Adult Day Care Center
ENROLLMENT STATEMENT

_____, DOB _____ is enrolled at
(Name of Participant)

_____
(Name of Center)

_____
(Address of Center)

Starting on _____
(Month/Day/Year)

Signature: _____
(Participant, Adult Household Member or Guardian)

_____
(Date)

You are not required to answer these questions. If you choose to do so:

Please mark one of the following ethnic identities: [ ] Hispanic or Latino [ ] Not Hispanic or Latino

Please mark one or more of the following racial identities: [ ] American Indian or Alaska Native
[ ] Asian [ ] Black or African American [ ] Native Hawaiian or Other Pacific Islander [ ] White

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For Center Use Only:

Adult Participant withdrew on _____
(Date)

An Enrollment Form needs to be completed one time when an Adult enters the day care program, after Adult Day Care Centers are responsible for updating each participant's Plan of Care annually and keep the Enrollment forms on file as long as the participant remains in the program

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)

Part 1. All Household Members

Name of Enrolled Adult(s):

Names of Household Members (including enrolled adult(s)) (First, Middle Initial, Last)	CHECK IF NO INCOME
	☐
	☐
	☐

Part 2. Benefits: If any member of your household receives SNAP, TANF, FDPIR, SSI or Medicaid, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME: _____ ELIGIBILITY NUMBER: _____

Part 3. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** participant(s), spouse and dependent children of participant(s) with income)	**B. Gross income and how often it was received** **Note:** Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$200/bi-monthly
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Part 4. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _*_*_*-_*_*-__ __ __ __ ❑ I do not have a Social Security Number

Part 5. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino ☐ Not Hispanic or Latino	☐ Asian ☐ White ☐ Black or African American	☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander