

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 (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:	\$22,459	\$30,451	\$38,443	\$46,435	\$54,427	\$62,419	\$70,411	+ \$7,992

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.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](http://www.ascr.usda.gov/complaint_filing_cust.html), (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
- (2) Fax: (202) 690-7442; or
- (3) Email: program.intake@usda.gov.

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