

**North Carolina Department of Health and Human Services  
Women's and Children's Health  
CHILD AND ADULT CARE FOOD PROGRAM  
ADULT ELIGIBILITY APPLICATION**

Name of Institution \_\_\_\_\_

Telephone # \_\_\_\_\_

CACFP Agreement # \_\_\_\_\_

1. Participant Name: \_\_\_\_\_  
First Last

2. MEDICAID, SSI, FDPIR, or SNAP HOUSEHOLDS: If the adult participant is currently included in a Medicaid, SSI, FDPIR and/or SNAP program, they are automatically eligible to receive free Program meal benefits, subject to the completion of the application. Please list the participant's case or program number instead of listing income.

Medicaid # \_\_\_\_\_

SNAP # \_\_\_\_\_

SSI # \_\_\_\_\_

FDPIR ID # \_\_\_\_\_

If you have provided the case number, **do not complete #3. Complete #4 (voluntary) and #5.**

3. HOUSEHOLD INCOME: List the income of the participant, and if residing with the participant, their spouse, and any dependents of the adult participant who reside with them. List all gross income (before deductions) received last month. **If you did not give a Medicaid, SSI, FDPIR and/or SNAP case number, you must complete the income information.**

Names of Household Members	Monthly Wages/Salaries	Monthly Social Security	Monthly Retirement Pensions Earnings	Other Monthly Earnings
	\$	\$	\$	\$
	\$	\$	\$	\$
	\$	\$	\$	\$

4. ETHNIC IDENTITY: (Check one)  Hispanic or Latino  Not Hispanic or Latino

RACE: (Check one or more)  White  Black or African American  Asian

American Indian or Alaskan Native  Native Hawaiian or Other Pacific Islander

5. SIGNATURE AND LAST FOUR DIGITS OF THE SOCIAL SECURITY NUMBER: I certify that all of the above information 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 Program officials may verify the information on the application and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal criminal laws.

Signature of Participant or Adult Household Member - Required \_\_\_\_\_ Date \_\_\_\_\_ Check here if no SSN   
Last four digits of the Social Security number  
(Required for households qualifying by income)

Printed Name \_\_\_\_\_ Telephone # \_\_\_\_\_

**Address**

Section 9 of the National School Lunch Act requires that, unless a SNAP, or FDPIR case number or SSI or Medicaid assistance identification number is provided for the adult for whom benefits are sought, you must include the last four digits of your social security number on the application. This must be the last four digits of the social security number of the adult household member signing the application. If the adult household member signing the application does not possess a social security number, he/she must indicate so on the application. Provision of the last four digits of the social security number is not mandatory, but if the last four digits of the social security number is not provided or an indication is not made that the adult household member signing the application does not have one, the application cannot be approved. This notice must be brought to the attention of the household member whose last four digits of his/her social security number is disclosed. The last four digits of the social security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a SNAP, Indian tribal organization or welfare office to determine current certification for receipt of SNAP or FDPIR benefits, contacting the issuing office of SSI or Medicaid benefits to determine current certification for receipt of these benefits, contacting the State employment security office to determine the amount of benefits received, and checking the documentation produced by household members to provide the amount of income received. These efforts may result in loss or reduction of benefits, administrative claims or legal action if incorrect information is reported.

**For Institution Use Only**

TOTAL HOUSEHOLD SIZE: \_\_\_\_\_ TOTAL HOUSEHOLD MONTHLY INCOME: \$ \_\_\_\_\_

Approved:  Free  Reduced  Denied

Reason for denial:  Income too high  Incomplete application  Other

Withdrawn on (Date) \_\_\_\_\_

**For state use only:**  
 Verified by: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Verified classification:  
 Free  Reduced  Denied  
 Reason for change in classification:

Signature of Eligibility Official (Individual at the Institution level) - Required \_\_\_\_\_ Date - Required \_\_\_\_\_

## CACFP ADULT ELIGIBILITY APPLICATION INSTRUCTIONS

Please complete the Child and Adult Care Food Program Adult Eligibility Application using the instructions below. Sign the statement and return it to the adult day care center.

### **PART 1 - PARTICIPANT'S INFORMATION: Complete this part.**

Print the name of the adult participant enrolled in the center.

### **PART 2 - HOUSEHOLDS RECEIVING SNAP, MEDICAID, SSI, OR FDPIR BENEFITS:**

**Complete PART 2 and PART 5.**

1. List the current SNAP, Medicaid, SSI, or FDPIR case or program number.
2. An adult household member must sign the statement in PART 5.

### **PART 3 - HOUSEHOLD INCOME: Complete this PART and PART 5**

1. List the income of the participant, and if residing with the participant, their spouse, and any *dependents of the adult participant who reside with them*.
2. Write the amount of income (the amount before taxes or anything else is taken out), the frequency of income (i.e. weekly, every two weeks, twice a month, or monthly) received **last month** for each person listed and where it came from, such as earnings, welfare, pensions and other income (refer to examples below for types of income to report). If any amount last month was less than usual, write the person's usual income.
3. An adult household member must sign this income eligibility statement and give the last four digits of his/her security number in PART 5.

