# CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)

**Part 1. All Household Members**

**Name of Enrolled Adult(s):**

| **Names of Adult Participants**<br>(First, Middle Initial, Last) | CHECK<br>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: _____

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

| **A. Name**<br>(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)*<br>*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 or Latino | ❑ Asian | ❑ American Indian or Alaska Native |
| ❑ Not Hispanic or Latino | ❑ White | ❑ Native Hawaiian or Other Pacific Islander |
| | ❑ Black or African American | |

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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 x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason: _____

Temporary: Free_____ Reduced_____ Time Period: _____(expires after _____ days)

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date:_____

**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.**

| Household size | Yearly |
|---|---|
| 1 | $ 27,861 |
| 2 | 37,814 |
| 3 | 47,767 |
| 4 | 57,720 |
| 5 | 67,673 |
| 6 | 77,626 |
| 7 | 87,579 |
| 8 | 97,532 |
| Each additional person: | + $ 9,953 |

USDA Nondiscrimination Statement | Food and Nutrition Service

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/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.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 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.