California Department of Education Child and Adult Care Food Program

Nutrition Services Division CACFP 52 (REV. 8/2018)

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# MEAL BENEFIT FORM FOR ADULT PARTICIPANTS

# PROGRAM YEAR

Name of Adult Care Center:

Please read the instructions. If you need help completing this form, call:

Complete, sign, and return form to:

## PARTICIPANT INFORMATION

Enter the names of any adult participants from the same household who are enrolled for care. If the participant receives Medi-Cal or Supplemental Security Income (SSI) benefits, provide the case number below. If all participants listed below have a case number, go to Section 4 and sign this form.

| **Last Name** | **First Name** | **Middle Initial** | **Medi-Cal or SSI Case Number** |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

## BENEFITS

If anyone in the household receives CalFresh or Food Distribution Program on Indian Reservations (FDPIR) benefits, list the case number and **do not** complete Section 3. Go to Section 4

| **Program** | **Case Number** |
| --- | --- |
| CalFresh |  |
| FDPIR |  |

## ALL OTHER HOUSEHOLDS

Complete this section if you did not complete Section 2. List all household members, spouse, and any dependent children of the participant(s). List total household gross income and how often it is received (e.g., weekly, every two weeks, twice a month, monthly, or annually).

Check here if this household receives no income. Go to Section 4.

Applicants without income must write a **zero** in the applicable field or mark **no income**. Any income field left blank is a positive indication of no income and certifies that there is no income to report. Applications with blank income fields will be processed as complete.

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| **Names of all household members, including adult participant(s)** | **Earnings from work before deductions** | **Child support, alimony** | **Payments from pensions, retirement, Social Security** | **Earnings from any other income** |
| --- | --- | --- | --- | --- |
| Example: Janet Smith | $200/weekly | $150/twice a month | $100/monthly | $0 |
|  | $ | $ | $ | $ |
|  | $ | $ | $ | $ |
|  | $ | $ | $ | $ |

## LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SSN) AND SIGNATURE

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the Medi-Cal, SSI benefits, CalFresh, or FDPIR case number is current and correct, or that all income is reported. I understand that this information is being given for the receipt of federal funds; that agency officials may verify the information on the meal benefit form (MBF) and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

**Printed Name:**

**Last Four Digits of SSN: No SSN:**

**Signature of Participant or Adult Household member:**

**Date:**

**PRIVACY ACT STATEMENT**

The Richard B. Russel National School Lunch Act (NSLA) requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the SSN of the adult household member who signs the application. The last four digits of the SSN are not required when you list a Supplemental Nutrition Assistance Program (SNAP, or CalFresh), Temporary Assistance for Needy Families (TANF, or CalWORKs), Program or 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 SSN. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for the administration and enforcement of the program.

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The last four digits of the SSN may be used to identify the household member in verifying the correctness of the information stated on the form. This may include program reviews, audits and investigations, and may include contacting employers to determine income, contacting a CalFresh, CalWORKs, or FDPIR office to determine current certification for CalFresh, CalWORKs, or FDPIR benefits, contacting the state employment security office to determine the amount of benefits received, and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported. The last four digits of the SSN may also be disclosed to programs as authorized under the NSLA and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain federal, state, and local education, and health and nutrition programs.

## RACIAL/ETHNIC IDENTITY

You are not required to answer these questions. If you choose to do so, please mark one or more of the following racial identities:

American Indian or Alaskan Native

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

White

Please mark one of the following ethnic identities:

Hispanic or Latino

Not Hispanic or Latino

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## FOR AGENCY USE ONLY

**PARTICIPATION ELIGIBILITY**

60 years of age or older: Yes \_\_\_\_ No \_\_\_\_

If under 60, qualifying impairment is documented: Yes \_\_\_\_ No \_\_\_\_

**PARTICIPATION ELIGIBILITY—RESIDENCE**

Lives in own residence: Yes \_\_\_\_ No \_\_\_\_

Lives with family members: Yes \_\_\_\_ No \_\_\_\_

Board and care (for supervision or monitoring): Yes \_\_\_\_ No \_\_\_\_

Room and board: Yes \_\_\_\_ No \_\_\_\_

Intermediate Care Facility (ICF)/Developmental Disabled-Habilitative: Yes \_\_\_\_ No \_\_\_\_

