



ADULT CARE CENTER INCOME-ELIGIBILITY APPLICATION

PART 1 - ADULT PARTICIPANT'S INFORMATION

| | |
|--------------------------|-----|
| ADULT PARTICIPANT'S NAME | AGE |
|--------------------------|-----|

PART 2 - ADULTS RECEIVING MEDICAID, SSI, WBF, OR FDPIR

| | |
|---|---------------------------------------|
| Check type of assistance and record number: | Identification/Case Number (Required) |
| <input type="checkbox"/> Medicaid | _____ |
| <input type="checkbox"/> Supplemental Security Income (SSI) | _____ |
| <input type="checkbox"/> Washington Basic Food (WBF) | _____ |
| <input type="checkbox"/> Food Distribution Program on Indian Reservations (FDPIR) | _____ |

PART 3 - TOTAL HOUSEHOLD INCOME FROM LAST MONTH - Not Required if You Have Reported a Case Number in Part 2.

List the name(s) of the adult participant, his or her spouse, and/or any other individual(s) who resides with the participants and who depend(s) on the adult participant for economic support. Functionally impaired adults living with their parents are considered a "family" separate from their parents.

| List Names (First and Last) of Everyone in Your Household | Earnings from Work Before Deductions | Alimony, Child Support, etc. | Retirement, Pensions, Social Security, etc. | Job Two or Any Other Income |
|---|--------------------------------------|------------------------------|---|-----------------------------|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

When a participant is qualifying based on Part 3, Total Household Income, the participant's social security number must be provided or the box must be checked that he/she does not have one.

Adult Participant's Social Security Number _____ Check if participant does not have a social security number

PART 4 - SIGNATURE AND CERTIFICATION

PENALTIES FOR MISREPRESENTATION: 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 the information on the application may be verified, and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Must be signed and dated by the adult participant or household member or guardian.

| | | |
|--------------------|---------------------|-----------------------------------|
| SIGNATURE OF ADULT | DATE | PRINT NAME OF ADULT SIGNING |
| | | RELATIONSHIP TO ADULT PARTICIPANT |
| ADDRESS | CITY/STATE/ZIP CODE | DAY TIME PHONE |

PART 5 - IDENTIFYING INFORMATION AND CERTIFICATION OF DATA (You are not required to answer this.)

Check the ethnic and racial category of the adult participant. We need this information to be sure that everyone receives benefits on a fair basis.

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino

No adult participant will be discriminated against because of race, color, national origin, gender, age, or disability.

Race:

- White
- Black or African American
- Asian
- American Indian or Alaskan Native
- Native Hawaiian or Pacific Islander
- Multi-racial

If you feel you have been discriminated against, you should write the Secretary of Agriculture, Washington, DC 20250.

PRIVACY ACT STATEMENT

Section 9 of the National School Lunch Act requires that, unless a WBF/food stamp case number, or SSI or Medicaid assistance number is provided, you must include the Social Security number of the adult household member, family member or legal guardian signing the form or indicate the adult does not have a Social Security number. Provision of a Social Security number is not mandatory, but if a Social Security number is not provided, or an indication is not made that the signer does not have such a number, the form cannot be approved. This notice must be used to identify the adult in carrying out efforts to verify the correctness of information stated on this form. Verification efforts may be in the form of program reviews, audits, and investigations that may result in the contacting of employers to verify the current certification for receipt of food stamps, making contact with the State employment security office to verify the receipt of benefits, and checking household member provided documentation to verify the receipt of income. If income is found to have been incorrectly reported, a loss or reduction in benefits, administrative claims or legal action may result.

CENTER USE ONLY

MONTHLY INCOME CONVERSION

Weekly X 4.33 Every 2 Weeks X 2.15 Twice a Month X 2

Check one:

- Free Category
- Reduced-Price Category
- Above-Scale Category

Total Monthly Income \$ _____

This form must be signed and dated by the institution's authorized representative.

SIGNATURE OF INSTITUTION'S AUTHORIZED REPRESENTATIVE

DATE