

HOUSEHOLD SIZE—INCOME STATEMENT

APPLICATION STATEMENT OF HOUSEHOLD SIZE—INCOME FOR THE CHILD AND ADULT CARE FOOD PROGRAM (ADULT CARE COMPONENT): Carefully complete this form, sign it and return it to the center. If you need assistance, please call the center. (FFY 2012, Rev. 6/11)

Name of Enrolled Participant ^{1,2}	Agency
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PART 1—HOUSEHOLDS RECEIVING FOOD STAMPS, FDPIR, SSI or MEDICAID¹

Complete this part if the enrolled participant is currently included in a Food Stamp (FoodShare Wisconsin) household or receives assistance under the Food Distribution Program on Indian Reservations (FDPIR), Supplemental Security Income (SSI) or Medicaid. Review PART 3, sign the form and return it to the center's office. **Do not** complete PART 2.

YES, the enrolled participant is currently included in a household or receives assistance under one of the following:¹

FDPIR Case No. _____ Food Stamp, *FoodShare Wisconsin*, Case No. _____

or SSI Case No. _____ Medicaid Case No. _____

PART 2 - ALL OTHER HOUSEHOLDS

If you did not give a Food Stamp (Food Share Wisconsin), FDPIR, SSI, or Medicaid case number, you **MUST** complete the following information or your application cannot be approved.

HOUSEHOLD MEMBERS: List below the names of the enrolled participant and his or her spouse and/or any other individual who resides with the enrolled participant and depends on the enrolled participant for economic support.

Name and last four digits of the Social Security Number of Adult Household Member who signs this form.²

Name: _____ Social Security Number (List last 4 digits) _____ I do not have a Social Security Number

INCOME: : List all income received and how often it was received on the same line with the person who received it. You must list gross income BEFORE deductions or taxes, social security, etc. (Self-employed individuals should report net income.) List each amount under the correct title. Use the following conversion factors to determine monthly income: Weekly income x 4.33 = Monthly income. Every 2 weeks income x 2.15 = Monthly income. Twice a month income x 2 = Monthly income.

LIST ALL HOUSEHOLD MEMBERS		GROSS INCOME AND HOW OFTEN IT WAS RECEIVED				
Name (Last, First)	Age	Earnings from Work (Before Deductions)	Welfare Payments Child Support and/or Alimony	Payments from Pensions Retirement Social Security	All Other Income Received Last Month	Check If NO income
<i>(Example) Jane Smith</i>	66	\$200/weekly	\$150/bi-weekly	\$100/monthly		
1. _____	_____	/	/	/	/	<input type="checkbox"/>
2. _____	_____	/	/	/	/	<input type="checkbox"/>
3. _____	_____	/	/	/	/	<input type="checkbox"/>
4. _____	_____	/	/	/	/	<input type="checkbox"/>
5. _____	_____	/	/	/	/	<input type="checkbox"/>
6. _____	_____	/	/	/	/	<input type="checkbox"/>

PART 3—ALL HOUSEHOLDS Please check the ethnic and racial identity of the enrolled participant. You are not required to answer this question. The collection of this information is strictly for statistical reporting and will have no effect on determination of eligibility for benefits.

ETHNICITY: Hispanic or Latino Not Hispanic or Latino

RACE: American Indian or Alaska Native Black or African American White Asian Native Hawaiian or Other Pacific Islander

I CERTIFY that all of 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 agency 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 laws. The signature on this application is that of an adult household member.

Print Name and Address, *Street, City, Zip*

Signature of Adult Household Member ^{1,2}	Signature Date <i>Mo./Day/Yr.</i>	Work: _____	Telephone Number Home: _____
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FOR CENTER USE ONLY			
Basis of Determining Eligibility	<input type="checkbox"/> FDPIR <input type="checkbox"/> FoodStamp <i>(FoodShareWisconsin)</i> <input type="checkbox"/> SSI <input type="checkbox"/> Medicaid	Eligibility Determination	Determining Official's Initials and Date
Total Household Size _____		<input type="checkbox"/> Free	_____ (Expires in one year from signature date of an adult household member)
<input type="checkbox"/>		<input type="checkbox"/> Free (based on zero income) temporarily until: _____ (45 days)	
Total Monthly Income \$ _____		<input type="checkbox"/> Reduced <input type="checkbox"/> Non-Needy	

¹ Information must be provided by applicant if establishing eligibility as a household **currently** receiving food stamps, FDPIR, SSI, or Medicaid.
² Information must be provided by applicant if establishing eligibility as a household **not currently** receiving food stamps, FDPIR, SSI, or Medicaid.