



## 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
	<input type="checkbox"/>
	<input type="checkbox"/>
	<input type="checkbox"/>

**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 <b>only</b> 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
<i>(Example)</i> Jane Smith	\$ <u>200/weekly</u>	\$ <u>150/ twice a month</u>	\$ <u>100/monthly</u>	\$ <u>  </u> / <u>  </u>
	\$ <u>  </u> / <u>  </u>	\$ <u>  </u> / <u>  </u>	\$ <u>  </u> / <u>  </u>	\$ <u>  </u> / <u>  </u>
	\$ <u>  </u> / <u>  </u>	\$ <u>  </u> / <u>  </u>	\$ <u>  </u> / <u>  </u>	\$ <u>  </u> / <u>  </u>
	\$ <u>  </u> / <u>  </u>	\$ <u>  </u> / <u>  </u>	\$ <u>  </u> / <u>  </u>	\$ <u>  </u> / <u>  </u>
	\$ <u>  </u> / <u>  </u>	\$ <u>  </u> / <u>  </u>	\$ <u>  </u> / <u>  </u>	\$ <u>  </u> / <u>  </u>

### 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:	
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> 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-\$19,578	\$19,579-\$27,861
2	\$0-\$26,572	\$26,573-\$37,814
3	\$0-\$33,566	\$33,567-\$47,767
4	\$0-\$40,560	\$40,561-\$57,720
5	\$0-\$47,554	\$47,555-\$67,673
6	\$0-\$54,548	\$54,549-\$77,626
7	\$0-\$61,542	\$61,543-\$87,579
8	\$0-\$68,536	\$68,537-\$97,532
Each additional person:	+\$6,994	+\$9,953

**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, audiotope, 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](mailto:Program.Intake@usda.gov)

**This institution is an equal opportunity provider.**