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|  | **ADULT CARE CENTER**  **INCOME-ELIGIBILITY APPLICATION** |

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| **PART 1 – ADULT PARTICIPANT’S INFORMATION** | |
| **Adult’s Name** | **Age** |
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| **Part 2 – HOUSEHOLD MEMBER Receiving Basic Food or FDPIR, OR PARTICIPANT(S) RECEIVING SSI OR MEDICAID—Only one household member receiving Basic Food or FDPIR must be listed in order to establish eligibility for free meals. SSI or Medicaid qualifies only that individual.** | | |
| **Name** | **Circle One** | **Case Number or Identification Number** |
|  | Basic Food FDPIR SSI Medicaid |  |
|  | Basic Food FDPIR SSI Medicaid |  |

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| **Part 3 – Total Household Income from Last Month—Not required if you have reported a case number in Part 2.** | | | | | |
| Functionally impaired adults living with their parents are considered a “family” separate from their parents. Complete Part 3 only if income eligibility is based on income. | | | | | |
| **Names (First and Last)**  **List only the participant(s), spouse and dependent children of participant(s)** | **Gross Income from Last Month (Or net income if self-employed)**  **Tell us how much and how often. If none, write “0”.** | | | | |
| **Earnings from Work Before Deductions** | | **Alimony,**  **Child Support** | **Retirement, Pensions, Social Security** | **Job Two or Any Other Income** |
| *Jane Smith (example)* | *$500 / month* | |  | *$400 / month* | *$ 100 / week* |
| 1. | $      / | | $      / | $      / | $      / |
| 2. | $      / | | $      / | $      / | $      / |
| 3. | $      / | | $      / | $      / | $      / |
| 4. | $      / | | $      / | $      / | $      / |
| 5. | $      / | | $      / | $      / | $      / |
| 6. | $      / | | $      / | $      / | $      / |
| When a participant is qualifying based on Part 3, Total Household Income, the last four digits of the participant’s Social Security Number must be provided or the box must be checked that he/she does not have one. | | | | | |
| Adult Participant’s Social Security Number (last four digits) XXX-XX- | | I do not have a Social Security Number. | | | |

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| **PART 4 – SIGNATURE AND CERTIFICATION** | |
| PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and all income is reported. I understand that this information is being given for the receipt of federal funds; that the information on the application may be verified, and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.  Must be signed and dated by the adult participant or household member or guardian. | |
| SIGNATURE OF ADULT DATE | PRINT NAME OF ADULT SIGNING |
|  | RELATIONSHIP TO ADULT PARTICIPANT |
| ADDRESS CITY/STATE/ZIP CODE | DAY TIME PHONE |

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| **PART 5 – PARTICIPANT’S ETHNIC AND RACIAL IDENTITY (You are not required to answer this)** |
| Check the ethnic and racial category of the adult participant. We need this information to be sure that everyone receives benefits on a fair basis.  Ethnicity:  Hispanic or Latino No adult participant will be discriminated against because of race,  Not Hispanic or Latino color, national origin, sex, age, or disability.  Race:  White  Black or African American  Asian  American Indian or Alaskan Native  Native Hawaiian or Pacific Islander  Multi-Racial |

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| 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, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Basic Food, 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 the meal reimbursement for your child care center/provider. 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. |

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| In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.  Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA’s TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.  To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant’s name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: | | | |
| **MAIL\*:** U.S. Department of Agriculture  Office of the Assistant Secretary for Civil Rights  1400 Independence Avenue, SW  Washington, D.C. 20250-9410; or | **FAX:** (833) 256-1665 or (202) 690-7442; or  **EMAIL:** [program.intake@usda.gov](mailto:program.intake@usda.gov) | **\*Only use this address if you are filing a complaint of discrimination.** |
| **This institution is an equal opportunity provider.** | | |

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| **CENTER USE ONLY** |
| Participant(s) are categorically free based on  Basic Food  FDPIR  SSI  Medicaid  Annual Income Comparison: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12  Participant(s) on this form who are not categorically eligible qualify as follows:    Check one:  Free  Reduced-Price  Above-Scale Total Income: $  Annual  Monthly  Twice Per Month  Every Two Weeks  Weekly      Signature of Institution’s Representative Date  **Not valid without signature and date.**  IEA Effective Date: If the institution is using the participant/household member/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the participant/household member/guardian signed the form or the immediately following month. If the institution representative does not evaluate and sign the IEA within these guidelines, the institution representative’s signature date must be used as the effective date. |