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

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)

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-$18,954	$18,855-$26,973
2	$0-$25,636	$25,637-$36,482
3	$0-$32,318	$32,319-$45,991
4	$0-$39,000	$39,001-$55,500
5	$0-$45,682	$45,683-$65,009
6	$0-$52,364	$52,365-$74,518
7	$0-$59,046	$59,047-$84,027
8	$0-$65,728	$65,729-$93,536
Each additional person:	+$6,682	+$9,509

The participant in the daycare facility may qualify for free or reduced-price meals if their 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: 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 compliant, 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/ad-3027.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 the 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.