CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)

Name of Enrolled Adult(s): CHECK Names of Adult Participants CHECK (First, Middle Initial, Last) 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 B. Gross income and how often it was received. 1. Earnings from work 2. Welfare, child support, alimony 3. Pensions, retirement, Social Security, SSI, VA	David All Llaurach and Marshan				
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A. Name B. Gross income and how often it was received. 1. Earnings from work late of dependent children of participant(s). 1. Earnings from work lations and how often it was received. 3. Pensions, retirement, social Security, SSI, VA benefits 4. All Other Income social Security, SSI, VA benefits (Example) \$200/weekly \$150/twice a month \$100/monthly \$_/	name and case number for the p	person who receives b	penefits. If no one receiv CASE NUMBE	es these benefits, skip to ER:	o part 3.
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(List only the participant(s), spouse and dependent children of participant(s)) 1. Earnings from work before deductions 2. Welfare, child support, alimony 3. Pensions, retirement, Social Security, SSI, VA 4. All Other Income Social Security, SSI, VA (Example) Jane Smith \$200/weekly \$150/twice a month \$100/monthly \$/		B. Gross income and	I how often it was received	l.	
Jane Smith \$200/weekly \$150/twice a month \$100/monthly \$/	(List only the participant(s), spouse and dependent children of participant(s))			Social Security, SSI, VA	4. All Other Income
Survey		\$200/weekly	\$150/twice a month	\$100/monthly	\$ /
\$					
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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:					
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: Print name: Other Number: Zip Code: City: State: Zip Code: 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 Native Hawaiian or Other Pacific Islander		\$/	\$/	\$/	\$/
Date: Address: Phone Number: City: State: Zip Code: Last four digits of Social Security Number: ************************************	An adult household member mu four digits of his or her Social Statement on the back of this pa I certify that all information on th will get Federal funds based on understand that if I purposely give	st sign this form. If Pa Security Number or age.) <i>is form is true and tha</i> <i>the information I give.</i>	art 3 is completed, the ad mark the "I do not have at all income is reported. I I understand that CACFF	e a Social Security Numb understand that the cente officials may verify the in	per" box. (See r or day care home formation. I
Date: Address: Phone Number: City: State: Zip Code: Last four digits of Social Security Number: ************************************	Sign bere:		Print name [.]		
Address: Phone Number: City: State: Last four digits of Social Security Number: *****-*******************************					
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🗖 Black or African American	•				
		Black or African Ame	erican		

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 x 26, Twice A Month x 24, Monthly x 12					
Total Income: Per: 🗖 Week, 📮 Every	2 Weeks, D Twice A Month, D Month, D Year Household size:				
Categorical Eligibility: Date Withdrawn:	Eligibility: Free Reduced Denied Tier I Tier I				
Reason:					
Temporary: Free Reduced Time Period:	days)				
Determining Official's Signature:	Date:				
Confirming Official's Signature:	Date:				
Follow-up Official's Signature:	Date:				
Determining Official's Signature: Confirming Official's Signature:	Date: 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.