HOUSEHOLD SIZE—INCOME STATEMENT

Child and Adult Care Food Program

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. Please contact the center if you need assistance.

First and Last Name(s) of Enrolled Participant(s)	Center

PART 1: BENEFITS

If no one receives these benefits, skip to PART 2.

Check the box for FoodShare Wisconsin or FDPIR AND list the case number if any member of your household currently receives these benefits.

☐ **FoodShare WI (10 digit #)** __ __ __ __ __ __ __ __ __ __

DO NOT list a 16 digit Quest Card # *(starts with 5077)*

☐ **FDPIR (9 digit #)** __ __ __ __ __ __ __ __ __

Check the box for Supplemental Security Income (SSI) or Medicaid AND list the case number only if the enrolled participant(s) currently receives these benefits.

☐ **SSI (10 digit #)** __ __ __ __ __ __ __ __ __ __

☐ **Medicaid (10 digit #)** __ __ __ __ __ __ __ __ __ __

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.

Household Member: anyone who is living with you and shares income and expenses, even if not related.

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 Members	Check if No Income	Gross wages, Net income (self-employed), Commission, Tips, Cash bonuses, Military pay & allowances for off-site housing/food/clothing, Work comp, strike ben., Unemployment	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Pensions, Retirement Social Security, VA benefits, SSI, Disability, Child Support, Adoption assistance, Alimony	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Private pensions, Trusts/estates, 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: 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 THE ENROLLED PARTICIPANT(S) HISPANIC OR LATINO? ☐ Yes, Hispanic or Latino ☐ No, neither Hispanic nor Latino

SELECT ONE OR MORE OF THE FOLLOWING CATEGORIES THAT APPLY TO THE ENROLLED PARTICIPANT(S):

☐ 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, FDPIR, SSI, and/or Medicaid. 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#)
		***-**-__ __ __ __ ☐ None

FOR CENTER USE ONLY – Complete all 3 sections and the *Effective Month of Determination*

Section 1: Basis of Determining Eligibility *(A or B)*

A. *Household Size & Income*

Total Household Size ________

[1]**Total Income $**__________/______
($ Amount) (Time Period)

B. *Benefits*

☐ **FoodShare WI**
☐ **FDPIR**
☐ **SSI**[2]
☐ **Medicaid**[2]

[2]Enrolled Participant(s) Only

Section 2: Eligibility Determination

☐ **Free**
☐ **Reduced**
☐ **Non-Needy**

Section 3: Determining Official's Initials & Approval Date

____

[3]**Effective Month of Determination**

____
Month/Year

[1]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

[3]This form expires one year from the *Effective Month of Determination*.