Instructions for completion

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) Please list everyone who lives in the home.	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

If one of these is selected, skip part 3.

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	$____/________
Client Name	$____/________	$____/________	$____/________	$____/________
Spouse Name	$____/________	$____/________	$____/________	$____/________
Dependent Children	$____/________	$____/________	$____/________	$____/________
	$____/________	$____/________	$____/________	$____/________

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. must be filled out by person completing the form:

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 or Latino ❑ Not Hispanic or Latino	❑ Asian ❑ White ❑ Black or African American	❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander