

Provider Name: _____
 Number: _____

**CHILD AND ADULT CARE FOOD PROGRAM - HOMES
 HOUSEHOLD INCOME STATEMENT
 For Participating Family**



MAIL TO:
CCNI
PO BOX 138
IVANHOE, MN 56142

Please complete this form if your household income is within the attached income guidelines, or you have children with public assistance case numbers or a foster child. The information requested is private data and will not be available to your child care provider. Return the completed form directly to your child care provider's sponsoring organization.

- 1.** I have completed this form for (check one):
- All children in my household (except foster children)**, from birth through high school. See definition of "household" below in Section 2. Attach an additional page if necessary.
 - One foster child** listed below, who is in my care and is the legal responsibility of a social services agency or court (see "Foster Care" section on back page). List the foster child's name, date of birth, and, in the last column, information about foster care funds for the child's personal use. Do not list any other children in the household. Skip Section 2 and sign in Section 3. Complete a separate form for each foster child.

Names of All Children or Name of One Foster Child First Name Last Name	Check here if child is enrolled in the family day care home ✓	Birth Date	If applicable Case Number(s) MFIP, Food Assistance (Stamps), or FDPIR Only Program Case Number		If applicable SSI or Other Regular Income to Child	If Foster Child
1					\$ _____ per _____	Foster care funds available for child's personal use (check one): ≤ \$ _____ per month ≤ None
2					\$ _____ per _____	
3					\$ _____ per _____	
4					\$ _____ per _____	
5					\$ _____ per _____	
6					\$ _____ per _____	

- 2.** List all adults in the household, all incomes, and how often each income is received. The household is all related or unrelated individuals who share housing and/or other significant expenses. Attach an additional page if necessary. Do not complete this section if all children in care in Section 1 have case numbers or if a foster child is listed.

Names of Adult Household Members (all household members not listed in Section 1)		Check this column if person has NO INCOME ✓	Incomes				
First Name	Last Name		Write in the gross incomes (before deductions) received by your household. Write in how often each income is received: per "week," "2 weeks," "2 X month," "month," or "year." If income fluctuates, write in the amount normally received. For farm or self-employment income only , list net income (after deductions).				
			Wages and Salaries from all jobs - before deductions -	Social Security, Pension, Retirement	Public Assistance, Child Support, Alimony	Unemployment, Worker's Comp, Strike Benefits	Any Other Income, including net Farm/ Self-Employment
<i>Example Jane</i>	<i>Smith</i>		\$ <u>500</u> per <u>2</u> weeks	\$ _____ per _____	\$ <u>200</u> per month	\$ _____ per _____	\$ _____ per _____
1			\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____
2			\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____
3			\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____

- 3.** I certify that the information provided on this application is true and correct. Because federal and state funds may be paid on the basis of this information, I understand that program officials may verify the information, and that deliberate misrepresentation may subject me to prosecution under applicable laws.

Signature of Adult Household Member (required) _____

Social Security Number (required if Section 2 is completed): _____ - _____ - _____

Or - if you do not have a Social Security number, check here:

Printed Name: _____ **Date:** _____

Address: _____ **Phone:** _____

Sponsor Use Only – Do Not Write Below

Total household members: _____

Total monthly incomes: \$ _____

Categorical eligibility

Approved Tier I Temporary until _____

Denied _____ Income _____ Incomplete _____ Other:

Sponsor Signature & Date: _____

Effective Dates: From _____ through _____

FLUCTUATING INCOME

FARMER OR SELF-EMPLOYED: Income is net income (after deducting expenses) during the year. List *average net income* per month or other frequency. A loss from self-employment must be listed as zero income and does not reduce other income for the purpose of completing this form.

SEASONAL WORKER: Income is the expected *average gross income* (before deductions) during the year. List *average gross income* per month or other frequency.

SOCIAL SECURITY NUMBER

The Richard B. Russell National School Lunch Act requires the information on this Household Income Statement. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include 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 Food Stamp, Minnesota Family Investment Plan (MFIP), or Food Distribution Program on Indian Reservations (FDPIR) case number 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 your child is eligible for free or reduced price meals, and for administration and enforcement of the program.

FOSTER CHILD

DEFINITION: A foster child is a child who is living with a household but who remains the legal responsibility of the welfare agency or court. A foster child is considered a household of one.

INCOME FOR FOSTER CHILDREN: In determining income for the foster child, include only funds provided by the welfare agency that are specifically identified by category for *personal use* of the foster child, such as clothing, school fees and allowances. Where funds cannot be identified by category, no portion of the provided funds is considered as income to the child.

Funds for shelter and care, and those identified as special needs funds, such as those for medical and therapeutic needs are not considered as income to the child.

CIVIL RIGHTS – NONDISCRIMINATION

In accordance with federal law and U.S. Department of Agriculture (USDA) policy, this organization is prohibited from discrimination on the basis of race, color, national origin, sex, age or disability.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue SW, Washington, D.C. 20250-9410 or call (800) 795-3272 or (202) 720-6382.

USDA is an equal opportunity employer and provider.