WISCONSIN CACFP Child and Adult Care Food Program

Group Child Care & Outside of School Hours Centers

FFY 2023, rev. 6/22

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

PART 1: BENEFITS

Do any household members currently participate in FoodShare WI, WI Works Programs, or FDPIR?
If yes, check the program and write the corresponding case number below; then go to Part 3. If no, skip to Part 2.

☐ **FoodShare Wisconsin (10-digit case number):**
DO NOT list a 16-digit Quest Card number:

____

☐ **FDPIR (9-digit case number):**

____

☐ **Wisconsin Works (W-2) Programs (10-digit case number):**
Wisconsin Shares Child Care Subsidy benefits is NOT a W-2 Program. It does not qualify a child as free in the CACFP.

____

PART 2: HOUSEHOLD SIZE AND INCOME

If you did not complete PART 1, complete a, b, and c below; then go to PART 3.

a) Household Members Information:
List full names of all members in first column, including yourself and all children.

b) List all income on the same line as the person who receives it.
- Record each income source only once.
- Check the box for how often each income source is received.

Household Member Names **Household Member:** anyone who is living with you and shares income and expenses, even if not related.	(Optional) **Age**	**Check if Foster Child**	**Check if No Income**	Gross wages, Net income (self-employed), Tips, Commission, Cash bonuses, Military pay & allowances, Work comp, Unemployment	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Retirement, Social Security, SSI, Disability, VA benefits, Child Support, Alimony	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Private pensions, Trusts, Annuities, Investments, Interest, Net rental income, Savings withdrawals, Any other income	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐

c) Record total # of household members: _____

PART 3: SIGNATURE

An adult household member must sign and date this form
If PART 2 is completed, the adult signing the form **must list the last four digits of their SS#** OR check "None" if they do not have a SS#.

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

I CERTIFY that all information on this form is true. I understand that this information is given in connection with the receipt of Federal funds and that CACFP officials may verify the information. I am aware that if I purposely give false information, my children 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#)
		***-**-___ ___ ___ ___ ☐ None

FOR CENTER USE ONLY – Complete all 3 sections

Section 1: Basis of Determining Eligibility *(A or B)*		**Section 2: Eligibility Determination**	**Section 3: Determining Official's Initials/Approval Date Effective Month of Determination**
A. ***Household Size & Income*** **Total Household Size** ________ ***Total Income $**\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ ($ Amount) (Time Period)	**B.** ***Benefits/Foster*** ☐ FoodShare WI ☐ W-2 Programs ☐ FDPIR ☐ Foster Child(ren)	☐ Free ☐ Reduced ☐ Non-Needy	**Initials/Date:** ____________________ ****Effective Month of Determination:** ________________ Month/Year

*Convert to yearly income <u>only</u> when multiple pay frequencies are reported, using only these multipliers:	Weekly x 52 Every 2 weeks x 26	Twice a month x 24 Monthly x 12	**This form expires one year from the *Effective Month of Determination.*

This institution is an equal opportunity provider.