

**Child and Adult Care Food Program
Adult Day Care
Income Eligibility Form (IEF) 2015-2016**

Part 1 - Write your name and age. Please indicate your race and ethnicity. If this information is left blank, a representative of the center will complete according to visual identification. This information is strictly for statistical reporting requirements and does not affect eligibility.

A=Asian; **AI/AN**=American Indian or Alaskan Native; **B/AA**=Black or African American; **H/PI**=Native Hawaiian or other Pacific Islander; **W**=White.

Your Name (First & Last)	Age	Ethnicity (select one) and Race (select one or more)	
Diana Smith	99	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino	Race: <input type="checkbox"/> A <input checked="" type="checkbox"/> AI/AN <input type="checkbox"/> B/AA <input type="checkbox"/> H/PI <input type="checkbox"/> W

Part 2 - Complete this section if you currently receive benefits from Medicaid or Supplemental Security Income (SSI), or if any member of your household receives Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance (SNAP), previously known as Food Stamps, or benefits of the Food Distribution Program on Indian Reservations (FDPIR). Only one is required to qualify for free meals.

If you complete Part 2, skip Part 3 and 4, and continue to Part 5.

Medicaid Number	SSI Number	SNAP, TANF, or FDPIR Case Number
G123456		

Part 3 - Complete this section if Part 2 did not apply to you. In the Name column, list your full name and the name of your spouse and/or any other people who live with you and depend on you for financial support. If you need more space, use a separate sheet of paper. Refer to the information below for descriptions of various types of income.

Gross Income/Salary/Wages

- Gross earned income or cash income before deductions. **List '0' if income is negative.**
- Monetary compensation for services, including wages, salary, tips, strike benefits, commissions, fees, withdrawals from savings, investments, trust accounts, and other accounts.
- Net income from self-owned businesses and farms.
- Social Security, public assistance or Welfare payments (e.g. TANF, General Assistance/General Relief), alimony, child support payments, and unemployment and worker's compensation.
- Private pensions or annuities, retirement benefits, disability benefits, veteran's benefits, dividends or interest, income from estates, trusts or investments, net rental income, cash withdrawals from savings, and net royalties.
- Student financial assistance (grants or scholarships) not used to meet education expenses.
- Regular contributions from persons not living in the household or any other money that may be available to pay for child(ren)'s meals.

Name	Gross Income/Salary/Wages	Other Income	TOTALS Center Use ONLY
(Yourself)	\$ W M A	\$ W M A	\$ W M A
	\$ W M A	\$ W M A	\$ W M A
	\$ W M A	\$ W M A	\$ W M A
Total Income			\$ W M A

Total number in household who depend on you for financial support (including yourself): _____

Note: If necessary, convert multiple income schedules to annual income. Multiply weekly income by 52, bi-weekly by 26, monthly by 12.

Part 4 Provide the last four digits of a Social Security Number (SSN) for yourself, your guardian, or the household member who signs this form. The SSN is not required if you provided a Medicaid, SSI, TANF, SNAP, or FDPIR case number in Part 2.

X	X	X	-	X	X	-				
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Check this box if the person signing the form does not have a SSN.

Part 5 I certify that all of the information on this form is true and correct and is provided in connection with the receipt of Federal funds. Center officials may verify information. Deliberate misrepresentation may subject me to prosecution under applicable State and Federal criminal statutes.

Signature of Person Completing Form: Diana Smith Date: 3/2/16 Street Address: 123 North St Denver CO City: Denver State: CO Zip Code: 80246

Printed Name: Diana Smith Home Telephone: 303 333 3333 Work Telephone: _____

FOR CENTER STAFF USE ONLY

Income Category (check one):
 Free Reduced Paid (Ineligible for Free or Reduced Priced meals)

This form expires 12 months after the month in which the Sponsor makes the determination. Example: If the determination date is July 2015, the form is valid from July 1, 2015 through July 31, 2016. The center may use the date the parent/guardian signs the income eligibility form; or the date on the center's official makes the determination, and signs and dates the income eligibility form. The same approval method selected must be used for all forms approved by the center.

