



CHILD AND ADULT CARE FOOD PROGRAM— Main Street Adult Care HOUSEHOLD INCOME STATEMENT

July 2015

The information requested on this form is private data. The information will be used to determine the amount of assistance that your center will receive through the Child and Adult Care Food Program (CACFP). You may refuse to provide this information, but refusal may affect the level of benefits to the center. Also please fill out the voluntary civil rights survey on the back page of this form.

1. Adult Care Participant

First Name	Last Name	Age

2. Benefits

If participant or any household member receives benefits from a program listed below, write in their name and case number and check the box for the program. Skip Section 3.

_____ Name _____ Case Number

- ☐ Medical Assistance (Medicaid)
☐ Supplemental Nutrition Assistance Program (SNAP)
☐ SSI ☐ Food Distribution Program on Indian Reservation (FDPIR)

3. Household Members List the name and incomes of the adult participant. If the adult participant is living with a spouse, also list the spouse and their income. Do not list other persons unless they live with *and* are dependents of the adult participant. Indicate how often each income is received: **W** for weekly, **BW** for bi-weekly (every other week), **TM** for twice per month, **M** for monthly or **Y** for yearly.

First Name	Last Name	GROSS Earnings from all jobs before deductions	Social Security, Pension, Retirement	Unemployment, Worker's Comp, Strike Benefits	Welfare, Child Support, Alimony	Farm/Self-Employment Net Income (see other side)	ALL OTHER Income
		\$ ____ per ____	\$ ____ per ____	\$ ____ per ____	\$ ____ per ____	\$ ____ per ____	\$ ____ per ____
		\$ ____ per ____	\$ ____ per ____	\$ ____ per ____	\$ ____ per ____	\$ ____ per ____	\$ ____ per ____

4. CERTIFICATION OF INFORMATION / SIGNATURE

I certify that all information on this form is true and 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 may lose meal benefits and I may be prosecuted.

Signature of Participant or Other Adult Family Member or Legal Guardian (required)

_____ Date: _____

Last four digits of Social Security Number * : X X X - X X - ____ - ____ - ____ - ____

Or ☐ I do not have a Social Security Number.

Printed Name: _____ Telephone Number: _____

FOR CENTER USE ONLY—DO NOT WRITE BELOW THIS LINE

For eligibility based on family size/income:

Total Household Members: _____

Total Income: \$ _____ per _____

Approved A: ☐

Approved B: ☐

Approved C: ☐

Signature—Center _____ Date: _____

Effective from: _____ through _____

Month/Year

Month/Year

* The last four digits of the Social Security number of the person signing the form, or an indication that the person does not have a Social Security number, are required if: (1) Section 3 of this form is completed *and* (2) the person signing this form is the adult participant or another adult family member.

CIVIL RIGHTS SURVEY (voluntary)

Your racial/ethnic information is requested only for the purpose of checking that the program is run without discrimination. This information will not affect the approval of this form.

1. Ethnicity (check one):

- ☐ Hispanic or Latino
☐ Not Hispanic/Latino

2. Race (check one or more):

- ☐ American Indian or Alaskan Native
☐ Asian
☐ Native Hawaiian or other Pacific Islander
☐ Black or African American
☐ White

Civil Rights Survey completed by: ☐ Adult Household Member ☐ Center Representative

PRIVACY ACT STATEMENT

The Richard B. Russell National School Lunch Act requires the information on this form. You do not have to give this information, but if you do not, we cannot approve the form for program reimbursement to the adult care center for meals provided to you. The person signing the form must provide the last four digits of their Social Security number if household income information is provided on the form and the form is signed by the adult participant or another household member. The last four digits of the Social Security number are not required when a Supplemental Nutrition Assistance Program (SNAP), Food Distribution Program on Indian Reservations (FDPIR), SSI or Medical Assistance number is provided for any household member or when you indicate that the person signing the form does not have a Social Security number. We will use your information to determine if the participant is eligible for free or reduced-price benefits, and for administration and enforcement of the CACFP.

FARMER OR SELF-EMPLOYED

Income is your net farm or self-employment income (after deducting business expenses) during the year, which is generally shown on Schedule C or F from the federal tax return. A loss from farm or self-employment income must be listed as zero income and does not reduce your other income for the purpose of completing this form.

SEASONAL WORKER

Income is your expected *average gross income* before deductions (*not* take-home pay) during the year. Write in your average gross *income* per month or other frequency.

NONDISCRIMINATION STATEMENT

This explains what to do if you believe you have been treated unfairly.

The U.S. Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by USDA. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at the USDA Complaint Filing website (http://www.ascr.usda.gov/complaint_filing_cust.html), or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). Persons with disabilities who wish to file a program complaint, please see information above on how to contact us by mail directly or by email. If you require alternative means of communication for program information (e.g., Braille, large print, audiotape, etc.) please contact USDA's TARGET Center at (202) 720-2600 (voice and TDD). USDA is an equal opportunity provider and employer.