomes unemployed, your child may become eligible for ‘Tier I’ meals during the period of unemployment, provided the loss of income causes the household income to fall within the eligibility guidelines.

If you are making application for a Foster Child, please indicate this on the application.

Thank you.

Sincerely,

CACFP Staff

PROVIDER'S NAME (*Not the Business Name*): _____

**APPLICATION FOR TIER 1 RATE MEALS
IN TIER II DAY CARE HOMES**

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

CHILD FOR WHOM APPLICATION IS BEING MADE: Name: _____ Age: _____

NOTE:

If you are applying for CACFP benefits on behalf of a Foster Child, please check this box: ☐

PART I:

Households Receiving SNAP, TANF or FDPIR Benefits:

If you are now receiving SNAP, TANF, or FDPIR benefits, and if the above named child is included in the grant, you may give your SNAP, TANF, or FDPIR case number on the allotted line. **DO NOT COMPLETE Part II, skip to Part III. Part III must include** the printed name and signature of the adult who completed this application and the date the application was completed.

- (a) ☐ YES: This household currently receives SNAP, TANF, or FDPIR for the above named child.
- (b) SNAP ID # _____ (not EBT)
- (c) TANF ID # _____
- (d) FDPIR ID # _____

NOTE # 1:

If you do not receive SNAP, TANF, or FDPIR benefits for the above named child, or if you fail to give your case number, you must complete Part II and Part III in order for your child to qualify for "Tier 1" rate meals.

PART II:

All Other Households:

- (a) Household Members: List the names of all persons living in your household. Be sure to include yourself and the child listed above.
- (b) Social Security Number: Sections 9 and 17 of the National School Lunch Act require that, unless your child's Food Stamp, TANF, or FDPIR ID number is provided, you must include the last four (4) digits of the Social Security number of the Adult household member or guardian who signs the application. If that person does not have a Social Security Number, that person must enter the word "NONE" in the allotted space. Provision of a Social Security Number is not mandatory, but if the last four (4) digits of the Social Security Number are not given, or if the word "NONE" is not entered in the allotted space, the application cannot be approved.
- (c) Income: List ALL income from ALL sources received last month on the same line as the name of the person who received it. Income must be GROSS, that is, it must be the amount received BEFORE DEDUCTIONS for taxes, Social Security, dues, insurance, etc. List each income amount under the correct column.

LIST ALL HOUSEHOLD MEMBERS:

Name of Household Member	Age	Monthly Gross Wages or Net Self- Employment	Monthly TANF, Alimony, Welfare, Child Support	Monthly Pensions, SSI, Social Security, Workers Comp,

				Insurance & Retirement
1.				
2.				
3.				
4.				
5.				
6.				
(Note: Weekly Income x 4.333 weeks; Bi-weekly Income x 2.15 weeks)				
TOTAL MONTHLY HOUSEHOLD INCOME:				

PART III:

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that all income is reported. I understand this information is being given in connection with the receipt of Federal Funds and Program Officials may verify the information on the application and that deliberate misrepresentation of any of the information on this application may subject me to prosecution under applicable State and Federal Criminal Statutes.

SIGNATURE:

(Name of Adult)	(Last 4 digits of SS#)	(Signature of Adult)	(Date)
(Household Address of Adult)		(Home Phone)	(Work Phone)

☐ I do not have a social security number.

THIS PORTION MUST BE COMPLETED BY THE DAY CARE HOME SPONSOR:

Signature: _____ Date: _____

Child's Eligibility Category (circle one): Tier I Tier II

Federal 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 Complaint Form* which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

(1) mail:

U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or

(2) fax:

(833) 256-1665 or (202) 690-7442; or

(3) email:

program.intake@usda.gov

This institution is an equal opportunity provider.