

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
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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:

FoodShare Wisconsin (10 digit #) <input type="checkbox"/>	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.
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.																																																																																																																																																										
Household Member: anyone who is living with you and shares income and expenses, even if not related.	<ul style="list-style-type: none"> Record each income source only once. Check the box for how often each income source is received. 																																																																																																																																																										
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:25%;">Household Members</th> <th style="width:5%;">(Optional) Age</th> <th style="width:5%;">Check if Foster Child <input type="checkbox"/></th> <th style="width:5%;">Check if No Income <input type="checkbox"/></th> <th style="width:15%;">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 style="width:5%;">Weekly</th> <th style="width:5%;">Every 2 Weeks</th> <th style="width:5%;">Twice per Month</th> <th style="width:5%;">Monthly</th> <th style="width:5%;">Annually</th> <th style="width:15%;">Pensions, Retirement Social Security, VA benefits, SSI, Disability, Child Support, Adoption assistance, Alimony</th> <th style="width:5%;">Weekly</th> <th style="width:5%;">Every 2 Weeks</th> <th style="width:5%;">Twice per Month</th> <th style="width:5%;">Monthly</th> <th 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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 Mo./Day/Yr.	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:</p> <p>Basis of Determining Eligibility (A or B)</p> <p>A. Household Size & Income</p> <p>Total Household Size _____</p> <p>*Total Income \$ _____ / _____ (\$ Amount) (Time Period)</p>	<p>Section 2:</p> <p>Eligibility Determination</p> <p><input type="checkbox"/> Free</p> <p><input type="checkbox"/> Reduced</p> <p><input type="checkbox"/> Non-Needy</p>	<p>Section 3:</p> <p>Determining Official's Initials & Approval Date</p> <p>_____</p> <p>**Effective Month of Determination</p> <p>_____</p> <p style="text-align: center;">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.