Child and Adult Care Food Program (CACFP) Adult Day Care Income Eligibility Form 2024-2025

Center Name: _____ **Additional instructions for completing this form are on the back of this sheet. If you have questions, please contact the Center Director for help.**

List **the Full Name (first and last name)** of Participant and **Birth Date** attending the center. If the participant receives **Medicaid or SSI**, please indicate the number below.

Name:	**Birthdate:**	**Medicaid Number:**	**Social Security Income Number:**

1. If any member of the household receives **3SquaresVT** or **Reach Up**, provide the name of the individual receiving the benefit and the **full case number** associated with the benefit. **If completed, skip to Number 5.**

Name: _____ **Case Number:** _____

2. List the **Full Name(s) (first and last name) of Household Members**. This includes all people living in the household.

3. Enter **gross income** (before deductions) of **each household member** for the last month under **how often it is received** (Weekly, monthly, every two weeks, twice a month, or annually).

		Gross Earnings from Work – Before Deductions					**Child Support, Alimony or Welfare**					**Social Security, Pensions, Retirement or Other Income**				
	Check if no income	Week	Every Two Weeks	Twice per Month	Month	Annual	Week	Every Two Weeks	Twice per Month	Month	Annual	Week	Every Two Weeks	Twice per Month	Month	Annual
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4. Please provide a signature and the last four digits of the signer's social security number.

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of Federal funds. Officials may verify the information on the application and deliberate misrepresentation of information may be subject to prosecution under applicable State or Federal laws.

Signature of Adult or Power of Attorney:	Street Address	City
Social Security Number: XXX – XX – __ __ __ __	State	Zip code
☐ I do not have a Social Security Number	Home/Cell Phone	**Date Signed**

Other Benefits: For information on free or low-cost health insurance contact Green Mountain Care at 1-800-250-8427 or www.GreenMountainCare.org. For information on 3SquaresVT to help with food costs, call 1-800-479-6151 or visit www.vermontfoodhelp.com.

CENTER PERSONNEL MUST COMPLETE THE SPACE BELOW

Household Size: _____ **Total Income Reported:** _____

Time Period Used (check off): ☐ Weekly ☐ Every Two Weeks ☐ Twice per Month ☐ Monthly ☐ Annually

Annual Income Conversion: Weekly x 52 · Every 2 weeks x 26 · Twice a Month x 24 · Monthly x 12

Current Income Eligibility Guidelines must be used to approve this form. Do not use the income guidelines listed on the back of this form. This form must be signed and dated by the individual approving the form.

_____ _____

Signature of Approver (Center Personnel Only) **Date**

Eligibility Determination (Below): Check the box and circle the qualifying reason.

[ ] Free	**[ ] Reduced**	**[ ] Denied**
Income 3SquaresVT or Reach Up Medicaid SSI	Income	Over Income Incomplete Application

Instructions:
Number 1: Print the Full Name(s) (first and last name) of Participant(s) attending the center**.** If the participant(s) receive **Supplemental Security Income (SSI) or Medicaid**, please list the number under the appropriate box and **Skip to number 5.**
Number 2: If the participant(s) live in a **3SquaresVT household** or **Reach Up**, please list the name of the person who receives the benefit and the case number associated with the benefit. **Skip to number 5.**

Number 3: Print the **Full Name(s) (first and last name) of each person** living in the household, related or not (such as grandparents, other relatives, or friends).
Number 4: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly. For earnings, be sure to list **gross income –** not take-home pay. *Gross income* is the amount earned before taxes and other deductions. This should be on your pay stub, or your boss can tell you. For *child support, alimony, or welfare,* list the amount each person got for the month. *Pensions, retirement, Social Security, Supplemental Security Income (SSI), Veterans Benefits (VA benefits), and disability benefits* must be listed for each person who received these benefits. *Any other Income* includes Worker's Compensation, unemployment or strike benefits, regular contributions from people who do not live in your household. Do not include income from 3SquaresVT, WIC, Federal Education benefits and foster payments received by the family from the placing agency. For self-employed, under *Gross Earnings from Work*, report income after expenses. This is for your business, farm, or rental property. If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.
Number 5: Adult household member must sign and date the form and list the last four digits of the Social Security number.

Income Eligibility Guidelines

The chart below shows **reduced-priced guidelines**. Households earning more than the income(s) listed per time period below are Over Income.
Please refer to the Current Income Eligibility Guidelines to view free guidelines.

Household Size	Yearly	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	27,861	2,322	1,161	1,072	536
2	37,814	3,152	1,576	1,455	728
3	47,767	3,981	1,991	1,838	919
4	57,720	4,810	2,405	2,220	1,110
5	67,673	5,640	2,820	2,603	1,302
6	77,626	6,469	3,235	2,986	1,493
7	87,579	7,299	3,650	3,369	1,685
8	97,532	8,128	4,064	3,752	1,876
For each additional household member add	9,953	830	415	383	192

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 your child 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 last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (3SquaresVT), Temporary Assistance for Needy Families (Reach-Up) 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 if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. 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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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/ad-3027.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 Right 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

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