ADULT DAY CARE INSTITUTION ORIGINALS

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ADULT
LETTER TO THE HOUSEHOLD

Dear Guardian:

The Child and Adult Care Food Program (CACFP) offers meal reimbursements to adult day care facilities that provide structured comprehensive services to nonresidential adults who are functionally impaired or aged 60 and older. By completing the attached Family-Size and Income Application (FSIA), the centers will be able to receive reimbursement that is based on the number of enrolled participants who are eligible for free or reduced-price meals.

1. **Do I need to fill out an FSIA for each adult in day care?** You may complete and submit one FSIA for the adults enrolled in day care in your household ***ONLY*** if they are enrolled in the same center. We cannot approve an FSIA that is not complete, so be sure to read the instructions carefully and fill out all required information. ***Return the completed FSIA to: (Name of Center)*** _____ ***, (Address)*** _____ ***, (Phone Number)*** _____ ***.***

2. **Who can get free meals?** Adults in households getting Supplemental Nutrition Assistance Program (SNAP), Food Distribution Program on Indian Reservations (FDPIR), Social Security Income (SSI), or Medicaid can get free meals. Adults in households participating in Women Infants and Children (WIC) ***MAY*** be eligible for free meals.

3. **Who can get reduced-price meals?** Adults can get low-cost meals if your household income is within the reduced-price limits on the Income-Eligibility Guidelines, shown on this application. Adults in households participating in WIC ***MAY*** be eligible for reduced-price meals.

4. **May I fill out an FSIA if someone in my household is not a United States (U.S.) citizen?** Yes. You or the adult in your care do not have to be U.S. citizens to qualify for meal benefits offered at the center.

5. **Who should I include as members of my household?** You must only include your spouse and your dependents who share income and expenses.

6. **How do I report income information and changes in employment status?** The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income-Eligibility Guidelines, the adult day care center will receive a higher level of reimbursement. Once properly approved for free or reduced-price benefits, whether through income or by providing a current SNAP or FDPIR case number or an SSI or Medicaid assistance number, you will remain eligible for those benefits for the current fiscal year. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income during the period of unemployment causes your household income to be within the eligibility standards.

7. **What if my income is not always the same?** List the amount that you normally get. For example, if you normally get $1000 each month but you missed some work last month and only got $900, put down that you get $1000 per month. If you normally get overtime, include it, but not if you only get it sometimes. If you have lost a job or had your hours or wages reduced, use your current income.

8. **We are in the military; do we include our housing allowance as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

This institution is an equal opportunity provider and employer.

If you have other questions or need help, call **(Phone Number)** _____ **.**

Sincerely,

(Signature) _____

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ADULT ONLY
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
FAMILY-SIZE AND INCOME APPLICATION (FSIA)

PART 1. ALL HOUSEHOLD MEMBERS

a. Name(s) of Adult Participant(s)

b. Names of All Household Members (First, Middle Initial, Last)	**Age of Adult Participant(s)**	**Check if *NO* Income**
		☐
		☐
		☐

PART 2. BENEFITS

If any member of your household receives ***SNAP***, ***FDPIR,*** SSI, or Medicaid benefits, provide the name and case number for the ***ONE*** person who receives benefits. ***If no one receives these benefits, skip to Part 3.***

NAME: _____ CASE NUMBER: _____

PART 3. 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**			
	Earnings From Work Before Deductions	**Welfare, Child Support, Alimony**	**Pensions, Retirement, Social Security, SSI, VA Benefits**	**All Other Income**
(Example) Jane Smith	$_*200*_/_*weekly*_	$_*150*_/_*twice a month*_	$_*100*_/_*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 also must 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 the next page.)

I certify (promise) that all information on this form is true and that all income is reported. I understand that the center or day care home will get federal funds based on the information that I give. I understand that CACFP officials may verify (check) 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.

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Part 5: Participant's Ethnic and Racial Identities (Optional)

Choose one ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Choose one or more (regardless of ethnicity):
- ☐ Asian
- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Black or African American

DO NOT FILL OUT THIS PART. THIS IS FOR OFFICIAL 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 ____ Denied _____

Reason: _____

Determining Official's Signature:_____ Date:_____

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

185% of Poverty Level

Household Size	Yearly
1	21,775
2	29,471
3	37,167
4	44,863
5	52,559
6	60,255
7	67,951
8	75,647
Each additional person:	7,696

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 last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier 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 Programs.