### **PART 4-ETHNIC/RACIAL IDENTITY: Complete the Ethnic/Racial identity question.**

Select the Ethnic Identity and Race of the Participant.

### **PART 5-SIGNATURE AND LAST FOUR DIGITS OF THE SOCIAL SECURITY NUMBER:**

**All households complete this PART.**

1. All eligibility statements must have the signature of an adult household member;
2. If the participant is qualifying by income, the adult household member who signs the statement must include **the last four digits** of his/her social security number. If he/she does not have a social security number, write "none". If you listed a SNAP, Medicaid, SSI, or FDIR number the last four digits of a social security number is not needed.

### **INCOME TO REPORT**

<b>Earnings from Employment</b>	<b>Pensions/Retirement/Social Security</b>	<b>Other Income</b>
Wage/Salaries/Tips Strike Benefits Unemployment Compensation Worker's Compensation Net Income from Self-Owned Business or Farm	Pensions Supplemental Security Income Retirement Income Veteran's Payments Social Security	Disability Benefits Cash withdrawn from savings Interest/Dividends Income from Estates/Trusts/Investments Regular contributions from persons not living in the household
<b>Welfare/Child Support/Alimony</b>	<b>Military Households</b>	Net Royalties/Annuities Net Rental Income Any Other Income
Public Assistance payments Welfare payments Alimony/Child support payments	All cash income including military housing/uniform allowances. Does not include "in-kind" benefits NOT paid in cash (base housing, clothing, food medical care, etc.)	

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 Women's and Children's Health  
**CHILD AND ADULT CARE FOOD PROGRAM  
 ADULT ELIGIBILITY APPLICATION**

**ADULT PARTICIPANT HOUSEHOLD LETTER FOR NON-PRICING INSTITUTIONS  
 CHILD AND ADULT CARE FOOD PROGRAM**

**Dear Participant or Adult Household Member,**

Please help us comply with the federal requirement mandating the annual submission of Program Eligibility Application (CAC 11A). This application will be used only for eligibility determination, placed in our files and treated as confidential information. In order for participants and the day care center to be considered eligible for program benefits, the adult participant or an adult household member must complete the Program Eligibility Application for each participant enrolled in the center as soon as possible, sign, date and return it to the day care center. Completion of the application is not mandatory for participants unless you wish to be considered for eligibility as a free or reduced priced participant.

**SNAP, Supplemental Security Income (SSI), Medicaid, Food Distribution Program on Indian Reservations**

**Households (FDPIR) participants:** If the participant currently receives SNAP, SSI, Medicaid or FDPIR the participant is automatically eligible for free meals. You only have to list the SNAP case number, SSI, Medicaid or FDPIR identification number, sign, date and return the application.

**Household Income:** If the participant does not participate in any of the programs mentioned above but the participant's household income is at or below the level shown on the scale below, the participant is eligible for either free or reduced price meals. To apply for meal benefits, the following information must be provided or the application cannot be approved.

**\*Household Members:** List the income of the participant, and, if residing with the participant, their spouse, and any dependents of the adult participant who reside with them.

**\*Current Income:** List the amount of income each person (participant, spouse, and dependent children) received last month (BEFORE deductions for taxes, social security, etc.), frequency of income and where it is from, such as wages, retirement, or public assistance. If any household member's income last month was higher or lower than usual, list that person's expected average monthly income.

**\*Signature:** an adult household member must sign the application.

**\*Social Security Number:** If the participant is qualifying by income, list the last four digits of the social security number of the adult who signs the application. If that adult does not have a social security number, print "None".

**If you have a household member whose last month's income was higher or lower than usual, list that person's expected average monthly income.**

**Effective from July 1, 2016 to June 30, 2017  
 REDUCED GUIDELINES**

HOUSEHOLD SIZE	YEARLY	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
1	\$21,978	\$1,832	\$916	\$846	\$423
2	\$29,637	\$2,470	\$1,235	\$1,140	\$570
3	\$37,296	\$3,108	\$1,554	\$1,435	\$718
4	\$44,955	\$3,747	\$1,874	\$1,730	\$865
5	\$52,614	\$4,385	\$2,193	\$2,024	\$1,012
6	\$60,273	\$5,023	\$2,512	\$2,319	\$1,160
7	\$67,951	\$5,663	\$2,832	\$2,614	\$1,307
8	\$75,647	\$6,304	\$3,152	\$2,910	\$1,455
<b>For each additional family member add:</b>	\$7,696	\$642	\$321	\$296	\$148

You may submit a program eligibility application any time during the fiscal year. Participants having family members who become unemployed are eligible for free or reduced-price meals during the period of unemployment, provided that the loss of income causes the family's income during the period of unemployment to be within the eligibility standards for those meals.