

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)

Part 1. All Household Mei								
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 mentange and case number of NAME:			ts. If no one recei		benefits, skip			
TYPE OF BENEFIT (CHEC	K ONE):	□ SNAP	☐ FDPIR	SSI	☐ Medicaid			
Part 3. Total Household 0	ross Income—Yo	u must tell u	s how much and	how often				
A. Name (List only the participant(s), spouse	B. Gross income	and how ofte	en it was received					
and dependent children of participant(s))	Earnings from w before deductions		2. Welfare, child support, alimony		3. Pensions, retirement, Social Security, SSI, VA benefits		4. All Other Income	
(Example) Jane Smith	\$ 200/weekly	\$ <u>150</u>	/ twice a month_	\$ <u>100/m</u>	onthly	\$	1	
	\$ <u>/</u>	\$	1	\$	1	\$	1	
	\$/	\$	1	\$	1	\$	1	
	\$ /	\$	1	\$	1	\$		
	\$ /	\$	1	\$	1	\$		
Part 4. Signature and Las	t Four Digits of Sc	cial Security	/ Number	_	<u> </u>	· -		
An adult household memb last four digits of his or his or his statement on the back of the last function of the last function will get Federal funds be understand that if I purpose be prosecuted.	ner Social Security this page.) on this form is true sed on the informa tely give false inform	Number or e, and that all ation I give. mation, the p	mark the "I do no income is reported I understand that participant receiving	t have a S d. I unders CACFP o g meals m	tand that the cer officials may ver ay lose the mea	Numb nter or ify the	er" box. (See daycare home information. I	
Sign here: Print name:								
Date:			-					
Address: Phone Number: Zip Code: Zip Zip Code: Zip								
City: Zip Code:								
Last four digits of Social Se	curity Number: ^^^-	.^^=	u	i do not na	ive a Social Sect	urity in	umper	
Part 5. Participant's ethnic and racial identities (optional)								
Mark one ethnic identity:	Mark one or more	racial identiti	es:					
☐ Hispanic or Latino☐ Not Hispanic or Latino	☐ Asian ☐ White ☐ Black or African Am	erican	☐ American Indian or Alaska Native☐ 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 x26, Twice a Month x24, Monthly x12						
Total income: Per:						
Categorical Eligibility: Free Reduced Paid Denied Denied Date Withdrawn:						
Reason:						
Determining Official's Signature: Date:						

Household size	Yearly- Free	Yearly- Reduced-Price		
1	\$0 - \$20,345	\$20,346 - \$28,953		
2	\$0 - \$27,495	\$27,496 - \$39,128		
3	\$0 - \$34,645	\$34,646 - \$49,303		
4	\$0 - \$41,795	\$41,796 - \$59,478		
5	\$0 - \$48,945	\$48,946 - \$69,653		
6	\$0 - \$56,095	\$56,096 - \$79,828		
7	\$0 - \$63,245	\$63,246 - \$90,003		
8	\$0 - \$70,395	\$70,396 - \$100,178		
Each additional person:	+\$7,150	+\$10,175		

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 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 complaint, 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.