

**CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)**

Facility Name \_\_\_\_\_

**Part 1. All Household Members**

|   |               |                    |
|---|---------------|--------------------|
| <b>Name of Enrolled Adult(s):</b>                                   |               |                    |
| <b>Names of Adult Participants</b><br>(First, Middle Initial, Last) | Date of Birth | CHECK 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: \_\_\_\_\_  
 A Case number is not the number found on the SNAP EBT card.

**Part 3. Total Household Gross Income—You must tell us how much and how often: weekly, monthly, yearly**

|  |  |                                    |  |                     |
|--|--|------------------------------------|--|---------------------|
| <b>A. Name</b><br>(List <b>only</b> the participant(s), spouse and dependent children of participant(s)) | <b>B. Gross income and how often it was received</b> |                                    |  |                     |
|  | 1. Earnings from work before deductions              | 2. Welfare, child support, alimony | 3. Pensions, retirement, Social Security, SSI, VA benefits | 4. All Other Income |
|  | \$ ____ / ____                                       | \$ ____ / ____                     | \$ ____ / ____   | \$ ____ / ____      |
|  | \$ ____ / ____                                       | \$ ____ / ____                     | \$ ____ / ____   | \$ ____ / ____      |
|  | \$ ____ / ____                                       | \$ ____ / ____                     | \$ ____ / ____   | \$ ____ / ____      |
|  | \$ ____ / ____                                       | \$ ____ / ____                     | \$ ____ / ____   | \$ ____ / ____      |
|  | \$ ____ / ____                                       | \$ ____ / ____                     | \$ ____ / ____   | \$ ____ / ____      |

**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: \_\_\_\_\_ (form valid for one (1) year from this date)  
 Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Last four digits of Social Security Number:             -       - \_\_\_\_\_ **O I do not have a Social Security Number**  
(required)

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

|  |   |   |
|--|---|---|
| Mark one ethnic identity:                    | Mark one or more racial identities:             |   |
| <input type="radio"/> Hispanic or Latino     | <input type="radio"/> Asian                     | <input type="radio"/> American Indian or Alaska Native          |
| <input type="radio"/> Not Hispanic or Latino | <input type="radio"/> White                     | <input type="radio"/> Native Hawaiian or Other Pacific Islander |
|  | <input type="radio"/> Black or African American |   |

**CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)**

Facility Name \_\_\_\_\_ Page 2

**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: Q Week, Q Every 2 Weeks, Q Twice A Month, Q Month, Q 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: \_\_\_\_\_

If applicable, Sponsor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Refer to the current USDA Income Eligibility Guidelines for making determinations of 'Free', 'Reduced', or 'Paid'.**

HNP Representative Initials/Date  
(for use during CACFP Reviews)

\_\_\_\_\_

\_\_\_\_\_

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:** This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider.