Dear Participant or Adult Family Member or Guardian:

Our center has been approved for participation in the Child and Adult Care Food Program (CACFP). The CACFP reimburses the center for the partial cost of meals. Participation in the CACFP enables us to keep our fees lower as well as serve nutritious meals to participants in our program.

***The participant/adult family member/guardian must complete Parts 1 and 4 and one of the following options**: Part 2, Part 3A or Part 3B, to determine the amount of CACFP funds the center will be eligible to receive. This form will be placed in our files and treated as confidential information.*
Note: no white out or erasure should be used. If there is an error cross through, correct, and initial.

Part 1 PARTICIPANT:
- PARTICIPANT'S NAME: List the first and last name of participant.
- DATE OF BIRTH: List participant's date of birth.
- ETHNICITY/RACE: Using the codes provided, enter the codes for ethnicity and race.

Part 2 FOR A HOUSEHOLD RECEIVING BENEFITS FROM THE FOOD ASSISTANCE PROGRAM (FA), TEMPORARY ASSISTANCE FOR FAMILIES (TAF), FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS (FDPIR), SUPPLEMENTAL SECURITY INCOME (SSI) OR MEDICAID:
- Complete Parts 1, 2 and 4 on the reverse side.
- Provide the name and case number for the program from which benefits are received.

Part 3A FOR A HOUSEHOLD EXCEEDING THE INCOME GUIDELINES LISTED ON THE CHART BELOW:
- Complete Parts 1, 3A and 4 on the reverse side.

TO CALCULATE ANNUAL INCOME

Weekly Income X 52 ♦ Every 2 Weeks Income X 26 ♦ Twice a Month Income X 24 ♦ Monthly Income X 12

Household Size:	1	2	3	4	5	6	7	Each Additional Family Member
Annual Income:	$28,953	$39,128	$49,303	$59,478	$69,653	$79,828	$90,003	+ $10,175

Part 3B FOR ALL OTHER HOUSEHOLDS:
- Complete Parts 1, 3B and 4 on the reverse side using the additional information below.
- HOUSEHOLD NAMES: Write the names of everyone in the household. Include participant, participant's spouse, and/or any other individuals who reside with the participant and depend on the participant for economic support. Functionally impaired adults living with their parents are considered a "family" separate from their parents.
- GROSS INCOME BEFORE DEDUCTIONS: Write the amount of income each person gets on the same line as their name. Use the appropriate column(s): Earnings from Work, Welfare/Child Support/Alimony, Pensions/Retirement/Social Security or Other Income (see list below). Next to the amount of income write how often the income was received. Income is all money before taxes or anything else is taken out. If a person does not have income, check the box for zero income.
  OTHER INCOME: strike benefits, unemployment compensation, worker's compensation, disability benefits, interest/dividends, cash withdrawn from savings, income from estates/trusts/investments, royalties/annuities/rental income, regular contributions from person not living in the household.
  MILITARY HOUSING BENEFITS: Report off-base housing allowance as income. If the housing is part of the Military Housing Privatization Initiative, do not include as income.
  SELF-EMPLOYMENT: Report income derived from the business venture less operating costs for net income. The loss from the business cannot be deducted from a positive income earned in other employment. The least possible income is zero.
- SOCIAL SECURITY NUMBER: Write the last four (4) digits of the social security number of the participant or adult family member or guardian who signs the forms. If the participant or adult family member or guardian does not have a social security number, check the box. Use of this information is for CACFP use only and is required.

Part 4 SIGNATURE AND CONTACT INFORMATION:
- Sign and date the application. The form must be signed by the participant or an adult family member or guardian.
- Complete the contact information – name, address, telephone number, and employer information.

INCOME ELIGIBILITY FORM FOR ADULT DAY CARE CENTERS
JULY 1, 2025 THROUGH JUNE 30, 2026

Part 1. PARTICIPANT: Complete the participant's name, date of birth, ethnicity and race.

Last Name, First Name	Date of Birth	Ethnicity *	Race *

*Ethnicity (select one): H=Hispanic or Latino or N=Not Hispanic or Latino
*Race (select one or more): W=White, B=Black or African American, I=American Indian or Alaskan Native, A=Asian, or P=Native Hawaiian or other Pacific Islander

Part 2. HOUSEHOLDS RECEIVING BENEFITS FROM THE FOOD ASSISTANCE PROGRAM (FA), TEMPORARY ASSISTANCE FOR FAMILIES (TAF), FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS (FDPIR), SUPPLEMENTAL SECURITY INCOME (SSI), OR MEDICAID: Complete Parts 1, 2 and 4.

Program Name: _____ Case No. _____

Part 3A. HOUSEHOLDS EXCEEDING THE INCOME GUIDELINES: Complete Parts 1, 3A and 4.

If your family income exceeds the income guidelines (listed on reverse side), check this box ❑

Part 3B. ALL OTHER HOUSEHOLDS: If you do not have a FA, TAF, FDPIR, SSI or Medicaid case number, complete Parts 1, 3B and 4.

List the Names of All Household Members not listed in Part 1	GROSS INCOME BEFORE ANY DEDUCTIONS (Net for Self Employed) W=Weekly E2=Every 2 weeks 2M=Twice a month M=Monthly Y=Yearly								Check If ZERO Income
	Earnings from Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		All Other Income		
	How much?	How often?	How much?	How often?	How much?	How often?	How much?	How often?	
(Example) Jane Smith	*$200*	*W*	*$150*	*2M*	*$100*	*M*			
1									❑
2									❑
3									❑
4									❑

Social Security Number of Household Member who signs form:

Last four digits of Social Security Number: XXX – XX - _____ If you do not have a Social Security Number, check this box ❑

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this meal benefit form. 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 Food Assistance Program (FA), Temporary Assistants for Families (TAF) or Food Distribution Program on Indian Reservation (FDPIR) case number for the participant or other (FDPIR) identifier, SSI or Medicaid identification number for the participant receiving meal benefits 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 CACFP.

Part 4. SIGNATURE AND CONTACT INFORMATION:

I certify that all information on this form is true and that all income is reported. I understand that the facility will receive 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 their meal benefits, and I may be prosecuted.

_____ _____
Signature of Participant or Adult Family Member or Guardian Date

Print Name _____ Daytime Telephone _____

Address _____ City/State/Zip _____

Employer(s) _____

FOR CENTER USE ONLY

_____ FA/TAF/FDPIR/SSI/MEDICAID HOUSEHOLD

____ Homeless Documentation from school, emergency shelter, or agency

_____ ANNUAL INCOME: _____ HOUSEHOLD SIZE: _____

HOUSEHOLD CATEGORY: ❒ Free ❒ Reduced Price ❒ Paid

_____
Sponsor's Determining Signature Date

_____
Sponsor's Confirming Signature Date