Reset

South Carolina Department of Social Services

APPLICATION FOR FREE AND REDUCED-PRICE MEALS IN ADULT CARE FOOD PROGRAMS

Part 1. Name of Enrolled Adult: _____
Last First M.I. Age

Part 2. All Household Members *(Including Enrolled Adult)*

Name of Household Members (See instructions for definition of household) (First, Middle Initial, Last)	Check If No Income
	❑
	❑
	❑
	❑
	❑

Part 3. Benefits: If any member of your household received SNAP (formerly Food Stamps) or Food Distribution Program on Indian Reservation (FDPIR), or the adult participant receives Social Security Income (SSI) or Medicaid, provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 4.**

Name: _____ Case No.: _____

Part 4. Total Household Gross Income – You must tell us how much and how often.

A. Name (List **only** household members with income)	**B. Gross income and how often it was received**			
	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	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)
An adult household member must sign this form. **If Part 4 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 page 3.)

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: xxx - xx - _____ ❑ I do not have a Social Security Number

INSTRUCTIONS FOR DSS FORM 1645

Follow these instructions, if your household gets SNAP, FDPIR, SSI or Medicaid:

Part 1: List all enrolled adult(s).

Part 2: List all household members. This includes the adult participant, and if residing with the adult participant, the spouse and dependent(s) of the adult participant. Functionally impaired adults living with their parents are considered a "family" or "household" separate from their parents for the purpose of determining household size and income.

Part 3: List the case number for any household member receiving Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamp), and/or Food Distribution Program on Indian Reservations (FDPIR). List the case number for the participant if he/she receives Social Security Income (SSI) or Medicaid benefits.

Part 4: Skip this part.

Part 5: Sign and date the form. The last four digits of a Social Security Number are **not** necessary.

ALL OTHER HOUSEHOLDS, follow these instructions:

Part 1: List all enrolled adult(s).

Part 2: List all household members. This includes the adult participant, and if residing with the adult participant, the spouse and dependent(s) of the adult participant. Functionally impaired adults living with their parents are considered a "family" or "household" separate from their parents for the purpose of determining household size and income.

Part 3: Skip this part.

Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of **each** household member with income. Household members include the adult participant, and if residing with the adult participant, the spouse and dependent(s) of the adult participants. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each **household member who is a spouse, or dependent of the participant,** list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign and date the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

INSTRUCTIONS FOR DSS FORM 1645, continued

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino

Mark one or more racial identities:
- ❑ Asian
- ❑ White
- ❑ Black or African American
- ❑ American Indian or Alaska Native
- ❑ Native Hawaiian or Other Pacific Islander

The participant in the adult day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Household Size	Yearly
1	$ 26,973
2	36,482
3	45,991
4	55,500
5	65,009
6	74,518
7	84,027
8	93,536
Each additional person	+ 9,509

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you list a Supplemental Nutrition Assistance Program (SNAP), Family Independence (FI) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier, Supplemental Security Income (SSI), Medicaid case number, or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: **https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf**, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or 2. FAX: (833) 256-1665 or (202) 690-7442; or 3. EMAIL: program.intake@usda.gov

This institution is an equal opportunity provider.

For Sponsoring Organization or Adult Care Facility Use ONLY.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ per: ❑ Week ❑ Every 2 Weeks ❑ Twice A Month ❑ Month ❑ Year

Household Size: _____

Categorical Eligibility: _____ Date Withdrawn: _____ Eligibility: ❑ Free ❑ Reduced ❑ Paid

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

ALL OTHER HOUSEHOLDS, follow these instructions:

Part 6: Answer this question if you choose.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

For Sponsoring Organization or Adult Care Use ONLY: To be complete by CACFP Institutions only.