

Dear Parent or Guardian:

Bear Buddies Child Development Ctr is enrolled in the CACFP, a USDA program which
(Name of Agency)

provides federal assistance dollars to eligible child care centers for serving more nutritious meals. The amount of money our agency receives from this program is based on the income levels of our families. In order to continue providing a quality meal service without additional charge, we request every family of our enrolled children to complete new a Household Size-Income Statement form (HSIS) each year. Please complete and return the attached HSIS form to our office. This information will be kept strictly confidential in our files. Only one completed HSIS is required for all children in your household. Once we have properly approved your HSIS as eligible, our agency will receive the higher ("Free" or "Reduced-price") meal reimbursement rates for your enrolled children, for 12 months from the Effective Month of Determination regardless of any change in your household size and/or income or termination from Benefits Programs.

• You are not required to complete this HSIS if no one in your household receives benefits from FoodShare WI (the Supplemental Nutrition Assistance Program (SNAP)), FDPIR (Food Distribution Program on Indian Reservations), Wisconsin Works Cash Assistance Programs and your household income is higher than the amount shown for your household size within the table below. In this case, however, we would appreciate you returning the HSIS to us with "N/A" written on it along with your signature and date.

Determining Eligibility based on Participation in Benefits Programs → Complete Part 1 and Part 3 of HSIS form

Our agency receives the Free meal reimbursement rate for children in households receiving benefits from FoodShare WI, FDPIR, or WI Works Cash Assistance. Wisconsin Works Cash Assistance is Wisconsin's Temporary Assistance for Needy Families (TANF) program. It provides temporary cash assistance through work placement and training programs and **IS NOT** the WI Child Care Subsidy Program. WI Works Cash Assistance Programs include Trial Employment Match Program (TEMP), Community Service Jobs (CSJ), W-2 Transitions (W-2T), Custodial Parent of an Infant (CMC), Minor Parents Services, Noncustodial Parents, and Pregnant Women

You must include the following information on the HSIS (a-c) for eligibility based on receiving benefits from FoodShare WI, FDPIR, WI Works Cash Assistance:

- (a) The names of your enrolled children; • **DO NOT list case numbers for:**
- (b) Checked box for the benefit your household receives and its case number; & Medicaid, SSI, OR Wisconsin Child Care Subsidy program AND
- (c) The signature of an adult member in the household & signature date • **DO NOT list a 16 digit Quest Card number (starts with 5077) for FoodShare W**

Determining Eligibility by Household Size and Income → Complete Part 2 and Part 3 of HSIS form

Household-Size Income Scale (Effective July 1, 2020 to June 30, 2021)

Household Size	Annual Income Level (at or below)
1	\$ 23,606
2	\$ 31,894
3	\$ 40,182
4	\$ 48,470
5	\$ 56,758
6	\$ 65,046
7	\$ 73,334
8	\$ 81,622
For each additional Household Member, add:	+\$ 8,288

If your household earns a total income that is less than or equal to the income levels listed within this table, we will receive higher meal reimbursement rates ("Free" or "Reduced-price" meal rate) for your children. For determining eligibility based on your household size and income, you must include the following information on the HSIS (a-e):

- (a) Full names of all household members who share income and expenses, including children, parents, and non-related persons;
 - (b) Income received by each household member identified by source of income and its pay frequency;
 - (c) Total number of household members;
 - (d) The signature of an adult member of the household and signature date; and
 - (e) The last four digits of the social security number of the adult household member signing the HSIS or an indication he/she does not have a social security number.
- Disclosure of United States citizenship or immigration status is not required and is not a condition of eligibility for higher meal reimbursement rates.

Eligibilities of Foster, Runaway, Homeless, and Migrant Children, and Children enrolled in Head Start:

Our agency will receive the Free meal reimbursement rates for foster, runaway, homeless, and migrant children and children enrolled in Head Start who reside in your household, when you provide the respective documentation listed below.

