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| Part 1. All Household Members  |
| **Name of Enrolled Adult(s):** |
| **Names of Adult Participants** (First, Middle Initial, Last) | CHECK IF NO INCOME |
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|  |  |
| 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**(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) 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❑ Not Hispanic or Latino | * Asian ❑ American Indian or Alaska Native
* 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 12Total 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Household size | Yearly |
| 1 | $ 23,828 |
| 2 | 32,227 |
| 3 | 40,626 |
| 4 | 49,025 |
| 5 | 57,424 |
| 6 | 65,823 |
| 7 | 74,222 |
| 8 | 82,621 |
| Each additional person: | + $ 8,399 |

**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.**

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To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](http://www.ocio.usda.gov/sites/default/files/docs/2012/Complain_combined_6_8_12.pdf), (AD-3027) found online at: <http://www.ascr.usda.gov/complaint_filing_cust.html>, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.