



Institution or Facility Name:

Part 1. Name of Enrolled Adult(s):

Names of Adult Participants (First, Middle Initial, Last)

Part 2. Benefits: If any member of your household received [State SNAP], [FDPIR], [State SSI] or [Medicaid], provide the name and case number for the person who receives benefits. If no one receives these benefits, skip to part 3.

NAME: CASE NUMBER:

Part 3. Total Household Gross Income—You must tell us how much and how often (whole dollar amounts, please)

Table with 5 columns: A. Name, B. Gross income and how often it was received, 1. Earnings from work before deductions, 2. Welfare, child support, alimony, 3. Pensions, retirement, Social Security, SSI, VA benefits, 4. All other income. Includes example row for Jane Smith.

This section required for all forms listing income in Part 3:

Last four digits of Social Security Number: XXX - XX - I do not have a Social Security Number

Total number of individuals in household:

Part 4. Signature

An adult household member must sign this form. 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: Print name:

Date:

Address: Phone Number:

City: State: Zip Code:

Part 5. Participant's ethnic and racial identities (optional)

Table with 2 columns: Mark one ethnic identity (Hispanic or Latino, Not Hispanic or Latino), Mark one or more racial identities (Asian, White, Black or African American, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander).

Part 6: Decline to provide information

I choose not to provide information about my household size and income.

Signature of Responsible Adult

Date

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 Income: _____ Per: Week, Every 2 Weeks, Twice A Month, Month, Year Household size: _____

Categorical Eligibility: Free___ Reduced___ Paid___ Tier I___ Tier II___ Date Withdrawn: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

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), Food Distribution Program on Indian Reservations (FDPIR), or Temporary Assistance for Needy Families (TANF) case number for the participant 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.

Non-discrimination Statement: "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, audiotape, 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. This institution is an equal opportunity provider."