Signature of Center's Eligibility Official: [Signature] Determination Date: 3 Month 2016 Year

The U.S. Department of Agriculture prohibits discrimination against its applicants and recipients of the Child Nutrition Programs on the bases of race, color, national origin, age, disability and sex. To file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.





Dedicated to protecting and improving the health and environment of the people of Colorado

Colorado Child and Adult Care Food Program Income Eligibility Form (IEF) 2015- 2016

Part 1 - Child(ren) Enrolled in Child Care: List name & age of each child enrolled. Indicate each child's race and ethnicity. If this information is left blank, the institution representative may complete it based on visual identification. This information is strictly for statistical reporting requirements and does not affect eligibility.

Note: A =Asian; AI/AN=American Indian or Alaskan Native; B/AA=Black or African American; H/PI=Native Hawaiian or other Pacific Islander; W=White.

Last Name	First Name	Age	Ethnicity (select one) and Race (select one or more)
Smith	Jessica	2	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino Race: <input type="checkbox"/> A <input type="checkbox"/> AI/AN <input type="checkbox"/> B/AA <input type="checkbox"/> H/PI <input checked="" type="checkbox"/> W
Smith	Alex	5	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino Race: <input type="checkbox"/> A <input type="checkbox"/> AI/AN <input type="checkbox"/> B/AA <input type="checkbox"/> H/PI <input checked="" type="checkbox"/> W
			Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino Race: <input type="checkbox"/> A <input type="checkbox"/> AI/AN <input type="checkbox"/> B/AA <input type="checkbox"/> H/PI <input type="checkbox"/> W

Other Source Categorically Eligible programs allow automatic eligibility at the Free rate in the CACFP when the institution obtains documentation from the corresponding agency and verifies children are enrolled in one of the programs listed below. If applicable, please check one of the boxes.

- One or more child listed above is a foster child who is the responsibility of the State or was placed by the court. The institution must obtain documentation from the placement agency verifying the child is a foster child.
- One or more child listed above is an Early Head Start, or Head Start child or pregnant mother or an Even Start enrolled child, who is categorically eligible for free meals and therefore is not required to complete an IEF. However, one of the following documents from the Head Start program must be on file: 1) An approved Head Start or Even Start application; 2) A statement of Head Start or Even Start enrollment; or 3) A list of participants from the Even Start or Head Start official listing the Early Head Start or Head Start child's or pregnant mother's name. 4) For the Even Start documentation from the Even Start official that confirms the child has not entered Kindergarten.
- If one or more child listed above is a homeless, migrant, or runaway child, the institution must obtain documentation verifying the status of the child from the director of the homeless shelter, Migrant Education Program Coordinator, or an official of the Runaway and Homeless Youth program.

Please note: If you marked one of the boxes listed above, you do not need to complete the rest of this form. **SKIP TO PART 5 – Signature.**

Part 2 - Assistance Programs: Does anyone in your household receive benefits from any of the programs listed below?

If **no**, go to Part 3.

If **yes**, please mark which assistance program (only one is required), write the case number, and **SKIP TO PART 5 – Signature.**

- Supplemental Nutrition Assistance Program (SNAP), previously known as Food Stamps Case Number: _____
- Temporary Assistance for Needy Families (TANF) Case Number: _____
- Food Distribution Program on Indian Reservations (FDPIR) Case Number: _____

(Quest Card or Social Security Numbers are not acceptable)

Part 3 - Income to report: List the names of all household members who are not listed in Part 1. Write the amount of income received by each household member for the current month, projected income for the first month of the application, or the month prior to the application. Indicate if income is weekly (W), monthly (M), or annually (A).

