VIRGINIA CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)

1 All Household Members

NAME OF ENROLLED ADULT(S): First, Middle Initial, Last	Check if **NO** income	**2** SNAP, SSI, Medicaid, or FDPIR CASE NUMBER Skip to Part 4 if you list a SNAP, SSI, Medicaid, or FDPIR case #. **SNAP MUST BE SEVEN (7) DIGITS** **SSI MUST BE NINE (9) DIGITS** **MEDICAID MUST BE TWELVE (12) DIGITS**
1.	☐	
2.	☐	
3.	☐	

3 Total Household Gross Income (before deductions). You must tell us how much and how often.

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	**GROSS INCOME AND HOW OFTEN IT IS RECEIVED** (Example: $100/month, $100/twice a month, $100/every other week, $100/week)							
	Earnings From Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp, Unemployment, SSI, etc. (All other income)	
	Amount	**How often?**	**Amount**	**How often?**	**Amount**	**How often?**	**Amount**	**How often?**
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	

4 Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part 3 is completed or if zero income is listed, 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.

X X X – X X – ___ ___ ___ ___
Social Security Number

☐ **I do not have a social security number.**

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.

___________________ *Date*   ___________________ *Printed Name of Adult Household Member*   ___________________ *Signature of Adult Household Member*

5 Participant's Residency/Living Arrangements

7 CFR 226.2 § 226.19
Each adult day care center shall maintain records which document that qualified adult day care participants reside in their own homes (whether alone or with spouses, children or guardians) or in group living arrangements. [*Group living arrangement* means residential communities which may or may not be subsidized by federal, State or local funds but which are private residences housing an individual or a group of individuals who are primarily responsible for their own care and who maintain a presence in the community but who may receive on-site monitoring.

I _____________________________ [name of participant] reside:

☐ In my own home (alone or with spouse, children, or guardian)   ☐ In the home of a family member/guardian   ☐ In a residential facility

If residential facility, identify type of facility: ☐ Assisted Living Facility   ☐ Nursing Home   ☐ Group Home   ☐ Other Facility

Name of facility/home _____________________________   Address of facility/home _____________________________

PRIVACY ACT STATEMENT: 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 your child for free or reduced-price meals. You must include the last four digits of your social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or 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 or other FDPIR identifier for your child 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 your child is eligible for free or reduced-price meals, and for administration and enforcement of the Child and Adult Care Food Program. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

NON-DISCRIMINATION STATEMENT: The U.S. Department of Agriculture 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 activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at 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 and wish to file either an EEO or program complaint please contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (in Spanish). USDA is an equal opportunity provider and employer.

DON'T FILL OUT THIS PART. OFFICIAL USE ONLY -- ELIGIBILITY DETERMINATION – COMPLETE SECTIONS A and B BELOW

SECTION A **Annual Income Conversion: Weekly X 52   Every 2 Weeks X 26   Twice a Month X 24   Once a Month X 12**   **Convert income only if different frequencies of pay are reported.**

TOTAL INCOME $ ______________ Per: ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year   **NUMBER IN HOUSEHOLD:** ______

☐ **FREE** based on:	☐ **REDUCED** based on:	☐ **DENIED** reason:
☐ SNAP ☐ SSI ☐ Medicaid ☐ household income ☐ FDPIR	☐ household income	☐ income too high ☐ incomplete application ☐ non-qualifying SNAP/SSI/Medicaid/FDPIR

SECTION B **Signature of Determining Official:** _____________________________ **Date:** ______________