Adults' & Children's Alliance
10 Yorkton Court
St. Paul MN 55117

Dear Family Child Care Provider:

Thank you for your participation in the Child and Adult Care Food Program (CACFP).

If you are a provider living in a Tier 2 area (lower reimbursement rates), it may be possible for your to receive Tier 1 (higher) rates for the Program meals you serve and to receive reimbursement for Program meals served to your own children under 13 years of age.

If your live in a Tier 1 area and receive the higher rates, it may be possible for you to receive reimbursement for Program meals served to your own children under 13 years of age.

Please read the enclosed "Instructions for Completing CACFP Provider Household Income Statement". If you believe your family would qualify because you already participate in a qualifying program (Supplemental Assistance Nutrition Program (SNAP), Minnesota Family Investment Program (MFIP), or Food Distribution Programs on Indian Reservations (FDPIR), or because your household income is at or below the amounts listed, complete and return to Adults & Childrens Alliance (ACA) a "Provider Household Income Statement".

Income Statements become effective no earlier than the first of the month in which all required information is received and approved by our office. For example, if your information is received and approved in our office June 3rd, June 1st is the earliest you could begin receiving Tier 1 rates.

**If your household participates in SNAP, MFIP or FDPIR**, you should complete sections 1, 2 and 4 on the
Program Household Income Statement. Please note, Medical Assistance is not a qualifying program.

Send to our office your completed Provider Household Income Statement along with the following documentation:

•SNAP, MFIP, or FDPIR certification notice showing the beginning and ending dates of the certification period;
•Letter from SNAP or the Minnesota Department of Human Services saying your now receives SNAP or MFIP;
•Letter from the Tribal Office stating you now receive benefits from FDPIR.

**If your household income will allow you to receive Tier 1 rates and/or to claim mea reimbursement for your own children's meals,** complete sections 1, 3, and 4 of the Provider Household Income Statement.

*If you live in a Tier 1 area* and are applying to claim meals for your own children, the completed Provider Household Income Statement is all you need to send to our office.

*If you live in a Tier 2 area* and are applying to receive Tier 1 rates you will also need to send in the following documentation:

•Last year's income tax statement/forms IRS 1040 including Schedule C and Schedule 8829 (home use);

•A copy of the previous month's pay stubs for each wage earner in your household. Frequency of pay must be shown on the pay stubs. If pay stubs are not available a completed Income Employer Documentation Form is needed.

*If last year's taxes are not an accurate reflection of your current income (e.g. you did not day care last year, your got married, your spouse got a new job) you will need to send the following additional documentation to our office:*

•A completed Tier 1 Verification Documentation Worksheet based on the prior month's income and expenses;

•**All documentation** to support the numbers you list on the Tier 1 Verification Documentation Worksheet (e.g. receipts, mortgage statements, bills, invoices).

Any Provider's Household Income Statement which is incomplete or does not contain sufficient documentation will be returned to you.

If you have any questions while completing your Provider Household Income Statement, please contact our office.

# How to Complete the Household Income Statement Form

Complete the Household Income Statement form if any of the following apply to your household:

- Any household member currently participates in the Minnesota Family Investment Program (MFIP), or the Supplemental Nutrition Assistance Program (SNAP), or the Food Distribution Program on Indian Reservations (FDPIR), or
- The household includes one or more foster children (a welfare agency or court has legal responsibility for the child), or
- The total income of household members is within the guidelines shown below (gross earnings before deductions, not take-home pay). Do not include as income: foster care payments, federal education benefits, MFIP payments, or value of assistance received from SNAP, WIC, or FDPIR. Military: Do not include combat pay or assistance from the Military Privatized Housing Initiative. The income guidelines are effective from July 1, 2020 through June 30, 2021.

Maximum Total Income

| Household Size | $ Per Year | $ Per Month | $ Twice Per Month | $ Per 2 Weeks | $ Per Week |
|---|---|---|---|---|---|
| 1 | 23,606 | 1,968 | 984 | 908 | 454 |
| 2 | 31,894 | 2,658 | 1,329 | 1,227 | 614 |
| 3 | 40,182 | 3,349 | 1,675 | 1,546 | 773 |
| 4 | 48,470 | 4,040 | 2,020 | 1,865 | 933 |
| 5 | 56,758 | 4,730 | 2,365 | 2,183 | 1,092 |
| 6 | 65,046 | 5,421 | 2,711 | 2,502 | 1,251 |
| 7 | 73,334 | 6,112 | 3,056 | 2,821 | 1,411 |
| 8 | 81,622 | 6,802 | 3,401 | 3,140 | 1,570 |
| Add for each additional person | 8,288 | 691 | 346 | 319 | 160 |

**Step 1 Children**

List all infants and children in the household and their birthdates. Attach an additional page if needed to list all children. Fill in circles to show which children are enrolled at the child care. If any children are foster children (a welfare agency or court has legal responsibility for the child), fill in the circle.