Gross Income/Salary/Wages

- Gross earned income or cash income before deductions.
- Monetary compensation for services, including wages, salary, tips, strike benefits, commissions, fees, withdrawals from savings, investments, trust accounts, and other accounts.
- Net income from self-owned businesses and farms.
- Social Security, public assistance or Welfare payments (e.g. TANF, General Assistance/General Relief), alimony, child support payments, and unemployment and worker's compensation.
- Private pensions or annuities, retirement benefits, disability benefits, veteran's benefits, dividends or interest, income from estates, trusts or investments, net rental income, cash withdrawals from savings, and net royalties.
- Student financial assistance (grants or scholarships) not used to meet education expenses.
- Regular contributions from persons not living in the household or any other money that may be available to pay for child(ren)'s meals.

List '0' if income is negative.

Last Name	First Name	Gross Income/ Salary/Wages	Other Income	TOTALS Center Use Only
Smith	Sally	\$ 1,000 W (M) A	\$ W M A	\$ 1,000 W (M) A
Smith	Zach	\$ 1,000 W (M) A	\$ W M A	\$ 1,000 W (M) A
		\$ W M A	\$ W M A	\$ W M A
		\$ W M A	\$ W M A	\$ W M A
Total Number in Household <u>4</u>			Total Income:	\$ W (M) A <u>2000</u>

Note: If necessary, convert multiple income schedules to annual income. Multiply weekly income by 52, bi-weekly by 26, monthly by 12.

Part 4 - Social Security Number: If the adult household member completing this form does not provide a TANF, SNAP, or FDIPIR number in Part 2, the person completing this form must provide the last four digits of his/her Social Security Number (SSN).

X X X - X X - 0 0 0 0

Check this box if the adult household member signing this form does not have a Social Security Number.

Part 5 - Signature: I certify that all of the information on this form is true and correct and is given in connection with the receipt of Federal Funds. Institution officials may verify information. Deliberate misrepresentation may subject me to prosecution under applicable State and Federal criminal statutes. Note: If the child is a foster child, an official of a court or other agency with responsibility for the child may sign this form.

Signature of Adult Household Member: Sally Smith Date: 3/2/16
 Street Address: 123 East St
 City: Denver State: CO Zip Code: 80240
 Printed Name: Sally Smith
 Home Telephone: 35555555 Work Telephone: _____

FOR CENTER STAFF USE ONLY

Income Category (check one): Free Reduced Paid (Ineligible for Free or Reduced Priced meals)

This form expires 12 months after the month in which the institution makes the determination. Example: If the determination date is July 2015, the form is valid from July 1, 2015 through July 31, 2016. The institution may use the date the parent/guardian signs the income eligibility form, OR the date the sponsor's official makes the determination and signs and dates the income eligibility form. The same approval method selected must be used for all forms approved by the Sponsor.

Signature of Center's Eligibility Official: _____ Determination Date: 3 / 2016
 Month Year

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Part 1- Child(ren) Enrolled in Child Care: List name & age of each child enrolled. Indicate each child's race and ethnicity. If this information is left blank, the institution representative may complete it based on visual identification. This information is strictly for statistical reporting requirements and does not affect eligibility.

Note: A =Asian; AI/AN=American Indian or Alaskan Native; B/AA=Black or African American; H/PI=Native Hawaiian or other Pacific Islander; W=White.

Last Name	First Name	Age	Ethnicity (select one) and Race (select one or more)
Jones	Robert	2	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino Race: <input type="checkbox"/> A <input type="checkbox"/> AI/AN <input type="checkbox"/> B/AA <input type="checkbox"/> H/PI <input checked="" type="checkbox"/> W
			Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino Race: <input type="checkbox"/> A <input type="checkbox"/> AI/AN <input type="checkbox"/> B/AA <input type="checkbox"/> H/PI <input type="checkbox"/> W
			Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino Race: <input type="checkbox"/> A <input type="checkbox"/> AI/AN <input type="checkbox"/> B/AA <input type="checkbox"/> H/PI <input type="checkbox"/> W

Other Source Categorically Eligible programs allow automatic eligibility at the Free rate in the CACFP when the institution obtains documentation from the corresponding agency and verifies children are enrolled in one of the programs listed below. If applicable, please check one of the boxes.

