Return this completed form to: (Insert Sponsor's name, address & telephone number) Provider:_____ #:_____

# Household Income Eligibility Statement – Adult Day Services Only

***Part 1: Participant Information: Enter Name, Age and Birthdate of adult participant(s).**

| | | |
|---|---|---|
| **Name:** | **Age:** | **Birthdate:** |
| **Name:** | **Age:** | **Birthdate:** |

****Part 2 – Households Receiving Medicaid, Supplemental Security Income (SSI), Food Assistance Program (FAP), or Food Distribution Program on Indian Reservations (FDPIR).** If any member of your household receives Medicaid, SSI, FAP, or FDPIR provide the name and valid case number for the person who receives the benefits. **Only one number is required.** If you complete this part, skip Part 3. Continue to Part 4.

| | | | |
|---|---|---|---|
| Medicaid Number: | SSI Number: | FAP Number: | FDPIR Number: |

****Part 3 – Household Members Gross Monthly Income Information. Complete if Part 2 did not apply to you.**

| | | | | | How Often? (x) | | | | | | How Often? (x) | | | | | | How Often? (x) | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| First and Last Names of All Household Members, Related and Unrelated | Age | Birth Date | Foster Child (x) | Amount of Earnings from Work (before deductions) | Annually | Monthly | 2x Month | Bi Weekly | weekly | Amount of Welfare, Child Support, or Alimony | Annually | Monthly | 2x Month | Bi Weekly | Weekly | Amount of All Other Income (Indicate source and amount) | Annually | Monthly | 2x Month | Bi Weekly | Weekly | Mark if No Income (x) |
| | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |

***Part 4 – All Households - Signature and Last Four (4) Digits of Adult Social Security Number** (Adult household member MUST sign and date)

I certify that all information on this form is true and that all income is reported. I understand that federal funds are 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.

**Adult Household Member or Applicant's Guardian Signature:** _____

**Print Name**: _____ **Date**: _____

Last four digits of Social Security Number: XXX-XX-_ _ _ _ _____I do not have a Social Security Number (only required if not eligible in Part 2)

**For Institution Use Only**

| | | | |
|---|---|---|---|
| Total Household Members: | Total Income: $ | ___ Annually ___ Bi-Weekly<br>___ Monthly ___ Weekly<br>___ 2x Month | APPROVED CATEGORY<br>Categorical Eligibility: Medicaid SSI FAP FDPIR<br>Income Eligible: A (Free) B (Reduced) C (Paid) |

Institution Official Signature: _____ Approval Date: _____

**This form is valid for 12 months from the date of sponsor signature. Approval date and sponsor signature are required.**

*** Required Information**
**** Either section 2 or 3 must be completed to qualify for Free or Reduced meal/snack reimbursements**

**Return this completed form to:** (*insert institution's name, address & telephone number)*

# Participant Enrollment Form

**Instructions:**

1. List full name of participant enrolled in care
2. Circle the typical days each participant is in care
3. List times each participant is in care
4. Circle the meals and snacks each participant typically receives while in care
5. Select the ethnicity of each participant using the following codes: H = Hispanic or Latino, N = Not Hispanic or Latino*
6. Select one or more racial designations of each participant using the following codes: A/I = American Indian or Alaskan Native, A = Asian, B = Black or African American, H/PI = Native Hawaiian or Pacific Islander, W = White*
7. Sign and date the form and return to your care center

| Participant's First and Last Name | Typical Days in Care (circle all that apply) | List Times in Care | Meals/Snacks Received (circle all that apply) | Ethnicity | Race |
|---|---|---|---|---|---|
| | Mon Tues Wed Thu Fri Sat Sun | | Breakfast AM Snack Lunch PM Snack Supper Evening Snack | | |
| | Mon Tues Wed Thu Fri Sat Sun | | Breakfast AM Snack Lunch PM Snack Supper Evening Snack | | |
| | Mon Tues Wed Thu Fri Sat Sun | | Breakfast AM Snack Lunch PM Snack Supper Evening Snack | | |
| | Mon Tues Wed Thu Fri Sat Sun | | Breakfast AM Snack Lunch PM Snack Supper Evening Snack | | |

* This information is voluntary. This will assist us in assuring the Child and Adult Care Food Program is administered in a nondiscriminatory manner.

_____ Adult/Parent/Guardian's Address

_____ Adult/Parent/Guardian's Phone Number

_____ Signature of Adult/Parent/Guardian

_____ Date Signed

**USDA Nondiscrimination Statement**

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: USDA Program Discrimination Complaint Form, 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

This institution is an equal opportunity provider.

USDA Civil Rights Complaint Link:
https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf



MICHIGAN Department of Education