If any children have regular earnings, write in the amount of income and frequency. Do not write in an hourly wage. Do not include occasional earnings like babysitting or lawn mowing.

**Step 2 Case Number**

If you or any other household member participates in SNAP, MFIP or FDPIR assistance programs, circle the name of the program, write in the case number, then go to Step 4. Medical Assistance (M.A.) and WIC do *not* qualify for this purpose.

**Step 3 Adults / Incomes / Last 4 Digits of Social Security Number**

- List all adults living in the household (everyone not listed in Step 1) whether related or not, such as grandparents, other relatives, or friends. Include any adult who is temporarily away from home, like a student away at college. Attach another page if necessary.
- List gross incomes before deductions, not take-home pay. **Do not list an hourly wage rate.** For adults with no income to report, enter a '0' or leave the section blank. This is your certification (promise) that there is no income to report for these adults.
- For each income, fill in a circle to show how often the income is received: each week, every other week, twice per month, or monthly.
- For farm or self-employment income only, list the net income per year or month after business expenses. A loss from farm or self-employment must be listed as 0 income and does not reduce other income.
- Last four digits of the Social Security number (SSN) – The adult household member signing the form must provide the last four digits of their SSN or check the box if they do not have an SSN.

**Step 4 Signature and Contact Information**

The provider must sign the form.

Provider Name: _____

Number: _____

# Child and Adult Care Food Program - Homes
## Provider Household Income Statement

DEPARTMENT OF EDUCATION

**Step 1** **List all infants, children and students through grade 12 in the household, even if they are not related.** If more space is needed, attach another sheet.

| Child's First Name | MI | Child's Last Name | Birthdate | Enrolled in this child care? If yes, fill in the circle | Foster Child? (An agency or court has legal responsibility for the child.) If yes, fill in the circle. | Regular Income Earned by Children. List any regular incomes earned by children. Do not include occasional earnings like babysitting or lawn mowing. Regular Income | Weekly | Bi-Weekly | 2X Month | Monthly |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | ○ | ○ | $ | ○ | ○ | ○ | ○ |
| | | | | ○ | ○ | $ | ○ | ○ | ○ | ○ |
| | | | | ○ | ○ | $ | ○ | ○ | ○ | ○ |
| | | | | ○ | ○ | $ | ○ | ○ | ○ | ○ |
| | | | | ○ | ○ | $ | ○ | ○ | ○ | ○ |

**Step 2** **Do any Household Members currently participate in any of these programs – SNAP, MFIP or FDPIR?** (Medical Assistance and WIC do not qualify.) If **No** > Go to STEP 3.

If **Yes** > Write in the **CASE NUMBER** here _____ and check the program ☐ **SNAP** ☐ **MFIP** ☐ **FDPIR**. Then go to STEP 4.

**Step 3** **A. List ALL Adult Household Members including yourself and report all incomes.** (Skip STEP 3 if you completed STEP 2 or if all participants are foster children.)

| Adults - Full Name. For the purpose of meal benefits, the members of your household are "Anyone who is living with you and shares income and expenses, even if not related." List the full name of each household member not listed in Step 1 and their income(s) in whole dollars. If a person has no income, write in 0 or leave the section blank. This is your certification (promise) of no income to report. Include any college students temporarily away from home. | Gross Pay from Work (*Do not write in an hourly wage.*) Gross pay before deductions (not take-home pay). | Weekly | Bi-Weekly | 2x Month | Monthly | Farm or Self-Employment. Net Income after business expenses. State if annual or monthly. | Public Assistance, Child Support, Alimony. Payments received. | Weekly | Bi-Weekly | 2x Month | Monthly | All Other Incomes. Pension, retirement, disability, unemployment, Veterans benefits, etc. | Weekly | Bi-Weekly | 2x Month | Monthly |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | ○ | ○ | ○ | ○ | $ | $ | ○ | ○ | ○ | ○ | $ | ○ | ○ | ○ | ○ |
| | $ | ○ | ○ | ○ | ○ | $ | $ | ○ | ○ | ○ | ○ | $ | ○ | ○ | ○ | ○ |
| | $ | ○ | ○ | ○ | ○ | $ | $ | ○ | ○ | ○ | ○ | $ | ○ | ○ | ○ | ○ |

**B. Last four digits of signer's Social Security Number (SSN) or no SSN (required):** X X X – X X – ☐☐☐☐ or ☐ I don't have a Social Security Number.

**Step 4** I certify (promise) that all information on this application is true and correct and all household members and incomes are reported. I understand that this information is given in connection with receipt of federal funds and that officials may verify (check) the information. I understand that if I purposely give false information, my children may lose benefits and I may be prosecuted under applicable federal and state laws.