- One or more child listed above is a foster child who is the responsibility of the State or was placed by the court. The institution must obtain documentation from the placement agency verifying the child is a foster child.
- One or more child listed above is an Early Head Start, or Head Start child or pregnant mother or an Even Start enrolled child, who is categorically eligible for free meals and therefore is not required to complete an IEF. However, one of the following documents from the Head Start program must be on file: 1) An approved Head Start or Even Start application; 2) A statement of Head Start or Even Start enrollment; or 3) A list of participants from the Even Start or Head Start official listing the Early Head Start or Head Start child's or pregnant mother's name. 4) For the Even Start documentation from the Even Start official that confirms the child has not entered Kindergarten.
- If one or more child listed above is a homeless, migrant, or runaway child, the institution must obtain documentation verifying the status of the child from the director of the homeless shelter, Migrant Education Program Coordinator, or an official of the Runaway and Homeless Youth program.

Please note: If you marked one of the boxes listed above, you do not need to complete the rest of this form. **SKIP TO PART 5 – Signature.**

Part 2 - Assistance Programs: Does anyone in your household receive benefits from any of the programs listed below?

If no, go to Part 3.

If yes, please mark which assistance program (only one is required), write the case number, and **SKIP TO PART 5 – Signature.**

- Supplemental Nutrition Assistance Program (SNAP), previously known as Food Stamps Case Number: _____
- Temporary Assistance for Needy Families (TANF) Case Number: 1823456
- Food Distribution Program on Indian Reservations (FDPIR) Case Number: _____

(Quest Card or Social Security Numbers are not acceptable)

Part 3-Income to report: List the names of all household members who are not listed in Part 1. Write the amount of income received by each household member for the current month, projected income for the first month of the application, or the month prior to the application. Indicate if income is weekly (W), monthly (M), or annually (A).

Gross Income/Salary/Wages

- Gross earned income or cash income before deductions.
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- Net income from self-owned businesses and farms.
- Social Security, public assistance or Welfare payments (e.g. TANF, General Assistance/General Relief), alimony, child support payments, and unemployment and worker's compensation.
- Private pensions or annuities, retirement benefits, disability benefits, veteran's benefits, dividends or interest, income from estates, trusts or investments, net rental income, cash withdrawals from savings, and net royalties.
- Student financial assistance (grants or scholarships) not used to meet education expenses.
- Regular contributions from persons not living in the household or any other money that may be available to pay for child(ren)'s meals.

List '0' if income is negative.

Last Name	First Name	Gross Income/ Salary/Wages	Other Income	TOTALS Center Use Only
		\$ W M A	\$ W M A	\$ W M A
		\$ W M A	\$ W M A	\$ W M A
		\$ W M A	\$ W M A	\$ W M A
		\$ W M A	\$ W M A	\$ W M A
Total Number in Household			Total Income:	\$ W M A

Note: If necessary, convert multiple income schedules to annual income. Multiply weekly income by 52, bi-weekly by 26, monthly by 12.

Part 4 – Social Security Number: If the adult household member completing this form does not provide a TANF, SNAP, or FDIPIR number in Part 2, the person completing this form must provide the last four digits of his/her Social Security Number (SSN).

X	X	X	-	X	X	-				
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Check this box if the adult household member signing this form does not have a Social Security Number.

Part 5 - Signature: I certify that all of the information on this form is true and correct and is given in connection with the receipt of Federal Funds. Institution officials may verify information. Deliberate misrepresentation may subject me to prosecution under applicable State and Federal criminal statutes. Note: If the child is a foster child, an official of a court or other agency with responsibility for the child may sign this form.