In accordance with federal civil rights law and United States Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, office, 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 [ASL]) 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

3. E-Mail: program.intake@usda.gov

This institution is an equal opportunity provider.

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INSTRUCTIONS FOR COMPLETING THE FAMILY-SIZE AND INCOME APPLICATION (Adult Care)

IF YOUR HOUSEHOLD RECEIVES BENEFITS FROM ***SNAP***, ***FDPIR***, **SSI, or Medicaid,** FOLLOW THESE INSTRUCTIONS:

Part 1: a. List names of enrolled participants.
b. List all household members, including enrolled adult participant(s). For each enrolled participant(s), include his/her age.

Part 2: List the case number for any household member receiving ***SNAP, FDPIR,*** **SSI, or Medicaid** benefits.

Part 3: Skip this part.

Part 4: Sign the form. The last four digits of a social security number are ***NOT*** necessary.

Part 5: Answer this question if you choose to.

ALL OTHER HOUSEHOLDS, FOLLOW THESE INSTRUCTIONS:

Part 1: a. List all enrolled adult participants.
b. List all household members, including enrolled adult participants in care. For each enrolled participant, include his/her age. For any person with no income, you must check the ***No Income*** box.

Part 2: Skip this part.

Part 3: 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*** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. 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.
  In 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 pay stub, or your boss can tell you.
  In Box 2, list the amount each person got for the month from welfare, child support, alimony.
  In Box 3, list retirement, Social Security, Supplemental Security Income (SSI), veteran's benefits (VA benefits), and disability benefits.
  In 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. Do not include income from SNAP, TANF, FDPIR, WIC, or federal education benefits. For ***ONLY*** the self-employed, under *Earnings From Work*, **report income after expenses. This is for your business, farm, or rental property. If you are in the Military Privatized Housing Initiative or get Combat Pay, do not include these allowances as income.**

Part 4: Adult household member must sign the form and list the last four digits of his/her social security number or mark the box if he/she does not have one.

Part 5: Answer this question if you choose to.

PRIVACY ACT STATEMENT: This explains how we will use the information you give us.

NONDISCRIMINATION STATEMENT: This explains what to do if you believe you have been treated unfairly.

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OKLAHOMA STATE DEPARTMENT OF EDUCATION
CHILD AND ADULT CARE FOOD PROGRAM

HOUSEHOLD-SIZE INCOME SCALES
FOR FREE AND REDUCED-PRICE MEALS
FISCAL YEAR 2016

To be used for applications obtained from July 1, 2015, through June 30, 2016.

(The Free Scale Should Not Be Distributed to Families)

ELIGIBILITY SCALE FOR FREE MEALS 130 Percent of Poverty Level					
Household Size	**Income**				
	Annual	**Monthly**	**Twice Per Month**	**Every Two Weeks**	**Weekly**
1	15,301	1,276	638	589	295
2	20,709	1,726	863	797	399
3	26,117	2,177	1,089	1,005	503
4	31,525	2,628	1,314	1,213	607
5	36,933	3,078	1,539	1,421	711
6	42,341	3,529	1,765	1,629	815
7	47,749	3,980	1,990	1,837	919
8	53,157	4,430	2,215	2,045	1,023
For each additional family member, add:	5,408	451	226	208	104

ELIGIBILITY SCALE FOR REDUCED-PRICE MEALS 185 Percent of Poverty Level					
Household Size	**Income**				
	Annual	**Monthly**	**Twice Per Month**	**Every Two Weeks**	**Weekly**
1	21,775	1,815	908	838	419
2	29,471	2,456	1,228	1,134	567
3	37,167	3,098	1,549	1,430	715
4	44,863	3,739	1,870	1,726	863
5	52,559	4,380	2,190	2,022	1,011
6	60,255	5,022	2,511	2,318	1,159
7	67,951	5,663	2,832	2,614	1,307
8	75,647	6,304	3,152	2,910	1,455
For each additional family member, add:	7,696	642	321	296	148

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INDIVIDUAL PLAN OF CARE

Adult Day Care Center: _____ **Fiscal Year:** _____

Participant's Name: _____ Current Date: _____

Medical Diagnosis: _____

Orders: _____

Caregiver's/Participant's Expectations: _____

Needs/Goals:

1. Physical: _____
2. Cognitive: _____
3. Social: _____
4. Other: _____

GOAL	RESPONSIBLE STAFF/DISCIPLINE	STRATEGY	MEASURE	OUTCOME

INDIVIDUAL PLAN OF CARE

Adult day care centers shall provide an individual plan of care designed to meet the needs of functionally impaired adults. Such a plan shall provide a variety of health, social, and related support services to each enrolled participant.

