



Child and Adult Care Food Program (CACFP)

**INCOME ELIGIBILITY APPLICATION FOR ADULT CARE CENTER PARTICIPANT**

**PART 1 – ADULT'S NAME**

(Please complete only one application form per adult) :

\_\_\_\_\_ Last First MI Date of Birth

**PART 2A – HOUSEHOLDS THAT ARE CURRENTLY RECEIVING BENEFITS THROUGH THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP), SUPPLEMENTAL SECURITY INCOME (SSI) PROGRAM, OR MEDICAID PROGRAM FOR ADULT CARE THROUGH THE TENNESSEE HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER** (If your household is now receiving benefits under one or more of these programs, complete this part and sign the statement in Part 3 - Do not complete Part 2B.)

SNAP Case No.: \_\_\_\_\_ SSI Case No.: \_\_\_\_\_

Medicaid HCBS Waiver Attached:  Yes  No (Check One)

**PART 2B – ALL OTHER HOUSEHOLDS** (If no information is entered in Part 2A above, complete this part and sign the statement in Part 3.)

Enter below the name of the adult participant, and his or her spouse and/or any other individual(s) who reside with the participant and who depend on the participant for economic support. If you need more space, use a separate piece of paper. Use Line 1 to identify the individual enrolled in the adult day care center.

Names of All Household Members	Earnings from Work (Before Deductions)	Child Support, Alimony or Other Income	Payments Received from Pensions, Retirement, & Social Security
1.	\$ _____ per year	\$ _____ per year	\$ _____ per year
2.	\$ _____ per year	\$ _____ per year	\$ _____ per year
3.	\$ _____ per year	\$ _____ per year	\$ _____ per year
4.	\$ _____ per year	\$ _____ per year	\$ _____ per year

**Total Number of Household Members:** \_\_\_\_ **Total Yearly Income for Household from All Sources:** \$ \_\_\_\_\_ Yearly income is calculated as follows: Multiply Weekly income by 52, Bi-weekly income (received every two weeks) by 26, Semi-monthly income (received twice a month) by 24, and Monthly income by 12. Do not round up any numbers.

**PART 3 - SIGNATURE** (The signature of the adult participant or other authorized individual is required.)

**PENALTIES FOR MISREPRESENTATION:** I certify that all of the above information is true and correct and that the SNAP and/or SSI case numbers are correct or that all income is reported. I understand that this information is being given for the receipt of Federal Funds; that institution officials may verify the information on the statement and the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Printed Name of Adult :		Signature of Adult:	Social Security Number (only last four digits):
Street:	City:	State and Zip Code:	Home Telephone:

**PART 4 – ETHNIC/RACIAL IDENTITY (You are not required to answer this question.):** For Ethnicity, please check one of the following:  Hispanic or Latino  Not Hispanic or Latino. For Race, please check one or more of the following:  American Indian or Alaskan Native  Asian  Black or African American  Native Hawaiian or Other Pacific Islander  White. Please see the definitions of Ethnicity and Race on the back of this application.

**FOR INSTITUTION OR SPONSOR STAFF USE ONLY:** Eligibility Classification (Circle) Free Reduced-Price or Paid Basis for Classification (Circle) Categorically Eligible or Income Eligible

Determining Official Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**INCOME ELIGIBILITY APPLICATION INSTRUCTIONS**

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**PART 1A - PARTICIPANT INFORMATION:** All HOUSEHOLDS COMPLETE THIS PART.

- (1) Print the name of the adult enrolled at the adult care facility.

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**PART 2A - HOUSEHOLDS RECEIVING SNAP, SSI ASSISTANCE OR MEDICAID PROGRAM BENEFITS THROUGH THE TENNESSEE HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER** COMPLETE THIS PART AND PART 3.

- (1) List your current SNAP or SSI case number for your household, or attach a copy of HCBS Waiver. Do not complete Part 2B.
- (2) The adult participant or other authorized household member must sign the statement in Part 3.

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**PART 2B - ALL OTHER HOUSEHOLDS:** COMPLETE THIS PART AND PART 3.

- (1) Write the names of everyone in your household.
- (2) Write the amount of the most recent income received on a yearly basis for each household member. The income may be for the current month, the amount projected for the first month the application is made for, or for the month prior to application. This income is the amount before taxes or any deductions are made. Also, indicate the source of the income. Refer to examples below for income to report.

**INCOME TO REPORT**

<u>Earnings from Work</u>	<u>Retirement/Social Security</u>	<u>Other Income Sources</u>	<u>Child Support/Alimony</u>
Wages/salaries/tips	Pensions	Disability benefits	Alimony/child support
Strike benefits	Supplemental Security Income	Cash withdrawn from savings	benefits/payments
Unemployment benefits	Retirement income	Interest/dividends	
Worker's Compensation	Veteran's payments	Income from estates/trusts/investments	
Net income from self-employment	Social Security Income	Regular contributions from persons not living in the household	
		Net royalties/annuities/net rental income	

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**PART 3 - SIGNATURE AND SOCIAL SECURITY NUMBER:** All households complete this part.

