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)

Names of Adult Participants (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 **only** the participant(s), spouse and dependent children of participant(s))	**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
(Example) Jane Smith	$ 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:	Mark one or more racial identities:	
❑ Hispanic ro latino ❑ Not Hispanic or Latino	❑ Asian ❑ White ❑ Black or African American	❑ American Indian or Alaska Native ❑ Native Hawaian 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 x26, Twice a Month x24, Monthly x12

❑ ❑ ❑ ❑ ❑

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 – $16,588	$ 16,589- $23,606
2	$ 0 – $22,412	$ 22,413- $31,894
3	$ 0 – $28,236	$ 28,237- $40,182
4	$ 0 – $34,060	$ 34,061- $48,470
5	$ 0 – $39,884	$ 39,885- $56,758
6	$ 0 – $45,708	$ 45,709 - $65,046
7	$ 0 – $51,532	$ 51,533- $73,334
8	$ 0 – $57,356	$ 57,357 - $81,622
Each additional person:	+ 5,824	+ 8,288

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, 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.

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 is an equal opportunity provider and employer."