GROUP PROGRAM

DAY CARE CENTER: _____
MONTH: _____ YEAR: _____

DAY/DATE:	Monday, _____	Tuesday, _____	Wednesday, ____	Thursday, _____	Friday, _____

DAY/DATE:	Monday, _____	Tuesday, _____	Wednesday, ____	Thursday, _____	Friday,_____

GROUP PROGRAM

Adult day care centers shall provide a group program. The comprehensive group program should be community-based, structured, and offer a variety of activities.

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
ADULT MEAL COUNT WORKSHEET

Agreement Number: AD- _____ Month _____ 20 _____ (To be maintained at institutions with CACFP records.)

	NUMBER MEALS SERVED PROGRAM PARTICIPANTS				NUMBER NONCLAIMABLE MEALS SERVED*			
DATE	**Breakfast**	**Lunch**	**Supper**	**Snack**	**Breakfast**	**Lunch**	**Supper**	**Snack**
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
TOTALS								

* Any nonclaimable or nonprogram meals must have income reported on the Expenditure/Reimbursement Worksheet and/or the center's summary of allowable costs.

MEAL COUNT WORKSHEET

The CACFP Meal Count Worksheet is to be completed at the time of each meal service. An actual physical count must be taken at mealtime. The verified meal count for each meal service is recorded under each of the following categories of meals served:

Meals Served to Program Participants Are:

- Meals meeting minimum meal pattern requirements.
- Meals served to participants enrolled for care in the center.

Number Nonclaimable Meals Served. The CACFP must be reimbursed for any nonclaimable meals served. This income must be reported on the Expenditure/Reimbursement Worksheet:

- Meals over license capacity.
- Meals not meeting meal pattern requirements.
- Nonprogram adult meals and contract meals.
- Any meals over the three meals per participant per day limit.

For the shifts at breakfast, lunch, and/or supper meals, record the first shift number, then a slash mark, then the second shift number, or maintain a meal count worksheet for each shift unit.

BREAKFAST
HOW TO CALCULATE NUMBER OF ADULT SERVINGS NEEDED

Number of Adults Served: _____

MILK (Only Approved Types Allowed)

Adults _____ x 8 fluid oz = _____
Total Number of Fluid Ounces Needed

There are 128 ounces of milk in one gallon. Total fluid ounces needed divided by 128 equals total gallons of milk needed.

FRUIT/VEGETABLE

Adults _____ x 2 (1/4 cups) = _____
Total Number of 1/4 Cups Needed

GRAINS/BREADS

Adults _____ x 2 servings = _____
Total Servings Needed

HOW TO CALCULATE NUMBER OF SERVINGS

Before determining the quantity of food to purchase or prepare, it is necessary to first calculate the amount of food or number of servings required.

Step 1: Determine the number of participants who normally participate in each meal service. You may use the Meal Count Worksheet to assist in determining the average counts. The Minimum Meal Pattern Requirements chart may also need to be referenced.

Step 2: For each component, multiply the number of participants by the minimum quantity requirement for the age group:

- For the approved fluid milk type, use the number of fluid ounces.
- For grains/breads, use the number of grains/breads servings.
- For fruit/vegetable, use the number of 1/4-cup servings.
- For meat/meat alternate, use the number of 2-ounce servings required.

Step 3: Total the quantities for each component.

The quantities per meal component can now be used with the CACFP Food-Buying Guide to determine the amount of food to purchase and prepare to meet meal pattern requirements.

LUNCH AND SUPPER
HOW TO CALCULATE NUMBER OF ADULT SERVINGS NEEDED

Number of Adults Served: _____

MILK (Only Approved Types Allowed)

Adults _____ x 8 fluid oz = _____
Total Number of Fluid Ounces Needed

There are 128 ounces of milk in one gallon. Total fluid ounces needed divided by 128 equals total gallons of milk needed .

FRUIT/VEGETABLE

Adults _____ x 4 (1/4 cups) = _____
Total Number of 1/4 Cups Needed

MEAT/MEAT ALTERNATE

Adults _____ x 2.0 oz = _____
Total Ounces Needed

GRAINS/BREADS

Adults _____ x 2 servings = _____
Total Servings Needed

HOW TO CALCULATE NUMBER OF SERVINGS

Before determining the quantity of food to purchase or prepare, it is necessary to first calculate the amount of food or number of servings required.

