Dear Participant or Adult Family Member or Guardian:

Our adult care institution has been approved by the Nebraska Department of Education for participation in the Child and Adult Care Food Program (CACFP). The CACFP reimburses our institution for the partial cost of meals. We are requesting your help to receive the maximum benefits from the CACFP by completing the attached form (NS)200-C. All information contained on this form is ***confidential.***

The participant/adult family member/guardian must complete Parts 1 and 4 and one of the following options*:* Part 2, Part 3A or Part 3B, to determine the amount of CACFP funds the center will be eligible to receive. This form will be placed in our files and treated as confidential information. **Note:** No ***white out*** or ***eraser ink*** should be used**.** If there is an error cross through, correct, and initial.

Part 1 – PARTICIPANT ENROLLMENT

- Participant's Name: List the first and last name of participant.
- Date of Birth: List participant's date of birth.
- Enrollment Date: List participant's enrollment date with organization.

Optional: Check the boxes of all appropriate race(s) and ethnicities regarding the participant being enrolled.

Part 2 - Households receiving *benefits* from the Supplemental Nutrition Assistance Program **(SNAP),** Temporary Assistance for Needy Families **(TANF),** or Food Distribution Program on Indian Reservations **(FDPIR):**

- Complete Parts 1, 2 and 4 on the attached form.
- Provide the name and case number for the program from which benefits are received.

Part 3A - Household **exceeding** the income guidelines listed on the chart below:

- Complete Parts 1, 3A and 4 on the reverse side.

TO CALCULATE ANNUAL INCOME

Weekly Income X 52 ♦ Every 2 Weeks Income X 26 ♦ Twice a Month Income X 24 ♦ Monthly Income X 12

Household Size:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	Each Additional Family Member
Annual Income:	$22,459	$30,451	$38,443	$46,435	$54,427	$62,419	$70,411	$78,403	+ $7,992

Part 3B - Household **below** the income guidelines listed complete as follows - Complete Parts 1, 3B and 4 on the attached form with the additional information below:

- HOUSEHOLD NAMES: Write the names of everyone in the household. Include participant, participant's spouse, and/or any other individuals who reside with the participant and depend on the participant for economic support. Functionally impaired adults living with their parents are considered a "family" separate from their parents.
- GROSS INCOME BEFORE DEDUCTIONS: Write the amount of income each person gets on the same line as their name. Use the appropriate column(s): Earnings from Work, Welfare/Child Support/Alimony, Pensions/Retirement/Social Security or Other Income (see list below). Next to the amount of income write how often the income is received. Income is all money before taxes or anything else is taken out. If a person does not have income, check the box for zero income.
  - OTHER INCOME: Strike benefits, unemployment compensation, workman's compensation, disability benefits, interest/dividends, cash withdrawn from savings, income from estates/trusts/investments, royalties/annuities/rental income, regular contributions from person not living in the household.
  - MILITARY HOUSING BENEFITS: Report off-base housing allowance as income. If the housing is part of the Military Housing Privatization Initiative, do not include as income.
  - SELF-EMPLOYMENT: Report income derived from the business venture less operating costs for net income. The loss from the business cannot be deducted from a positive income earned in other employment. The least possible income is zero.
- SOCIAL SECURITY NUMBER: Write the last four (4) digits of the social security number of the participant or adult family member or guardian who signs the forms. If the participant or adult family member or guardian does not have a social security number, check the box. Use of this information is for CACFP use only and is required.

Part 4 SIGNATURE AND CONTACT INFORMATION:

- Sign and date the application. The form must be signed by the participant or an adult family member or guardian.
- Complete the contact information – name, address, telephone number, and employer information.

Privacy Act Statement:
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 funds your adult care center receives may be impacted. 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 apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-Discrimination Statement:
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.

As stated above, all protected bases do not apply to all programs, "*the first six protected bases of race, color, national origin, age, disability and sex are the six protected bases for applicants and recipients of the Child Nutrition Programs.*"

For assistance completing this form, contact the center:

Center Name:_____

Address:_____

City, State, Zip:_____

Center Contact Person:_____

Telephone: _____

E-Mail:_____

The State Agency administering the Child and Adult Care Food Program is:
Nebraska Department of Education
Nutrition Services
P.O. Box 94987
Lincoln, NE 68509
Telephone: 402-471-2488
Web site: http://www.education.ne.gov/NS

Revised 3/2018

INCOME ELIGIBILITY AND ENROLLMENT FORM FOR ADULT DAY CARE CENTERS
JULY 1, 2018 THROUGH JUNE 30, 2019

Part 1. PARTICIPANT: Complete the participant's name, date of birth, ethnicity and race.

Last Name, First Name	Date of Birth	Enrollment Date

OPTIONAL: Please check the ethnicity and race of the participant you are enrolling.

Ethnicity (select one or more): ❑Hispanic or Latino ❑ Not Hispanic or Latino

Race (select one or more): ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or other Pacific Islander ❑ White or Caucasian

Part 2. Households receiving *benefits* from the Supplemental Nutrition Assistance Program (**SNAP**), Temporary Assistance for Needy Families (**TANF**), or Food Distribution Program on Indian Reservations (**FDPIR**): Supplemental Security Income **(SSI), or Medicaid: Complete Parts 1, 2 and 4.**

Check Applicable Program(s): ❑ **SNAP** ❑: **TANF** ❑ **FDPIR** ❑**SSI** ❑ **Medicaid** **Master Case #:** _____

Part 3A. HOUSEHOLDS EXCEEDING THE INCOME GUIDELINES: Complete Parts 1, 3A and 4.

If your family income exceeds the income guidelines (listed on attached letter), check this box ❑

Part 3B. ALL OTHER HOUSEHOLDS – If you **do not have** a SNAP, TANF, FDPIR, SSI or Medicaid case number, complete Parts 1, 3B and 4.

List the Names of All Household Members including participant.	GROSS INCOME BEFORE ANY DEDUCTIONS (Net for Self Employed) W=Weekly E2=Every 2 weeks 2M=Twice a month M=Monthly Y=Yearly								
	Earnings from Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		All Other Income		Check If ZERO income
	How much?	How often?	How much?	How often?	How much?	How often?	How much?	How often?	
1									❑
2									❑
3									❑
4									❑

Social Security Number of Household Member who signs form:

Last four digits of Social Security Number: XXX – XX - _____ If you do not have a Social Security Number, check this box ❑

Part 4. SIGNATURE AND CONTACT INFORMATION:

I certify that all information on this form is true and that all income is reported. I understand that the facility will receive 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 their meal benefits, and I may be prosecuted.

_____ _____
Signature of Participant or Adult Family Member or Guardian Date Signed

Street Address: _____ Telephone:_____

City/State: _____ E-Mail:_____

FOR CENTER USE ONLY

_____ SNAP/TANF/FDPIR/SSI/MEDICAID HOUSEHOLD

_____ ANNUAL INCOME: _____ HOUSEHOLD SIZE: _____

HOUSEHOLD CATEGORY: ❒ Free ❒ Reduced Price ❒ Paid

Center Official Signature:_____ Date of Signature:_____

Effective Date:_____ Expiration Date:_____