Virginia CACFP Meal Benefit Income Eligibility Form (Adult)

Center Name	

1 All Household Members

2

NAME OF ENROLLED ADULT(S):		SNAP, SSI, Medicaid, or FDPIR CASE NUMBER
First, Middle Initial, Last	Check if **NO** income	Skip to Part 4 if you list a SNAP, SSI, Medicaid, or FDPIR case #. **SNAP MUST BE NINE (9) DIGITS SSI MUST BE NINE (9) DIGITS MEDICAID MUST BE TWELVE (12) DIGITS**
1	☐	
2	☐	
3	☐	

3 Total Household Gross Income (before deductions). You must tell us how much and how often.

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT IS RECEIVED (Example: $100/month, $100/twice a month, $100/every other week, $100/week)							
	Earnings From Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp, Unemployment, SSI, etc. (All other income)	
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	

4 Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part 3 is completed or if zero income is listed, 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.

XXX - XX - _ _ _ _
Social Security Number

☐ **I do not have a social security number.**

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.

Date | *Printed Name of Participant or Legal Guardian* | *Signature of Participant or Legal Guardian*

5 Participant's Residency/Living Arrangements

Each adult day care center shall maintain records which document that qualified adult day care participants reside in their own homes (whether alone or with spouses, children or guardians) or in group living arrangements. [*Group living arrangement* means residential communities which may or may not be subsidized by federal, State or local funds but which are private residences housing an individual or a group of individuals who are primarily responsible for their own care and who maintain a presence in the community but who may receive on-site monitoring. 7 CFR 226.2 § 226.19

I ______________________ [name of participant] reside:

☐ In my own home (alone or with spouse, children, or guardian) ☐ In the home of a family member/guardian ☐ In a residential facility

If residential facility, identify type of facility: ☐ Assisted Living Facility ☐ Nursing Home ☐ Group Home ☐ Other Facility

Name of facility/home ______________________ Address of facility/home ______________________

DON'T FILL OUT THIS PART. CHILD CARE RESOURCES ONLY -- ELIGIBILITY DETERMINATION - COMPLETE SECTIONS A and B BELOW

SECTION A **Annual Income Conversion: Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12** — **Convert income only if different frequencies of pay are reported.**

TOTAL INCOME $ ________ Per: ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year **NUMBER IN HOUSEHOLD: _____**

☐ **FREE** based on:	☐ **REDUCED** based on:	☐ **DENIED** reason:
☐ SNAP ☐ SSI ☐ Medicaid ☐ household income ☐ FDPIR	☐ household income	☐ income too high ☐ incomplete application ☐ non-qualifying SNAP/SSI/Medicaid/FDPIR

SECTION B **Signature of Determining Official:** ______________________ **Date:** ______________

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.

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

Revised June 2022; Previous Versions Obsolete

Virginia Annual CACFP Enrollment Form (Adult)

CENTER COMPLETE THIS SECTION

____
Center Name

Street Address	City	State	Zip Code
		VA	

An enrollment form must be completed when the participant enters the program. Adult Day Care Centers are responsible for updating each participant's Individual Plan of Care annually and keep the enrollment form on file as long as the participant remains in the program.
The participant or guardian must complete and ensure accuracy of Sections 1 through 5 below.

1 FULL NAME OF ENROLLED PARTICIPANT (Include Birth Date/Age)	2 DAYS OF WEEK IN ATTENDANCE	3 TIMES PARTICIPANT NORMALLY ATTENDS CARE DURING THE WEEK			4 MEALS RECEIVED
		TIME IN	TIME OUT	SPORADIC SCHEDULE (not set schedule of days)	
First Name	☐ Monday				☐ Breakfast
Last Name	☐ Tuesday	NOTES:			☐ AM Snack
Date of Birth	☐ Wednesday				☐ Lunch
Age	☐ Thursday				☐ PM Snack
	☐ Friday				☐ Supper
	☐ Saturday				☐ EV Snack
	☐ Sunday				

5 Parent/Guardian Signature and Date:
By signing this form, I certify that I am the participant or legal guardian of the participant named in Section 1 of this enrollment form and that the information contained on this form is true and correct.

Printed Name _______________ *Signature* _______________

Street Address _______________ , , *City, State, Zip Code* _______________

Phone Number *WORK/CELL (circle one)* _______________ *Date* _______________

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Child Care Resources Use Only:

Effective Date of This Enrollment Form: _______________ *(m/d/yy)*

Effective Date of Withdrawal: _______________ *(m/d/yy)*

The effective date may be retroactive to the first day the enrollee participates in the CACFP as long as it occurs in the same month this form is received.

Printed Name of Center Representative _______________

Signature of Center Representative _______________ *Date* _______________