**Signature** of provider (required): _____

Printed Name: _____ Date: _____

Address: _____

Phone: _____

**Sponsor Use Only - Do Not Write Below**

Total Household Members: _____ Total Income: $_____ per _____

☐ Approved Tier 1: ☐ Case Number ☐ Foster ☐ Income

☐ Denied Tier 1: ☐ Income ☐ Incomplete

Area Eligible: ☐ Yes ☐ No Verified: ☐ Yes ☐ No

Sponsor Signature _____ Date: _____

Effective Dates: From: _____ through _____

**Farmer or Self-Employed**
Income is your *net* income (after deducting business expenses) from farm or self-employment during the year, which is generally shown on Schedule C or F from the federal tax return. A loss from farm or self-employment must be listed as zero income and does not reduce other household income for the purpose of completing this form.

**Seasonal Worker**
Income is your expected *average gross income* before deductions (*not* take-home pay) from seasonal work during the year. List your *average gross income* from seasonal work per month or other frequency.

**Privacy Act Statement / How Information Is Used**
The Richard B. Russell National School Lunch Act requires the information on this form. You do not have to give this information but if you do not, we cannot approve your child for free or reduced-price school meals. You must include the last four digits of the Social Security number of the adult household member who signs the application. The last four digits of the Social Security number are not required when you apply on behalf of a foster child, or you provide a Minnesota Family Investment Program (MFIP), Supplemental Nutrition Assistance Program (SNAP) or Food Distribution Program on Indian Reservation (FDPIR) assistance number, or 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 your household meets program eligibility guidelines, and for administration and enforcement of the program.

**Nondiscrimination Statement**
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* (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.

ACA
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# TIER 1 VERIFICATION DOCUMENTATION WORKSHEET

As you are self-employed, the calculation of you income is based on your business income minus your business expenses to arrive at your net income. Use the worksheet below to determine your monthly income and expenditures.
**Remember, documentation must be submitted to verify your income and expenses.**

| **INCOME:** Determine your current monthly income from your child care business. | |
|---|---|
| Child Care Fees from Parents: | **$** |
| CACFP Reimbursement: | **$** |
| Other: (List specific income) | **$** |
| **TOTAL MONTHLY INCOME** | **$** |

| **EXPENSES: (Child Care Business only)** | | | | | |
|---|---|---|---|---|---|
| Mortgage or Rent | $ | Office Supplies | $ | Other (List specific expenses): | $ |
| Food | $ | Toys & Supplies | $ | Other | $ |
| Utilities | $ | Postage | $ | Other | $ |
| Insurance | $ | Salaries & Wages | $ | Other | $ |
| Paper & Cleaning Supplies | $ | | | Other | $ |
| | $ | | | Other | $ |
| **TOTAL MONTHLY EXPENSES: $** | | | | | |
| **TIME-SPACE PERCENTAGE BEING USED (see below):** | | | | | |

To calculate your Time-Space percentage, please see the following instructions: A percentage of your home expenses may be claimed as a business expense. For example, if 1,500 square feet of your 2000 square foot home is used 10 hours per day 5 days per week for child care, you would calculate your business expense percentage as follows:
Time Factor Example:
10 hours/day of child care X 5 days/week X 50 weeks/year = 2500=28.53%
24 hours in day X 365 days in a year = 8760
Space Factor Example:
6 rooms used for family care = 75% OR 1500 square feet child care use = 75%
8 rooms in house 2000 square foot house

Space X times =% used for business 75% (space) X 28.53% (time) = 21.39%

To determine your net income from your business, use the following formula:
Subtract monthly expenses from monthly income = Net monthly income from child care business

| | |
|---|---|
| **NET MONTHLY INCOME FROM YOUR CHILD CARE BUSINESS:** (This is the amount to record on your Provider Household Income Statement.) | $ |

Adults' & Children's Alliance

# INCOME EMPLOYER DOCUMENTATION FORM

| Child Care Provider's Name: | Child Care Provider's Number: | Child Care Provider's Phone Number: |
|---|---|---|
| | | |

Instructions: Complete the upper portion of this form. Submit this form to your employer to compete. Return this form of our office with your Provider Household Income Statement as verification of your household member's income to be eligible for Tier 1 CACFP reimbursement rates. Additional forms may be obtained by calling ACA's office or going to our web site at www.acainc.org. Keep a copy for your files.

**Authorization to Release Information**

To my Employer:

I,_____hereby authorize my employer to release and make income
(Employee's Name)
information (classified as private) available to Adult's and Children's Alliance (ACA) and/or officials of United States Department of Agriculture (USDA) and the Minnesota Department of Education (MDE). I further understand that this information will be used for the strict purpose of processing an income application for the Child and Adult Care Food Program (CACFP).

Signature:_____ Date: _____

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**STATEMENT OF EARNINGS** – To be completed by the employer

This statement confirms_____receives the following amount of gross
(Employee's Name)
income **before** deductions for taxes, Social Security, insurance etc. during their last pay period $_____.

This income is received: (check one)_____weekly
_____every 2 weeks
_____twice a month
_____monthly
_____other _____

Please state the date of the paycheck listed above: _____

Name of Employer Date

Employer's Authorizing Signature Position

Address City

State Zip Code Telephone Number