VIRGINIA CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)

1 All Household Marsh					_	2	_	_		_	_					
- All Household Michigers																
NAME OF ENROLLED ADULT(S): First, Middle Initial, Last					Check if NO income		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.												Ì				
2.																
3.																
Total Household Gross Income (before deductions). You must tell us how much and how often.																
NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	Earnings From Work		Welfare, Child Alimor	Support,			\$100/twice a month, \$10 ons, Retirement, Social Security			00/every other week, \$100/week) Worker's Comp, Unemployment, SSI, etc. (All other income)						
i.	Amount	How often?	Amount	How often?		ount	ŀ	ow ofte			Amou	ınt	H	ow oft	en?	
ii.	\$		\$		\$					\$ \$						
iii.	\$		\$		\$					۶ \$						
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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>I do not have a social security number</i> box. \[\begin{array}{c ccccccccccccccccccccccccccccccccccc										cial						
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.																
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