

## Iowa CACFP Adult Day Care Center Household Letter

Rev. 7/15

Instructions: Complete, sign and return the enclosed Income Eligibility Form as soon as possible. This form is necessary so that we may receive reimbursement for the meals served to you under the Child and Adult Care Food Program (CACFP). This form will be treated as confidential information. If you are unable to complete and sign the form, a guardian or household member may complete it. Your form must be completed as follows:

**Food Assistance/SSI/Medicaid Households:** If you currently receive Food Assistance or Supplemental Security Income (SSI) or Medicaid, you have to list your name and the case number and **Sign** the form.

OR

**All Other Households:** If your household is at or below the level shown on the Income Eligibility Guidelines at the bottom of this page, you must provide the following information on this form or it cannot be approved:

- Household Members:** List your name and the name of your spouse and/or any other people who live with you and depend on you for financial support. **If the people who live with you do not depend on you financially, then their names and income do not need to be included on this form unless you are married. If married, you and your spouse must be listed.**
- Social Security Number:** List the last four digits of the Social Security Number (SSN) of the adult household member who signs the form. If an adult signing this form does not have a SSN, mark the box, "I do not have a social security number."
- Monthly Income:** List your monthly income by source **and** monthly income by source of all the people you live with who depend on you for financial support.
- Signature:** You or a guardian or a household member must sign the form. If you are unable to complete and sign the form, a guardian or household member must complete and sign it.

If you do not qualify now to receive free or reduced-price meals, you may at any time during the year. If you have a decrease in household income, an increase in family size or start receiving Food Assistance, SSI, or Medicaid Benefits, you may complete a form at that time.

This center does not charge separately for meals (skip to the next page).

This center charges the following rates for meals:

Meal	Full Price	Reduced Charge
Breakfast		.30
Lunch/Supper		.40
Snacks		.15

If you do not agree with the center's decision about your application, you may wish to discuss it with them. You also have a right to a fair hearing. This can be done by calling or writing the following hearing official: \_\_\_\_\_  
 Contact information for hearing official: \_\_\_\_\_

**Income Eligibility Guidelines for Reduced-price Meals  
Effective 7-1-2015 to 6-30-2016**

Household Size	Reduced-price Meals				
	Yearly	Monthly	Twice per Month	Every Two Weeks	Weekly
1	21,775	1,815	908	838	419
2	29,471	2,456	1,228	1,134	567
3	37,167	3,098	1,549	1,430	715
4	44,863	3,739	1,870	1,726	863
5	52,559	4,380	2,190	2,022	1,011
6	60,255	5,022	2,511	2,318	1,159
7	67,951	5,663	2,832	2,614	1,307
8	75,647	6,304	3,152	2,910	1,455
For each additional family member add:	+7,696	+642	+321	+296	+148

## Iowa CACFP Adult Day Care Center Income Eligibility Form (front)

Rev. 7/15

Carefully complete this form, sign, and return it to the center

**PART 1 - Complete Part 1 if you or any family member currently receives Food Assistance or Supplemental Security Income (SSI) or Medicaid. If you complete this part, skip Part 2 and go on to Part 3.**

Name	Medicaid (Title XIX) Case No.	SSI Case No.	Food Assistance Case No.

**PART 2 - Complete Part 2 if you did not complete Part 1.**

Below, under “**Name**”, list your name and the names of your spouse and/or any other people who **live with you and depend on you for financial support**. If you need more space, use a separate piece of paper. In the last 4 columns, list **all** income received last month on the same line as the name of the person who received it. You must list the **gross** monthly income, (the amount **before** deductions for taxes, Social Security, etc.) List each amount under the correct source. If income is negative, it should be listed as “**zero**” income. If last month’s income does not accurately reflect your circumstances, you may estimate the amount that you expect to receive each month. Income that changes from month to month, such as farm income, may be averaged over the previous 12 months.

Name (Last, First) Enrollee	Age	Salary/ Wages Before Deductions	Welfare, Child, Support & Alimony	Pensions & Social Security	All Other Income
1.		\$	\$	\$	\$
2.		\$	\$	\$	\$
3.		\$	\$	\$	\$
4.		\$	\$	\$	\$
5.		\$	\$	\$	\$
6.		\$	\$	\$	\$
7.		\$	\$	\$	\$

**Privacy Act Statement: This explains how we will use the information you give us.**

If you did not give a Food Assistance, SSI, or Medicaid Identification Number, Federal law (PL97-35) requires you to list the last four digits of the Social Security Number of the adult household member signing this form before the adult day care center may receive reimbursement for meals served to you under the CACFP. You do not have to give the Social Security information, but if you refuse, the center cannot receive free or reduced-price meals reimbursement. Verification may include audits, investigations, contacting the State Employment Security office, Food Stamp or Welfare office, employers, and checking the written information provided by you to confirm the information received. If incorrect information is discovered a loss of benefits or legal action may occur. These facts must be told to the household member whose Social Security Number is reported on this form.

**PART 3 - Racial/Ethnic Data and Signature**

Please check off the racial/ethnic group to which you belong. You are not required to answer this question. If you do not answer the question, someone at the center will make a determination. No one will be discriminated against because of race, sex, color, national origin, age or disability.

1.  Hispanic or Latino  Not Hispanic or Latino
2.  White  Black or African American  American Indian or Alaskan Native  
 Asian  Native Hawaiian or Other Pacific Islander

**Penalties for Misrepresentation:** I certify that all of the information on this form is true and correct and that all income is reported. I understand that this information is being given for the receipt of Federal funds; that the information given may be verified; and that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws. **You or a guardian or an adult household member must sign below. If Part 2 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the box "I do not have a Social Security Number".** (See Privacy Act Statement on the back of this page.)

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

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Signature

\_\_\_\_\_  
City

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Telephone Number

**FOR ADMINISTRATIVE USE ONLY**

This form must be signed by center personnel and the Free, Reduced, or Paid category determined in order for this form to be valid. **This form is valid only for one year plus one month from the date below.**

**Total Monthly Income (if applicable): \$** \_\_\_\_\_ **Family Size** \_\_\_\_\_

Incomplete/Denied  Free (Food Assistance SSI Medicaid or Income),  Reduced,  Paid (Ineligible for free or reduced-price meals)

\_\_\_\_\_  
Determining Official Signature

\_\_\_\_\_  
Date

**Nondiscrimination Statements (explain what to do if you believe you have been treated unfairly).**

**USDA Nondiscrimination Statement:** The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), or at any USDA office, or call (866)632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax 202-690-7442 or email at [program.intake@usda.gov](mailto:program.intake@usda.gov). *Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339; or 800-845-6136 (Spanish).* USDA is an equal opportunity provider and employer.

**Iowa Nondiscrimination Notice:** "It is the policy of this CNP provider not to discriminate on the basis of race, creed, color, sex, sexual orientation, gender identity, national origin, disability, age, or religion in its programs, activities, or employment practices as required by the Iowa Code section 216.6, 216.7, and 216.9. If you have questions or grievances related to compliance with this policy by this CNP Provider, please contact the Iowa Civil Rights Commission, Grimes State Office Building, 400 E. 14<sup>th</sup> St., Des Moines, IA 50319-1004; phone number 515-281-4121, 800-457-4416; website: <https://icrc.iowa.gov/>."