



## CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)

### Part 1. All Household Members

Name of Enrolled Adult(s): (List name under Names of Adult Participants)			
<b>Names of Adult Participants</b> (First, Middle Initial, Last)		CHECK IF NO INCOME	

**Part 2. Benefits:** If any member of your household received [State SNAP], [FDPIR], [State SSI] or [Medicaid], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME: \_\_\_\_\_ CASE NUMBER: \_\_\_\_\_

TYPE OF BENEFIT (CHECK ONE):     SNAP     FDPIR     SSI     Medicaid

### Part 3. Total Household Gross Income—You must tell us how much and how often

A. Name (List <b>only</b> the participant(s), spouse and dependent children of participant(s)) <i>(Example)</i> <i>Jane Smith</i>	B. Gross income and how often it was received			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	\$200/weekly	\$150/twice a month	\$100/monthly	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____

### Part 4. Signature and Last Four Digits of Social Security Number

An adult household member must sign this form. **If Part 3 is completed, 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.** (See Statement on the back of this page.)

*I certify that all information on this form is true and that all income is reported. I understand that the center or day care home 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: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Last four digits of Social Security Number:  \* \* \* - \* \* \* - \_\_\_\_\_  I do not have a Social Security Number

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

Mark one ethnic identity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	Mark one or more racial identities: <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander
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**Don't fill out this part. This is 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: \_\_\_\_\_ Week, \_\_\_\_\_ Every 2 Weeks, \_\_\_\_\_ Twice A Month, \_\_\_\_\_ Month, \_\_\_\_\_ Year Household size: \_\_\_\_\_

Categorical Eligibility: \_\_\_\_\_ Date Withdrawn: \_\_\_\_\_ Eligibility: Free \_\_\_\_\_ Reduced \_\_\_\_\_ Paid/Denied \_\_\_\_\_

Reason: \_\_\_\_\_

Determining Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Household size	Yearly- Free	Yearly- Reduced-Price
1	\$ 0 – \$16,237	\$ 16,238- \$23,107
2	\$ 0 – \$21,983	\$ 21,984- \$31,284
3	\$ 0 – \$27,729	\$ 27,730- \$39,461
4	\$ 0 – \$33,475	\$ 33,476- \$47,638
5	\$ 0 – \$39,221	\$ 39,222- \$55,815
6	\$ 0 – \$44,967	\$ 44,968 - \$63,992
7	\$ 0 – \$50,713	\$ 50,714- \$72,169
8	\$ 0 – \$56,459	\$ 56,460 - \$80,346
Each additional person:	+ 5, 746	+ 8,177

**The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.**

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 the participant 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 list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier 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 the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

**Non-discrimination Statement:** “The U.S. Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or if all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at [program.intake@usda.gov](mailto:program.intake@usda.gov).

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (in Spanish). USDA

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