Signature of Adult Household Member: Suzie Jones Date: 3/2/16
 Street Address: 123 West St
 City: Denver State: CO Zip Code: 80240
 Printed Name: Suzie Jones
 Home Telephone: 34444444 Work Telephone: _____

FOR CENTER STAFF USE ONLY

Income Category (check one): Free Reduced Paid (Ineligible for Free or Reduced Priced meals)

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Signature of Center's Eligibility Official: [Signature]

Determination Date: 3 / 2016
Month Year

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Part 1 - Write your name and age. Please indicate your race and ethnicity. If this information is left blank, a representative of the center will complete according to visual identification. This information is strictly for statistical reporting requirements and does not affect eligibility.

A =Asian; AI/AN=American Indian or Alaskan Native; B/AA=Black or African American; H/PI=Native Hawaiian or other Pacific Islander; W=White.

Your Name (First & Last)	Age	Ethnicity (select one) and Race (select one or more)
Christopher Jones	82	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino Race: <input type="checkbox"/> A <input type="checkbox"/> AI/AN <input type="checkbox"/> B/AA <input type="checkbox"/> H/PI <input checked="" type="checkbox"/> W

Part 2 - Complete this section if you currently receive benefits from Medicaid or Supplemental Security Income (SSI), or if any member of your household receives Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance (SNAP), previously known as Food Stamps, or benefits of the Food Distribution Program on Indian Reservations (FDPIR). Only one is required to qualify for free meals.

If you complete Part 2, skip Part 3 and 4, and continue to Part 5.

Medicaid Number	SSI Number	SNAP, TANF, or FDPIR Case Number

Part 3 - Complete this section if Part 2 did not apply to you. In the Name column, list your full name and the name of your spouse and/or any other people who live with you and depend on you for financial support. If you need more space, use a separate sheet of paper. Refer to the information below for descriptions of various types of income.

Gross Income/Salary/Wages

- Gross earned income or cash income before deductions. List '0' if income is negative.
- Monetary compensation for services, including wages, salary, tips, strike benefits, commissions, fees, withdrawals from savings, investments, trust accounts, and other accounts.
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- Private pensions or annuities, retirement benefits, disability benefits, veteran's benefits, dividends or interest, income from estates, trusts or investments, net rental income, cash withdrawals from savings, and net royalties.
- Student financial assistance (grants or scholarships) not used to meet education expenses.
- Regular contributions from persons not living in the household or any other money that may be available to pay for child(ren)'s meals.

Name	Gross Income/Salary/Wages	Other Income	TOTALS Center Use ONLY
(Yourself)			
Christopher Jones	\$ 250.00 W M A	\$ W M A	\$ 13,000 W M A
Erica Jones	\$ 1000.00 W M A	\$ W M A	\$ 12,000 W M A
	\$ W M A	\$ W M A	\$ W M A
Total Income			\$ 25,000 W M A

Total number in household who depend on you for financial support (including yourself): 2

Note: If necessary, convert multiple income schedules to annual income. Multiply weeklv income by 52. bi-weeklv by 26. monthlv by 12.

Part 4 Provide the last four digits of a Social Security Number (SSN) for yourself, your guardian, or the household member who signs this form. The SSN is not required if you provided a Medicaid, SSI, TANF, SNAP, or FDPIR case number in Part 2.

X X X - X X - 9999 Check this box if the person signing the form does not have a SSN.

Part 5 I certify that all of the information on this form is true and correct and is provided in connection with the receipt of Federal funds. Center officials may verify information. Deliberate misrepresentation may subject me to prosecution under applicable State and Federal criminal statutes.

Signature of Person Completing Form: Erica Jones Date: 3/22/16 Street Address: 123 South Street City: Denver State: CO Zip Code: 80246

Printed Name: Erica Jones Home Telephone: 3022-0000 Work Telephone:

FOR CENTER STAFF USE ONLY

Income Category (check one):
 Free Reduced Paid (Ineligible for Free or Reduced Priced meals)

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Signature of Center's Eligibility Official: [Signature] Determination Date: Month 3 Year 2016

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