• Please note: These children's eligibility for Free meals does not extend to other children in your household

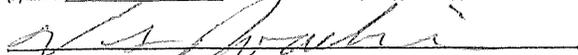
The respective documentation is required for these children to be eligible for Free Meals:

- **Foster children:** Your completed HSIS with the 'Foster Child' box checked next to your foster children's names. When including them on your HSIS completed for your non foster children, any income reported for your foster children must only be for their personal use. Your foster children will then be eligible at the "Free" meal rate. Your non foster children's eligibilities will be based on the benefits or income information provided on your household's completed HSIS form.
- **Children Enrolled In Head Start:** Written certification of your child's Head Start enrollment eligibility period from the Head Start administering agency.
- **Runaway, Homeless, and Migrant Children:** Written certification of the child's status from an official of the appropriate Runaway and Homeless Youth Program, Migrant Education Program, or school official.

Use of Information Statement: The Richard B. Russell National School Lunch Act requires the information on this form. You are not required to provide this information, but if you do not, our agency cannot receive higher reimbursement rates for meals served to your children. You must include the last four digits of the social security number of the household member signing the form unless: the HSIS is only for your foster child(ren); you list a case number for receiving benefits from FoodShare WI, WI Works Cash Assistance, or FDPIR; or when the household member signing the HSIS checks "None" for not having a SS#.

Sharing Eligibility Information: Children's eligibility information may be shared in accordance with disclosure protection requirements without prior notification, with education, health, and nutrition programs to assess their eligibility for benefits. The law allows us to share your children's eligibility information with programs such as Medicaid or BadgerCare for ensuring their access to free or low cost health insurance, unless you tell us not to. This information may only be used for determining eligibility for their programs; if your children are eligible, they may contact you to offer their enrollment options. Please note that filling out this HSIS does not automatically enroll your children in these programs. If you do not want your information to be shared with these programs, please notify us in writing. This notification will not change whether your children's meals are eligible for meal reimbursement. Your eligibility information provided on the HSIS may also be shared with auditors for program reviews and law enforcement officials for the purpose of investigating violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. 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 USD 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, (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; (2) Fax: (202) 690-7442; or (3) Email: program.intake@usda.gov. This institution is an equal opportunity provider.


Signature of Agency Representative

HOUSEHOLD SIZE—INCOME STATEMENT

Child and Adult Care Food Program

An adult household member must complete this form (HSIS) and return it to the center. Complete one HSIS per household. Refer to the accompanying *Household Letter* for instructions on completing this form.

First and Last Name(s) of Enrolled Child(ren)	Center BBCDC UR
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PART 1: BENEFITS

If no one receives these benefits, skip to PART 2.

If any member of your household currently receives benefits from:	Check the box for the benefit received AND provide the case number:	<ul style="list-style-type: none"> • DO NOT list a 16 digit Quest Card number (starts with 5077) for FoodShare • Wisconsin Child Care Subsidy is NOT Wisconsin Works Cash Assistance. It does not qualify a participant as free for CACFP.
FoodShare Wisconsin (10 digit #) <input type="checkbox"/>	_____	
Wisconsin Works Cash Assistance (10 digit #) <input type="checkbox"/>	_____	
FDPIR (9 digit #) <input type="checkbox"/>	_____	

PART 2: TOTAL HOUSEHOLD SIZE AND INCOME (Complete a, b, and c)

If you completed PART 1, you do not need to list household and income information below.

a) List full names of all household members below, including yourself and all children.	b) List all income on the same line as the person who receives it. <ul style="list-style-type: none"> • Record each income source only once. • Check the box for how often each income source is received. 																																																																																																																																																																														
Household Member: anyone who is living with you and shares income and expenses, even if not related.																																																																																																																																																																															
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2">Household Members</th> <th rowspan="2">Age</th> <th rowspan="2">Check if Foster Child <input type="checkbox"/></th> <th rowspan="2">Check if No Income <input type="checkbox"/></th> <th rowspan="2">Gross wages, Net income (self-employed), Commission, Tips, Cash bonuses, Military pay & allowances for off-site housing/food/clothing, Work comp, strike ben., Unemployment</th> <th>Weekly</th> <th>Every 2 Weeks</th> <th>Twice per Month</th> <th>Monthly</th> <th>Annually</th> <th rowspan="2">Pensions, Retirement Social Security, VA benefits, SSI, Disability, Child Support, Adoption assistance, Alimony</th> <th>Weekly</th> <th>Every 2 Weeks</th> <th>Twice per Month</th> <th>Monthly</th> <th>Annually</th> <th rowspan="2">Private pensions, Trusts/estates, Annuities, Investments, Interest, Net rental income, Savings withdrawals, Any other income</th> <th>Weekly</th> <th>Every 2 Weeks</th> <th>Twice per 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PART 3: ALL HOUSEHOLDS

ETHNICITY AND RACE DATA COLLECTION – Completion is optional
 This center is required by Federal law to ask the following two questions concerning ethnicity and race. Your answers are strictly for statistical reporting and will have no effect on determination of eligibility for benefits. Please answer both questions.

