MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE (CFNA)
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

INCOME ELIGIBILITY FORM FOR ADULT CARE CENTERS

To apply for free and reduced-price meals in an adult care center, complete this form.

PART 1 ENROLLEE INFORMATION

Complete information below for the enrollee at the adult care center. If the participant is a Medicaid, Supplemental Security Income (SSI), or Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamp) participant, complete Parts 1, 3, and 4 only. Complete Parts 1, 2, 3, and 4 if you did not provide a Medicaid, SSI, or SNAP case number.

ENROLLEE'S NAME	DATE OF BIRTH

Check all that apply and provide the appropriate case number.

❑ MEDICAID _____ ❑ SSI _____ ❑ SNAP (FOOD STAMPS) _____

PART 2 HOUSEHOLD AND INCOME INFORMATION

Complete information below for all household members. A household member is defined as the adult participant, and if residing with the adult participant, the spouse and dependents of the adult participant. Functionally impaired adults living with their parents are considered a "family" separate from their parents. For each household member, indicate income by source and amount of current monthly gross income for all members of the household before deductions, such as taxes and social security.

INCOME BASED ON (CHECK ONE): YEARLY ❑ MONTHLY ❑ 2 X A MONTH ❑ EVERY 2 WEEKS ❑ WEEKLY ❑

HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT, SOCIAL SECURITY	OTHER

PART 3 RACIAL ETHNIC INFORMATION (You are not required to answer this section)

Are you of Hispanic or Latino origin? ☐ YES ☐ NO

What is your race? (Select one or more)

AMERICAN INDIAN OR ALASKA NATIVE ❑ ASIAN ❑ BLACK OR AFRICAN AMERICAN ❑ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ❑ WHITE ❑

PART 4 SIGNATURE

I hereby certify that all information provided is correct. I understand that this information is being given in connection with the receipt of federal funds, that institution officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

SIGNATURE OF ADULT ENROLLEE OR GUARDIAN	SOCIAL SECURITY NUMBER (LAST FOUR DIGITS ONLY) XXX – XX -	DATE SIGNED

(IF NOT ENROLLEE SIGNATURE, RELATIONSHIP OF ADULT TO THE ENROLLEE)

PRINTED NAME OF ADULT

ADDRESS	HOME PHONE NUMBER	WORK PHONE NUMBER

Section 9 of the National School Lunch Act requires that, unless your SNAP, Medicaid, or SSI case number is provided, you must include the last four digits of the social security number of the adult household member signing the application or indicate that the household member signing the application does not possess a social security number. Provision of the last four digits of the social security number is not mandatory, but if it is not provided or an indication is not made that the signer has none, the application cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the accuracy of information stated on the application. These verification efforts may be carried out through program reviews and investigations, and may include contacting employers to determine income, contacting a SNAP or welfare office to determine current certification for receipt of SNAP, Medicaid, or SSI benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to provide 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.

FOR CENTER USE ONLY

TOTAL HOUSEHOLD SIZE:	INCOME:	INCOME BASED ON (CHECK ONE): YEAR ❑ MONTH ❑ 2 X A MONTH ❑ EVERY 2 WEEKS ❑ WEEKLY ❑ SNAP ❑ SSI ❑ MEDICAID ❑

Eligibility Determination: ❑ Free ❑ Reduced ❑ Paid

SIGNATURE OF CENTER REPRESENTATIVE ►	DATE

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

1. **mail:** U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or

2. **fax:** (833) 256-1665 or (202) 690-7442; or

3. **email:** program.intake@usda.gov

This institution is an equal opportunity provider.