Meal Application for Adult Day Care Centers
Program Year 2019-2020

Part 1. All Household Members

Name of Enrolled Adult(s):

Names of Adult Participants (First, Middle Initial, Last)	CHECK IF NO INCOME
	☐
	☐
	☐

Part 2. Benefits: If any member of your household received [Mississippi SNAP], [FDPIR], [Mississippi 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 ❑ White ❑ Native Hawaiian or Other Pacific Islander ❑ Black or African American ❑ American Indian or Alaska Native ❑ Other

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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: _____

The participant in the adult day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Household Size	Yearly
1	$ 23,107
2	31,284
3	39,461
4	47,638
5	55,815
6	63,992
7	72,169
8	80,346
Each additional person:	+ 8,177

The Richard B. Russell National School Lunch Act requires the information on this application. 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 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 eligibility information.

INSTRUCTIONS FOR COMPLETING THE CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)

Follow these instructions, if your household gets SNAP, FDPIR, SSI or Medicaid:

Part 1: List only the adult participants' names.
Part 2: List the case number for any household member receiving [State SNAP] or [FDPIR] or [SSI] or [Medicaid] benefits.
Part 3: Skip this part.
Part 4: Sign the form. The last four digits of a Social Security Number are **not** necessary.
Part 5: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, follow these instructions:

Part 1: List only the adult participants' names. For any participant with no income, you must check the "No Income" Box.

Part 2: Skip this part.

Part 3: Follow these instructions to report total household income form this month or last month.

Column A – Name: List the first and last name of the adult participant, his or her spouse and his or her dependent(s) living in your household who share income and expenses.

Column B – Gross Income and How Often it was Received: For each **household member who is the participant, his or her spouse, or a dependent of the participant,** list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.
Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

You must send the information we need, or contact [name] by [date], or our center will no longer receive free or reduced price reimbursement for meals served the adult participant.

Center/Sponsoring Organization: **[Name]**

[Date]

Dear **[Name]**:

We are checking your CACFP Meal Benefit Income Eligibility Form. We must do this to make sure that CACFP benefits only those who are eligible. You must send us information to prove that **[name(s) of participant(s)]** is eligible.

If possible, send copies, not original papers. If you do send originals, they will be sent back to you only if you ask. Do not send your EBT card or any other benefit card that you will need.

1. If you were getting SNAP, FDPIR, SSI or Medicaid when you applied for free or reduced price meals, or at any time since then, send us a copy of one of these:

- SNAP, FDPIR, SSI or Medicaid Certification Notice that shows dates of certification.
- Letter from SNAP that says you have been approved to get SNAP.

2. If you do not get SNAP, FDPIR, SSI or Medicaid: Send this page along with papers that show the amount of money your household gets from each source of income. The papers you send must show the **name** of the person who received the income, the **date** it was received, **how much** was received, and **how often** it was received. **Send information to: [address].**

Acceptable papers include:

Jobs: Paycheck stub or pay envelope that shows the amount and how often pay is received; letter from employer stating gross wages and how often they are paid; or business or farming papers, such as ledger books or tax returns.

Social Security, Pensions, or Retirement: Social Security retirement benefit letter, statement of benefits received, or pension award notice.

Unemployment, Disability, or Worker's Comp: Notice of eligibility from State employment security office, check stub, or letter from Worker's Compensation.

Welfare Payments: Benefit letter from welfare agency.

Child Support or Alimony: Court decree, agreement, or copies of checks received.

Other income (such as rental income): Information that shows the amount of income received, how often it is received, and the date it is received.

No income: A brief note explaining how you provide food, clothing and housing for your household, and when you expect to receive an income.

Military Housing Privatization Initiative: Letter or rental contract showing that your housing is part of the Military Housing Privatization Initiative.

Timeframe of Acceptable Income Documentation: Please submit papers that show your income at the time that you applied for benefits. If you do not have this information, you may submit papers from the time of completing the CACFP Meal Benefit Income Eligibility Form up to the time of verification.

If you have questions or need help, please call **[name]** at **[phone number]**.

Sincerely,

[signature]

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 all adult household members, including the adult day care participant. The social security number is not required when you list a Supplemental Nutrition Assistance Program (SNAP), Food Distribution Program on Indian Reservations (FDPIR) or other FDPIR identifier, SSI or Medicaid case 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.

Non-Discrimination Statement: This explains what to do if you believe you have been treated unfairly. “In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.”