IS YOUR CHILD(REN) HISPANIC OR LATINO? Yes, Hispanic or Latino No, neither Hispanic nor Latino

SELECT ONE OR MORE OF THE FOLLOWING CATEGORIES THAT APPLY TO YOUR CHILD(REN):
 American Indian or Alaska Native Black or African American White Asian Native Hawaiian or Other Pacific Islander

ADULT HOUSEHOLD MEMBER SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SS#)
 If Part 2 is completed, the adult signing the form must list the last four digits of his/her SS# OR check "None" if he/she does not have a SS#.

I CERTIFY (promise) that all information on this form is true, and that all income is reported unless eligibility is established by receiving FoodShare, WI Works Cash Assistance, and/or FDPIR. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws.

Signature of Adult Household Member	Signature Date <i>Mo./Day/Yr.</i>	Last 4 digits of SS# (or check "None" if you do not have a SS#) ***_*_*_ _____ <input type="checkbox"/> None
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FOR CENTER USE ONLY – Complete all 3 sections and the Effective Month of Determination

<p>Section 1: Basis of Determining Eligibility (A or B)</p> <p>A. Household Size & Income Total Household Size _____</p> <p>*Total Income \$ _____ / _____ (\$ Amount) (Time Period)</p>	<p>Section 2: Eligibility Determination</p> <p><input type="checkbox"/> Free <input type="checkbox"/> Reduced <input type="checkbox"/> Non-Needy</p>	<p>Section 3: Determining Official's Initials & Approval Date</p> <p>_____</p> <p>**Effective Month of Determination</p> <p>_____</p> <p>Month/Year</p>
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*Convert to yearly income only when multiple pay frequencies are reported, using only these multipliers: Weekly x 52, Twice a month x 24, Every 2 weeks x 26, Monthly x 12

**This form expires one year from the Effective Month of Determination.



Parent/Guardian Instructions:

Use a separate form for each enrolled child. In the spaces below list the child's name, current age, the days and hours normally in care, and the meals normally received while in care. If the child is of school age report the hours in care both before and after school. Child and Adult Care Food Program (CACFP) regulations require that the enrollment form be updated annually and signed by the child's parent or guardian. This form can be used for three years for the same child, to meet the annual updating requirements.

GENERAL INFORMATION

Child's Name	Child Care Facility BBCDC OR.	Child's Age
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HOURS AND MEALS WHILE IN CARE

Days Normally in Care (Check ✓)	Hours Normally in Care				Meals Normally Received While in Care (Check ✓)					
	From	To	From	To	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
<input type="checkbox"/> Sunday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Monday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/> Friday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Saturday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Information

Signature of Parent/Guardian

➤

Date Signed *Mo./Day/Yr.*

ANNUAL UPDATE 1

Please review the information above and write in any changes to your child's days and hours normally in care, and the meals normally received while in care. **Initial and date all changes.**

Additional Information

Signature of Parent/Guardian

➤

Date Signed *Mo./Day/Yr.*

ANNUAL UPDATE 2

Please review the information above and write in any changes to your child's days and hours normally in care, and the meals normally received while in care. **Initial and date all changes.**

Additional Information

Signature of Parent/Guardian

➤

Date Signed *Mo./Day/Yr.*

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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](https://www.ascr.usda.gov/filing-program-discrimination-complaint-usda-customer), (AD-3027) found online at: <https://www.ascr.usda.gov/filing-program-discrimination-complaint-usda-customer>, 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;
- (2) Fax: (202) 690-7442; or
- (3) Email: program.intake@usda.gov

This institution is an equal opportunity provider.