North Carolina Department of Health and Human Services
Division of Child and Family Well-Being, Community Nutrition Services Section
Child and Adult Care Food Program

ADULT INCOME ELIGIBILITY APPLICATION

INSTITUTION NAME: Granville Health System FACILITY NAME: HSADC AGREEMENT#: 6586

1. Participant Name: _____
   First Last

2. MEDICAID, SNAP, Supplemental Security Income (SSI), or FDPIR: Provide the participant's case or program number if applicable.

   Medicaid # _____ **SNAP #** _____

   SSI # _____(Last 4 digits only) **FDPIR #**_____

   If you have provided a Medicaid, SNAP, SSI, or FDPIR 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 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.

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

_____ _____
Printed Name Telephone #

_____
Address

For Institution Use Only

TOTAL HOUSEHOLD SIZE: _____TOTAL HOUSEHOLD MONTHLY INCOME: $_____
Approved: ☐ Free ☐ Reduced-Price ☐ Denied
Reason for denial: ☐ Income too high ☐ Incomplete application ☐ Other_____

Withdrew on (Date) _____

For state use only:
Verified by: _____ Date: _____
Verified classification:
☐ Free ☐ Reduced-Price ☐ Denied
Reason for change in classification: _____

_____ _____
Signature of Eligibility Official (Individual at the Institution level) - Required Date – Required

This institution is an equal opportunity provider.

NC CACFP ADULT INCOME ELIGIBILITY APPLICATION INSTRUCTIONS

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

1 - PARTICIPANT'S INFORMATION: Complete this part.

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

2 - HOUSEHOLDS RECEIVING MEDICAID, SNAP, 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.

3 - HOUSEHOLD INCOME:

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.

Monthly Income Conversion: Weekly X 4.33 Every 2 Weeks X 2.15 Twice a Month X 2

INCOME TO REPORT

<table>
<tr><th>Earnings from Employment</th><th>Pensions/Retirement/Social Security</th><th rowspan="3">Other Income</th></tr>
<tr><td>Wage/Salaries/Tips
Strike Benefits
Unemployment Compensation
Worker's Compensation
Net Income from Self-Owned Business or Farm</td><td>Pensions
Supplemental Security Income
Retirement Income
Veteran's Payments
Social Security</td></tr>
<tr><th>Welfare/Child Support/Alimony</th><th>Military Households</th></tr>
<tr><td>Public Assistance payments
Welfare payments
Alimony/Child support payments</td><td>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.)</td><td>Disability Benefits
Cash withdrawn from savings
Interest/Dividends
Income from Estates/Trusts/Investments
Regular contributions from persons not living in the household
Net Royalties/Annuities
Net Rental Income
Any Other Income</td></tr>
</table>

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

Select the Ethnic Identity and Race of the Participant.

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 FDPIR number, the last four digits of a social security number is not needed.

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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. This application will be used only for eligibility determination, placed in our files, and treated as confidential information. 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 which to be considered for eligibility as a free or reduced priced participant.

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

REDUCED GUIDELINES EFFECTIVE JULY 1, 2023 - JUNE 30, 2024*

HOUSEHOLD SIZE	YEARLY	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
1	$26,973	$2,248	$1,124	$1,038	$519
2	$36,482	$3,041	$1,521	$1,404	$702
3	$45,991	$3,833	$1,917	$1,769	$885
4	$55,500	$4,625	$2,313	$2,135	$1,068
5	$65,009	$5,418	$2,709	$2,501	$1,251
6	$74,518	$6,210	$3,105	$2,867	$1,434
7	$84,027	$7,003	$3,502	$3,232	$1,616
8	$93,536	$7,795	$3,898	$3,598	$1,799
For each additional family member add:	$9,509	$793	$397	$366	$183

*Households with income less than or equal to these levels are eligible for free or reduced-price meals.

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.

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