ICF/Developmental Disabled-Nursing: (**Not eligible to participate**): Yes \_\_\_\_ No \_\_\_\_

Skilled Nursing Facility (**Not eligible to participate**) Yes \_\_\_\_ No \_\_\_\_

**CATEGORICAL ELIGIBLITY**

CalFresh/FDPIR household categorically eligible free? Yes \_\_\_\_ No \_\_\_\_

Medi-Cal or SSI categorically eligible free? Yes \_\_\_\_ No \_\_\_\_

**INCOME ELIGIBILITY**

Annual Conversion (required if household reports various pay frequencies in Section 3): weekly times (x) 52, every 2 weeks x 26, twice a month x 24, monthly x 12

Total Household Income and Frequency: $ per

Household Size

**ELIGIBILITY CLASSIFICATION**

Eligibility Classification: Free Reduced-price Base

Determining Official Name:

Determining Official Signature: Date:

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# HOW TO COMPLETE THE MEAL BENEFIT FORM

## PARTICIPANT INFORMATION:

1. Print the participant’s name.
2. If applicable, provide the participant’s Medi-Cal or SSI number.
3. If you provide a case number, skip to Section 4 and sign the form. You do not have to provide an SSN.

## BENEFITS: Complete this section, then skip to Section 4 and sign the form.

1. If applicable, provide the current CalFresh or FDPIR case number(s) for any member of the household.
2. If you provide a case number, skip to Section 4 and sign the form. You do not have to provide an SSN.
3. If you did not provide a case number in either Section 1 or 2, you must complete Section 3.

## ALL OTHER HOUSEHOLDS: Complete this section only if you do not have a case number.

1. Write the names of each participant, spouse, and any dependent children of the participant(s) in your household, even if they do not have an income.
2. Write the amount of income each person received last month before taxes or anything else was taken out **and**where it came from, such as earnings, pensions, and other income (see examples below for types of income to report). Each income amount should be entered in the appropriate column on the form. If any amount **last month** was more or less than usual, write that person’s usual monthly income.
3. If anyone is self-employed, write the amount of income that person earns from

self-employment. Please call the number listed at the top of the form if you need help.

1. Sign the form and include the last four digits of your SSN in Section 4. If you do not have an SSN, place a checkmark next to **No SSN**.

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## LAST FOUR DIGITS OF SSN AND SIGNATURE:

1. The form must have the signature of an adult household member.
2. The participant or adult household member who signs the statement must include the last four digits of his or her SSN. If they do not have an SSN, they will place a checkmark next to **No SSN**.
3. The last four digits of the participant’s or adult household member’s SSN is not needed if a CalFresh, FDPIR, Medi-Cal, or SSI case number is provided.
4. **RACIAL/ETHNIC IDENTITY:** You are not required to answer this question to get meal benefits, but completion of this information will help ensure that everyone is treated fairly.

## INCOME TO REPORT

### Earnings from Work

* Wages, salaries, or tips
* Strike benefits
* Unemployment compensation
* Worker’s compensation
* Net income from self-employment

### Child Support or Alimony

* Public assistance payments
* Alimony or child support payments

### Pensions, Retirement, or Social Security

* Pensions
* Supplemental security income
* Retirement income
* Veteran’s payments
* Social Security

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### Other Monthly Income

* Disability benefits
* Cash withdrawn from savings
* Interest dividends
* Income from estates, trusts, or investments
* Regular contributions from persons not living in the household
* Net royalties, annuities, or net rental income
* Military allowance for off-base housing
* Any other income

# DESCRIPTION OF RACIAL AND ETHNIC CATEGORIES

The federal government has established the following five racial categories and two ethnic categories:

## RACE

**American Indian or Alaska Native**

**Asian**

**Black or African American**

**Native Hawaiian or Other Pacific Islander**

**White**

## ETHNICITY

**Hispanic or Latino**

**Not Hispanic or Latino**

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**U.S. DEPARTMENT OF AGRICULTURE NONDISCRIMINATION STATEMENT**

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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](http://www.ascr.usda.gov/complaint_filing_cust.html), (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

1. Fax: 202-690-7442
2. Email: [program.intake@usda.gov](mailto:program.intake@usda.gov)

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