- (1) The adult participant or other authorized household member must sign the certification statement. If a functionally impaired or elderly adult is not able to complete an application for himself or herself, an adult family member or guardian may complete the application. However, if the participant is unable to complete the application and if no adult family member or guardian is available, the center's staff may complete the application on the participant's behalf only if the participant is categorically eligible for free meals. The participant's file must contain documentation of his or her categorically eligibility. If the signature is provided by an individual other than the adult for whom the application is being made, a written statement that outlines the circumstances must be attached to the application.
- (2) The adult household member who signs the statement must include the last four digits of his/her Social Security Number. If he/she does not have a Social Security Number, write "none". If you listed a SNAP or SSI case number or provided documentation of Medicaid Program benefits through the Tennessee Home and Community Based Services (HCBS) Waiver, the last four digits of the Social Security Number is not needed.
- (3) The income eligibility application is valid for one calendar year from the date of the signature of the Determining Official. You will be contacted by the staff of the CACFP Sponsoring Agency to update the information contained in this application before the close of the eligibility period. The staff of the CACFP Sponsoring Agency is required to verify and certify the eligibility of your household every 12 months. Section 9 of the National School Lunch Act requires that, unless Part 2A is completed, you must include the last four digits of the Social Security Number of the household member signing the statement or an indication that the household member signing the statement does not possess a Social Security Number. Provision of the last four digits of the Social Security Number is not mandatory, but if this Social Security information is not provided or an indication is not made that the adult household member signing the statement does not have a Social Security Number, the statement cannot be approved. The last four digits of the Social Security Number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the statement. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a SNAP, SSI or HCBS Waiver Office to determine current certification for receipt of benefits under these programs, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

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**PART 4 - RACIAL/ETHNIC IDENTITY:** You are **not required** to answer this question to receive meal benefits. However, this information will help ensure that everyone is treated fairly.

**Definition of Ethnicity:** *Hispanic or Latino* means a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

**Definition of Race:** *American Indian or Alaskan Native* means a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. *Asian* means a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. *Black or African American* means a person having origins in any of the black racial groups of Africa. *Native Hawaiian or Other Pacific Islander* means a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. *White* means a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

**No person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the CACFP on the grounds of race, color, sex, age, disability, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law.**

**CHILD AND ADULT CARE FOOD PROGRAM  
SAMPLE HOUSEHOLD LETTER FOR  
NONPRICING ADULT CARE CENTER**

Dear Household Member:

This adult care facility participates in the Child and Adult Care Food Program (CACFP) which is administered by the Tennessee Department of Human Services and funded by the U.S. Department of Agriculture. The CACFP provides reimbursements to our facility for the costs of serving nutritious meals to all enrolled adults. This allows our facility to better serve the adult member of your household who is enrolled at our facility.

As provided by the program's regulations, the amount of reimbursement that we may receive for our meal services is dependent upon the income eligibility of the enrolled adults. The eligibility categories for enrolled adults are free, reduced-price and paid. The highest meal reimbursement is provided for adults who are eligible for the free meal category. The lowest meal reimbursement is provided for adults who are placed in the paid meal category. The eligibility of each enrolled adult must be updated at least once each year.

To determine the amount of meal reimbursements for our facility, we need your assistance. You will find attached a copy of an income eligibility application and income guidelines for the reduced-price meal category. Please use the instructions on the back of the application to complete and return it to our facility. All income eligibility applications that are received for enrolled adults are placed in secured files at our facility and treated as confidential information. The information given on the application may be verified by authorized state and federal officials.

If the enrolled adult now receives benefits under the Supplemental Nutrition Assistance Program (SNAP), Supplemental Security Income (SSI) Program, or Tennessee Home and Community Based Services (HCBS) Waiver for Adult Care through the Medicaid Program, you do not have to enter any income data on the application. If these benefits are received, please only provide the case number for the SNAP or SSI assistance, copy of the HCBS waiver and the name of the enrolled adult. If more than one adult from your household is enrolled at our facility, please complete a separate application for each adult. Also, please have the enrolled adult or other authorized person sign the application. Please note that if the benefits under the SNAP, SSI Program or HCBS Waiver for Adult Care are terminated for the enrolled adult, our facility must be notified by the enrolled adult or authorized household member.

If benefits under the SNAP, SSI Program, or HCBS Waiver for Adult Care are not received, please provide income information for all household members who reside with the adult participant and who depend on the adult participant for economic support. Do not enter any information on the application for those household members who do **not** depend upon the adult participant for economic support. If the household income is equal to or less than the attached income guidelines, the enrolled adult is eligible for the free or reduced-price category. The loss of income through the unemployment of any members of your household or family may qualify

the enrolled adult for the free or reduced-price meal category during the period of unemployment.

To enter yearly income amounts, you will need to convert your income as follows: Multiple Weekly income by 52, Bi-weekly income (received every two weeks) by 26, Semi-monthly income (received twice a month) by 24, and Monthly income by 12. Do not round up any numbers during the conversion.

Please be sure that the enrolled adult or other authorized person signs the application, and returns it by \_\_\_\_\_ to \_\_\_\_\_.

The meal services provided by this facility are available to all enrolled adults regardless of race, color, national origin, sex, disability, or age. If you believe that you or an enrolled adult from your household have been discriminated against, please immediately write to one or both of the following addresses:

U.S. Department of Agriculture  
Director of Office of Civil Rights  
Whitten Building, Room 326-W  
1400 Independence Avenue, SW  
Washington, DC 20250-9410  
Telephone: (202) 720-5964 (Voice and TDD)

Tennessee Department of Human Services  
Child and Adult Care Services  
400 Deaderick Street  
Nashville, Tennessee 37243-1403  
Telephone (615) 313-4749

You may also file a complaint with our facility. Complaint forms and procedures are available from our facility upon request.

Sincerely,

\_\_\_\_\_  
Name of Title of Facility Representative

\_\_\_\_\_  
Date

Attachments: Income Eligibility Application  
Income Eligibility Guidelines for Reduced-Price Meals