CACFP Meal Benefit Income Eligibility Letter for Adult Day Centers

Dear Participant/Guardian:

The Child and Adult Care Food Program, CACFP, offers meal reimbursements to adult day care centers which provide structured comprehensive services to nonresidential adults who are functionally impaired, or age 60 and older. By completing the attached Meal Benefit Income Eligibility Form, the centers will be able to receive reimbursement, which is based on the number of enrolled participants that are eligible for free or reduced-price meals. A household with income less than or equal to the income chart for reduced-priced meals below is eligible for free or reduced-priced meals. In order for the center to be considered eligible for free and reduced-price meals based on income, an application must contain complete documentation of eligibility information including total current household income, names of all household members, the social security numbers of the household member who signs the application, or the word "None," and the date and signature of the adult household member who completed the application. This information will be kept confidential and only available to staff directly connected with administering the CACFP. The participant in the adult day care center may qualify for free or reduced-price meals if your household income falls within the limits on this chart:

Household Size:	Annual Income:
1	
2	
3	
4	
5	
6	
7	
8	
Each additional person:	

If an adult participant is a member of a SNAP (formerly food stamps) or FDPIR household or is a SSI or Medicaid participant, the adult participant is automatically eligible to receive free Program meal benefits, subject to the completion of the application. Participants having family members who become unemployed are eligible for free or reduced-price meals during the period of unemployment; provided that the loss of income causes the family income during the period of unemployment to be eligible for those meals.

Privacy Act Statement (how your information is used): The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to provide 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 (what to do if you believe you have been treated unfairly):

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:

mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
fax: (202) 690-7442; or
email: program.intake@usda.gov.

This institution is an equal opportunity provider

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

Part 1. All Household Members - Name of Enrolled Adult(s):

Names of Adult Participants (First, Middle Initial, Last)	DATE OF BIRTH (MM/DD/YY)	CHECK IF NO INCOME

Part 2. Benefits: If any member of your household received SNAP, FDPIR, State SSI or AHCCCS, 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 (income before any deductions) —You must tell us how much and how often

A. Name (List **all** people living in the household, including spouse and/or children)	**B. Gross income and how often it was received: identify weekly, every other week, monthly, yearly…**			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	how much/how often	**how much/how often**	**how much/how often**	**how much/how often**
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Part 4. Signature and Last Four Digits of Social Security Number: A responsible adult 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 write the word None if the signer doesn't have a Social Security Number.** (See Privacy Act 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 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: _*_*_*-_*_*-_____If no SSN, write the word "None." _____

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	❑ White	❑ Native Hawaiian or Other Pacific Islander
	❑ Black or African American	

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, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical/Income Eligibility: Free_____Reduced_____Paid_____

Determining Official's Signature:_____Date: _____

Confirming Official's Signature:_____Date: _____

Parte 1. Todos los miembros de la unidad familiar - Nombres de los adultos inscritos:

Nombres de los participantes adultos (primer nombre, inicial del segundo nombre, y apellido)	Fecha de Nacimiento	MARQUE SI NO TIENE INGRESOS
		❑
		❑
		❑

Parte 2. Beneficios: Si cualquier miembro de su unidad familiar recibe beneficios de los programas SNAP, FDPIR, SSI, AHCCCS, anote el nombre y el número de caso de la persona que recibe los beneficios. **Si nadie recibe estos beneficios, pase directamente a la Parte 3.**

NOMBRE:_____ NÚMERO DE CASO: _____

Parte 3. Ingresos totales brutos de la unidad familiar—Tiene que decirnos cuánto reciben en ingresos y con qué frecuencia.

A. Nombre (Liste **únicamente** a los participantes, cónyuges e hijos dependientes de los participantes)	**B. Ingresos brutos y con qué frecuencia se recibieron**			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Ejemplo) Ana Cabrera	$200/semanal	$150/dos veces al mes	$100/mensual	$ /
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$

Parte 4. Firma y últimos cuatro dígitos del número de Seguro Social (adulto tiene que firmar)
Uno de los miembros adultos de la unidad familiar tiene que firmar este formulario. **Si se llena la Parte 3, el adulto que firme el formulario también tiene que anotar los últimos cuatro dígitos de su número de Seguro Social o bien marcar la casilla que dice "No tengo número de Seguro Social"**. (Vea la Declaración al dorso de esta página.)

Certifico que toda la información que indiqué en este formulario es verdadera y que declaré todos los ingresos. Entiendo que el centro u hogar de cuidado diurno recibirá fondos federales con base en la información que yo declare. Entiendo que los funcionarios del programa CACFP pueden verificar la información. Entiendo que si doy información falsa a propósito, el participante que recibe las comidas podría perder sus beneficios de comidas y a mí se me podría procesar judicialmente.

Firme aquí: _____ Nombre en letra de imprenta: _____

Fecha: _____

Dirección: _____ Número de teléfono: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Últimos cuatro dígitos del número de Seguro Social: * * * - * * - _____ ❑ No tengo número de Seguro Social

Parte 5. Identidades étnicas y raciales del participante (opcional)

Marque una identidad étnica:	Marque una o más identidades raciales:
❑ **Hispano o Latino** ❑ **Ni Hispano o Latino**	❑ Asiático ❑ Blanco ❑ Negro o Afroamericano ❑ Amerindio o Nativo de Alaska ❑ Nativo de Hawaii o otra isla del Pacífico

Favor de no llenar. Es solo para uso oficial.

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, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical/Income Eligibility: Free Reduced_____Paid_____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____