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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 | $ 26,973 |
| 2 | 36,482 |
| 3 | 45,991 |
| 4 | 55,500 |
| 5 | 65,009 |
| 6 | 74,518 |
| 7 | 84,027 |
| 8 | 93,536 |
| Each additional person: | + $ 9,509 |

**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.**

[USDA Nondiscrimination Statement | Food and Nutrition Service](https://urldefense.com/v3/__https%3A/www.fns.usda.gov/civil-rights/usda-nondiscrimination-statement-other-fns-programs__;!!Oai6dtTQULp8Sw!QkRyajDmRUkECXL6LrycazcGSyIJtyEfNq-0vEBT1notxs2ftGSnWaDgqQo2P9Vci9DsU23UmDMWpcnfTeJdTzIL5gZyh1_L4rZ0$)

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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](https://urldefense.com/v3/__https%3A/www.usda.gov/sites/default/files/documents/USDA-OASCR%2A20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf__;JQ!!Oai6dtTQULp8Sw!QkRyajDmRUkECXL6LrycazcGSyIJtyEfNq-0vEBT1notxs2ftGSnWaDgqQo2P9Vci9DsU23UmDMWpcnfTeJdTzIL5gZyh1Ofy1jK$), 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

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