**CONFIDENTIAL INCOME STATEMENT (CIS) ADULT DAY CARE**

**ADULT DAY CARE NAME** _____

(Effective July 1, 2019 – June 30, 2020)

**Part 1. All Household Members**

| **Names of Adult Participants** (First, Middle Initial, Last) | CHECK IF NO INCOME |
|---|---|
| | ☐ |
| | ☐ |
| | ☐ |

**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**

| **A. Name** (List **only** spouse and dependent children of participant(s)) | **B. Gross income and how often it was received** | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Earnings from work before deductions | Weekly | Every 2 weeks | Twice Monthly | Monthly | Welfare, child support, alimony | Weekly | Every 2 weeks | Twice Monthly | Monthly | Social Security, SSI, VA, retirement benefits | Weekly | Every 2 weeks | Twice Monthly | Monthly | All Other Income (unemployment) | Weekly | Every 2 weeks | Twice Monthly | Monthly |
| *(Example) Jane Smith* | $200 | | | | | $150 | | | | | $100 | | | | | $ | | | | |
| | $ | | | | | $ | | | | | $ | | | | | $ | | | | |
| | $ | | | | | $ | | | | | $ | | | | | $ | | | | |
| | $ | | | | | $ | | | | | $ | | | | | $ | | | | |
| | $ | | | | | $ | | | | | $ | | | | | $ | | | | |
| | $ | | | | | $ | | | | | $ | | | | | $ | | | | |

**Part 4. 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 the 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 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 I may be prosecuted.*

Sign here: _____ Print name: _____ Date: _____

Address: _____ Phone Number: _____

City:_____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _*_*_*-_*_*-__ __ __ __ ❑ I do not have a Social Security Number

| **Part 5. Participant's ethnic and racial identities (optional)** | |
|---|---|
| **Mark one ethnic identity:** | **Mark one or more racial identities:** |
| ❑ Hispanic or Latino<br>❑ Not Hispanic or Latino | ❑ Asian<br>❑ White<br>❑ Black or African American<br>❑ American Indian or Alaska Native<br>❑ Native Hawaiian or Other Pacific Islander |

**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: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___

Reason: _____

Determining Official's Signature: _____ Date: _____

REDUCED PRICE INCOME GUIDELINES
JULY 1, 2019 - JUNE 30, 2020

| Household Size | Income | | | | |
|---|---|---|---|---|---|
| | Annual | Monthly | Twice Per Month | Every Two Weeks | Weekly |
| 1 | 23,107 | 1,926 | 963 | 889 | 445 |
| 2 | 31,284 | 2,607 | 1,304 | 1,204 | 602 |
| 3 | 39,461 | 3,289 | 1,645 | 1,518 | 759 |
| 4 | 47,638 | 3,970 | 1,985 | 1,833 | 917 |
| 5 | 55,815 | 4,652 | 2,326 | 2,147 | 1,074 |
| 6 | 63,992 | 5,333 | 2,667 | 2,462 | 1,231 |
| 7 | 72,169 | 6,015 | 3,008 | 2,776 | 1,388 |
| 8 | 80,346 | 6,696 | 3,348 | 3,091 | 1,546 |
| For each additional family member add: | 8,177 | 682 | 341 | 315 | 158 |

**Privacy Act Statement: This explains how we will use the information you give us.** 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, the facility may get less money for the meals served. 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 case number or identifier for Supplemental Nutrition Assistance Program (SNAP), (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR), Social Security Income (SSI), Medicaid, or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information for administration and enforcement of the Program and to verify that the information on the statement is true.

**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, 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, (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.