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| Follow these instructions, if your household gets Supplemental Nutrition Assistance Program (SNAP), or Supplemental Security Income (SSI) or Medicaid:  Part 1: List participant’s name and a SNAP, SSI, or Medicaid case number.  Part 3: Sign the form. The last 4 digits of your Social Security Number is not necessary.  Part 4: Answer this question if you choose to. |

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| ALL OTHER HOUSEHOLDS, follow these instructions:  Part 1: List each participant’s name.  Part 2: Follow these instructions to report total household income from last month.  **Column A–Name:** List the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children living with you. Attach another sheet of paper if you need to.  **Column B–Gross income last month and how often it was received**. Next to each person’s name, list each type of income received for the month, and how often it was received.  In Box 1, list the **gross income** each person earned from work, not take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).  In box 2, list the amount each person got last month from welfare, child support, alimony.  In box 3, list Social Security, pensions, and retirement.  In box 4, list ALL OTHER INCOME SOURCES including Worker’s Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran’s benefits (VA benefits), disability benefits, and regular contributions from people who do not live in your household. Report net income for self-owned business, farm, or rental income. Next to the amount, write how often the person got it. Do not include income from SNAP, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance.  **Column C–Check if no income:** If the person does not have any income, check the box.  Part 3: An adult household member must sign the form and list his or her last four digits of their Social Security Number, or mark the box if he or she doesn’t have one.  Part 4: Answer this question if you choose to. |

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| **Privacy Act Statement:** This explains how we will use the information you give us. |

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| **Non-discrimination Statement:** This explains what to do if you believe you have been treated unfairly. |

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| Part 1. Participant enrolled to receive day care. | | | | | | | | |
| **Names** (First, Middle Initial, Last) | | | |  | SNAP, SSI or Medicaid case number.  Skip to Part 3 if you listed a case # | | | |
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| **Part** 2. Total Household Gross Income—You must tell us how much and how often | | | | | | | | |
| **A. Name** (List **everyone** in household, including children) | | **B. Gross income and how often it was received**  *Example: $100/monthly $100/twice a month $100/every other week $100/weekly* | | | | | | **C. Check  if NO income** |
| 1. Earnings from work before deductions | 2. Welfare, child support, alimony | | | 3. Social Security, pensions, retirement, | 4. All Other Income |
| *(Example) Jane Smith* | | $ 200 / weekly\_ | $ 150 / weekly\_\_ | | | $100 / monthly\_\_ | $\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ |  |
|  | | $\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ | $\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ | | | $\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ | $\_\_\_\_\_\_/\_\_\_\_\_\_\_ |  |
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|  | | | | | | | | |
| Part 3. Signature and Last Four Digits of Social Security Number (Adult must sign)  An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list his or her last four digits of his or her Social Security Number or mark the “I do not have a Social Security Number” box. (See Privacy Act Statement on the back of this page.)  *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.*  Sign here: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\*\_\*\_\* - \_\* \_\* - \_\_ \_\_ \_\_ \_\_ ❑ I do not have a Social Security Number | | | | | | | | |
| **Part 4. Participant’s ethnic and racial identities** | | | | | | | | |
| Mark one ethnic identity: | Mark one or more racial identities: | | | | | | | |
| ❑ Hispanic or Latino  ❑ Not Hispanic or Latino | * Asian ❑ American Indian or Alaska Native * White ❑ Native Hawaiian or Other Pacific Islander * Black or African American | | | | | | | |
| **Don’t fill out this part. This is for official use only.**  Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12  Total Annual Income: \_\_\_\_\_\_\_\_\_\_\_\_ Household size: \_\_\_\_\_\_\_\_\_  Eligibility Determination: Free\_\_\_\_\_\_ Reduced\_\_\_\_\_\_ Above Scale\_\_\_\_\_\_  Determining Official’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Confirming Official’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |

**Income Guidelines for Reduced Priced Meals**

**Effective July 1, 2024 to June 30, 2025**

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| Household size | Yearly |
| 1 | $32,024 |
| 2 | $43,475 |
| 3 | $54,927 |
| 4 | $66,378 |
| 5 | $77,830 |
| 6 | $89,281 |
| 7 | $100,733 |
| 8 | $112,184 |
| Each additional person: | +$11,452 |

**The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.**

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| **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 the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you list a Supplemental Nutrition Assistance Program (SNAP), Supplemental Security Income (SSI) or Medicaid Case Number for the participant or other identifier 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 the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program. |

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| **Non-Discrimination Statement:**  This explains what to do if you believe you have been treated unfairly.  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:   1. **mail:** U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; or 2. **fax:** (833) 256-1665 or (202) 690-7442; or 3. **email:** [program.intake@usda.gov](http://mailto:program.intake@usda.gov/)   This institution is an equal opportunity provider |