WE HAVE CHECKED YOUR CACFP MEAL BENEFIT
INCOME ELIGIBILITY FORM INFORMATION (Adult Care)

Center/Sponsoring Organization: **[Name]**

[Date:]

Dear **[Name]**:

We checked the information you sent us to prove that **[name(s) of participant]** is eligible for free or reduced price meal benefits at our facility and have decided that:

- ❑ The participant's eligibility has not changed.
- ❑ Starting **[date]**, the participant's eligibility for meal benefits will be changed **from reduced price to free** because the verified income is within the free meal eligibility limits. The participant will receive meals at no cost.
- ❑ Starting **[date]**, the participant's eligibility for meals will be changed **from free to reduced price** because the verified income is over the limit.
- ❑ Starting **[date]**, **the participant is no longer eligible** for free or reduced price meals for the following reason(s):
  ___ Records show that you did not receive SNAP, FDPIR, SSI, or Medicaid.
  ___ Your income is over the limit for free or reduced price meals.
  ___ You did not provide: _____
  ___ You did not respond to our request.

  If your household income goes down or your household size goes up, you may complete another CACFP Meal Benefit Income Eligibility Form. If you did not provide proof of current eligibility, you will be asked to do so if you reapply.

If you disagree with this decision, you may discuss it with **[name]** at **[phone]**. You also have the right to a fair hearing. If you request a hearing by **[date]**, the participant will continue to receive free or reduced price meals until the decision of the hearing official is made. You may request a hearing by calling or writing to: **[name]**, **[address]**, **[phone number]**.

Sincerely,

[signature]

SHARING INFORMATION WITH MEDICAID/SCHIP

Dear Parent/Guardian:

If your children qualify for free or reduced price meals, they may also be able to get free or low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP). Children with health insurance are more likely to get regular health care and are less likely to become sick.

Because health insurance is so important to children's well-being, **the law allows us to tell Medicaid and SCHIP that your children are eligible for free or reduced price meals, *unless you tell us not to***. Medicaid and SCHIP only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children in this health insurance program. Filling out the CACFP Meal Benefit Income Eligibility Forms does not automatically enroll your children in health insurance.

If you do not want us to share your information with Medicaid or SCHIP, fill out the form below and send it with your Income Eligibility Form to **[address] by [date]**. (Sending in this form will not change whether your children get free or reduced price meals.).

☐ **No! I DO NOT** want information from my CACFP Meal Benefit Income Eligibility Form shared with Medicaid or the State Children's Health Insurance Program.

If you checked no, fill out the form below.

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Signature of Parent/Guardian: _____

Today's Date: _____

Print Your Name: _____

Address: _____

_____

For more information, you may call **[name]** at **[phone]**

Income Eligibility Guidelines

(Effective from July 1, 2019 to June 30, 2020)

Scale for Free Meals ***Effective from July 1, 2019 to June 30, 2020***					
Household Size	**Annual**	**Monthly**	**Twice per Month**	**Every 2 Weeks**	**Weekly**
1	$ 16,237	$ 1,354	$ 677	$ 625	$ 313
2	21,983	1,832	916	846	423
3	27,729	2,311	1,156	1,067	534
4	33,475	2,790	1,395	1,288	644
5	39,221	3,269	1,635	1,509	755
6	44,967	3,748	1,874	1,730	865
7	50,713	4,227	2,114	1,951	976
8	56,459	4,705	2,353	2,172	1,086
For each additional Family member add	+5,746	+479	+240	+221	+111

Scale for Reduced Price Meals ***Effective from July 1, 2019 to June 30, 2020***					
Household Size	**Annual**	**Month**	**Twice per Month**	**Every 2 Weeks**	**Weekly**
1	$ 23,107	$ 1,926	$963	$ 889	$ 445
2	31,284	2,607	1,304	1,204	602
3	39,461	3,289	1,645	1,518	759
4	47,638	3,970	1,985	1,833	917
5	55,815	4,652	2,326	2,147	1,074
6	63,992	5,333	2,667	2,462	1,231
7	72.169	6.015	3,008	2,776	1,388
8	80,346	6,696	3,348	3,091	1,546
For each additional Family member add	+8.177	+682	+341	+315	+158

Agrees that the reduced price for lunch will not exceed 40 cents, that the reduced price for breakfast will not exceed 30 cents, that the reduced price for a snack shall not exceed 15 cents, and that the reduced price charge established will be below the full price for a lunch or breakfast or snack.

MASTER ROSTER

CENTER	CATGORY OF ENROLLEE			DATE ENTERED	DATE EXITED
ENROLLEE	FREE	REDUCED	PAID		
TOTALS					