CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care) FY: _____

Part 1. Name of Adult Participant(s)- (First and Last; use additional sheets if necessary)

Part 2. Benefits: If the participant or anyone in the household receives SNAP (food stamps) or SSI or Medicaid, provide a case number below. **If these benefits are not received, skip to part 3.**

CASE NUMBER: _____

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

A. Name – First and Last (List name of the participant's spouse and any dependent children)	B. Gross Income and how often it was received *For example $200/week or $150/twice a month* 1.Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. Other Income	5. Check if no income
	$_____/_____	$_____/_____	$_____/_____	$_____/____	☐
	$_____/_____	$_____/_____	$_____/_____	$_____/____	☐
	$_____/_____	$_____/_____	$_____/_____	$_____/____	☐
	$_____/_____	$_____/_____	$_____/_____	$_____/____	☐
	$_____/_____	$_____/_____	$_____/_____	$_____/____	☐

Part 4. Signature and Last Four Digits of Social Security Number (Adult must sign) – You or 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 Privacy Act Statement below*)

I certify that all information on this form is true and that all income is reported. I understand that the center will get Federal funds based on the information I give; that center officials may verify the information on the form; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Sign here: _____ Print name: _____ Date: _____

Last four digits of Social Security Number: X X X – X X – ____ ____ ____ _____ ❑ I do not have a Social Security Number

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

*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 apply on behalf of a foster child or 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.

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

Mark one ethnic identity:	Mark one or more racial identities:	
❑ Hispanic or Latino	❑ Asian	❑ American Indian or Alaska Native
❑ Not Hispanic or Latino	❑ White	❑ Native Hawaiian or Other Pacific Islander
	❑ Black or African American	❑ Other

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

Household size: _____ Total Annual Income: _____ SNAP/SSI/Medicaid Household: _____

Determination for: Free Meals _____ Reduced-Price Meals: _____ Paid Meals _____

Determining Official's Signature: _____ Date: _____

ADULT CARE FOOD PROGRAM
(Household Letter for Non-Pricing Programs in Adult Care Centers)

To: The Household Member

From: The Official Representative of the Sponsor_____

(Name of Center or Organization) _____

Please help us to comply with the requirements of the USDA Child and Adult Care Food Program (CACFP). The information requested on this Income Eligibility Form (IEF) is necessary in order for us to receive reimbursement for meals served to participants in our center. The form will be placed in our files and will be treated as confidential information.

INSTRUCTIONS FOR COMPLETING THE INCOME ELIGIBILITY FORM

PART 1 - ENROLLED Participant(s) - Print the names of all enrolled adults (use additional sheets if necessary) in the household.

PART 2 - Benefits: If you or anyone in your household receives supplemental nutrition assistance program (SNAP; formerly known as FOOD STAMPS) supplemental security income (SSI) or Medicaid.

1. Complete this Part and Part 4.
2. List a current SNAP case number, SSI identification number, or Medicaid number.
3. Sign the form in PART 4. **SKIP PART 3**

PART 3 - HOUSEHOLD INCOME

1. Write the name of the adult participant's spouse and any dependent(s).
2. Write the amount of any income each household member receives on the same line as their name, how often the person receives it, such as weekly, every two weeks, twice a month or monthly, and where it comes from. Income is all money before taxes or anything else is taken out. If any amount last month was more or less than usual, write that person's usual monthly income. If any of the household members receive no income, check the box in the last column.
3. Complete PART 4.

The participant in the day care facility may qualify for Free or Reduced priced meals if your household income falls within the limits on the current Evaluation Sheet for Income Eligibility which **is posted annually on the website**. The amounts are for **FREE and REDUCED-PRICE MEALS.**

PART 4 - SIGNATURE AND SOCIAL SECURITY NUMBER: ALL HOUSEHOLDS COMPLETE THIS PART

1. An adult household member must sign the form.
2. The form must have the last four digits of the social security number of the adult who signs **if part 3 was completed**. If the adult does not have a social security number, select the box indicating this.

PART 5 - ETHNIC AND RACIAL IDENTITY: This information is requested solely for the purpose of determining compliance with Federal civil rights laws and will not affect your approval. If you do not mark this, a visual identification will be made and recorded.

Confidentiality: The information on the application is used only to determine eligibility for free or reduced-price meals and to verify eligibility.

The information reported on this form is valid for one year. You should, however, notify us if you or someone in your household becomes unemployed and the loss of income during the period of unemployment causes your household income to be within the eligibility standards.

USDA Non-Discrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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;

(2) Fax: (202) 690-7442; or

(3) Email: program.intake@usda.gov

"This institution is an equal opportunity provider".