Step 1: Determine the number of participants who normally participate in each meal service. You may use the Meal Count Worksheet to assist in determining the average counts. The Minimum Meal Pattern Requirements chart may also need to be referenced.

Step 2: For each component, multiply the number of participants by the minimum quantity requirement for the age group:

- For the approved fluid milk type, use the number of fluid ounces.
- For grains/breads, use the number of grains/breads servings.
- For fruit/vegetable, use the number of 1/4-cup servings.
- For meat/meat alternate, use the number of 2-ounce servings required.

Step 3: Total the quantities for each component.

The quantities per meal component can now be used with the CACFP Food-Buying Guide to determine the amount of food to purchase and prepare to meet meal pattern requirements.

SUPPLEMENT
HOW TO CALCULATE NUMBER OF ADULT SERVINGS NEEDED
(Choose two of the four food components.)

Number of Adults Served:_____

MILK (Only Approved Types Allowed)

Adults _____ x 8 fluid oz = _____
Total Number of Ounces Needed

There are 128 ounces of milk in one gallon. Total fluid ounces needed divided by 128 equals total gallons of milk needed.

FRUIT/VEGETABLE

Adults _____ x 2 (1/4 cups) = _____
Total Number of 1/4 Cups Needed

GRAINS/BREADS

Adults _____ x 1 serving = _____
Total Servings Needed

MEAT/MEAT ALTERNATE

Adults _____ x 1.0 oz = _____
Total Ounces Needed

HOW TO CALCULATE NUMBER OF SERVINGS

Before determining the quantity of food to purchase or prepare, it is necessary to first calculate the amount of food or number of servings required.

Step 1: Determine the number of participants who normally participate in each meal service. You may use the Meal Count Worksheet to assist in determining the average counts. The Minimum Meal Pattern Requirements chart may also need to be referenced.

Step 2: For each component, multiply the number of participants by the minimum quantity requirement for the age group:

- For the approved fluid milk type, use the number of fluid ounces.
- For grains/breads, use the number of grains/breads servings.
- For fruit/vegetable, use the number of 1/4-cup servings.
- For meat/meat alternate, use the number of 2-ounce servings required.

Step 3: Total the quantities for each component.

The quantities per meal component can now be used with the CACFP Food-Buying Guide to determine the amount of food to purchase and prepare to meet meal pattern requirements.

☐ Regular Meals
☐ At-Risk Meals

MENUS AS SERVED

Comments/Special Dietary Needs:

Date: _____

Meal Type	Menu	Qty. Served: Meat/Meat Alternate	Qty. Served: Grains/Breads	Qty. Served: Fruit/Veg/Juice	Qty. Served: Milk	Leftovers
BREAKFAST Total participants served: ___ Program Adults: _____						
A.M. SNACK Total participants served: ___ Program Adults: _____						
LUNCH Total participants served: ___ Program Adults: _____						
P.M. SNACK Total participants served: ___ Program Adults: _____						
SUPPER Total participants served: ___ Program Adults: _____						
EVENING SNACK Total participants served: ___ Program Adults: _____						

FOOD PRODUCTION RECORDS/MENUS AS SERVED

The food production record is to begin on October 1 of each fiscal year and end on September 30. Make copies of the *Menus as Served* original on the previous page for your records.

All meal services offered each day are recorded on the same page. In addition, it is required that the following information be recorded:

- Date of meal service
- Meal counts of total participants served
- Total number served by meal type
- Menu as served
- Food item(s) credited toward each required meal component (Be specific as to the form of food; i.e., fresh, frozen, cooked, deboned)
- Quantity of each food item served (Be specific as to can size, number of pounds or ounces, etc.)
- Leftovers—All leftovers should be listed in this column and how they will be used.

The Food Production Records/Menus as Served must be completed on a daily basis. In addition, records must be kept on site at all times.

This record is the institution's documentation that meals claimed for reimbursement met minimum meal pattern requirements.

As with all other record-keeping forms provided by the State Agency, the Food Production Records/Menus as Served Book is a prototype management tool. If an institution has a food production record-keeping system that is equal to or better than the one provided, it may be used. Contact your area consultant to evaluate the alternate form.