

CACFP Adult Day Care



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)

Part 1. All Household Members

Name of Enrolled Adult(s): _____

Names of Household Members (including enrolled adult(s))
(First, Middle Initial, Last)

CHECK
IF NO INCOME

Part 2. Benefits: If any member of your household receives SNAP, TANF, FDPIR, 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 participant(s), spouse and dependent children of participant(s) with income) <i>(Example)</i> <i>Jane Smith</i>	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
	\$200/weekly _____	\$150/twice a month _____	\$100/monthly _____	\$200/bi-monthly _____
	\$____/____	\$____/____	\$____/____	\$____/____
	\$____/____	\$____/____	\$____/____	\$____/____
	\$____/____	\$____/____	\$____/____	\$____/____
	\$____/____	\$____/____	\$____/____	\$____/____

Part 4. Signature and Last Four Digits of Social Security Number (Adult must sign)

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 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: _*_*_*_*_*_*_*_ _____ 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"/> Asian	<input type="checkbox"/> American Indian or Alaska Native
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
	<input type="checkbox"/> 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 12

Total 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: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____