

This letter and the attached Household Size-Income Statement form (HSIS) must be given to all home providers who do not qualify as Tier I by area eligibility.

Dear Provider:

To establish eligibility as a Tier I home provider under the CACFP, you must complete and return the attached Household Size-Income Statement form (HSIS) to our office. Once properly approved for Tier 1 rates, your family day care home will remain eligible for Tier 1 meal rates for a period not to exceed 12 months, regardless of any change in household size and/or income or termination from Benefits Programs during this 12 month period. This information is kept confidential in our files.

You are not required to complete this HSIS if no one in your household receives benefits from FoodShare WI (the Supplemental Nutrition Assistance Program (SNAP)), FDPIR (Food Distribution Program on Indian Reservations), or the W-2 (Wisconsin Works) Cash Assistance Program and your household income is higher than the amount shown for your household size within the table below.

- You must submit documentation supporting all listed sources of household income or your household's eligibility for FoodShare Wisconsin, W-2 Cash Assistance, or FDPIR in order for the HSIS to be approved.

Determining Eligibility based on Participation in Benefits Programs → Complete Part 1 and Part 3 of HSIS form

Your family day care home will receive Tier 1 meal reimbursement rates if your household receives benefits from FoodShare WI, FDPIR, or W-2 Cash Assistance.

W-2 Cash Assistance is Wisconsin's Temporary Assistance for Needy Families (TANF) program. It provides temporary cash assistance through work placement and training programs and IS NOT the Wisconsin Shares Child Care Subsidy Program. W-2 Cash Assistance Programs include Trial Employment Match Program (TEMP), Community Service Jobs (CSJ), W-2 Transitions (W-2 T), Custodial Parent of an Infant (CMC), and At Risk Pregnancy (ARP).

You must include the following information on the HSIS (a-c) for eligibility based on receiving benefits from FoodShare WI, FDPIR, W-2 Cash Assistance:

- (a) Your full name (the home provider);
 - (b) Checked box for the benefit your household receives and its case number; and
 - (c) Your signature and signature date
- **DO NOT list case numbers for:** Medicaid, SSI, OR Wisconsin Shares Child Care Subsidy program AND
 - **DO NOT list the 16 digit Quest Card number for FoodShare WI**

Determining Eligibility by Household Size and Income → Complete Part 2 and Part 3 of HSIS form

Household-Size Income Scale (Effective July 1, 2018 to June 30, 2019)

Household Size	Annual Income Level (at or below)
1	\$ 22,459
2	\$ 30,451
3	\$ 38,443
4	\$ 46,435
5	\$ 54,427
6	\$ 62,419
7	\$ 70,411
8	\$ 78,403
For each additional Household Member, add:	+\$ 7,992

If your household earns a total income that is less than or equal to the income levels listed within this table, your home will receive Tier 1 meal rates for your enrolled children (including your own children).

For determining eligibility based on your household size and income, you must include the following information on the HSIS (a-e):

- (a) Full names of all household members who share income and expenses, including children, parents, and non-related persons;
- (b) Income received by each household member identified by source of income and its pay frequency;
- (c) Total number of household members;
- (d) Your signature and signature date; and
- (e) The last four digits of your social security number or an indication that you do not have a social security number.

- Disclosure of United States citizenship or immigration status is not required and is not a condition of eligibility for higher meal reimbursement rates.

Eligibilities of Foster, Runaway, Homeless, and Migrant Children, and Children enrolled in Head Start:

If your household does not qualify for Tier 1 meal rates based on the information provided on this form, any child residing in your home who is a foster, runaway, homeless, or migrant child, or a child enrolled in Head Start will qualify for Tier 1 meal rates when the respective documentation listed below is provided. Please note: **These children's Tier 1 meal eligibility does not extend to any other children in the household or qualify your home for Tier 1 rates.**

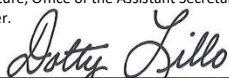
The respective documentation is required for these children to be eligible for Tier 1 rates:

- **Foster Children:** Your completed HSIS with the 'Foster Child' box checked next to your foster children's names. When including them on your HSIS completed for your non-foster children, any income reported for your foster children must only be for their personal use. Your foster children will then be eligible for Tier 1 meal reimbursement rates. Your non-foster children's eligibilities will be based on the benefits or income information provided on your household's completed HSIS form.
- **Children Enrolled In Head Start:** Written certification of your child's Head Start enrollment eligibility period from the Head Start administering agency.
- **Runaway, Homeless, and Migrant Children:** Written certification of the child's status from an official of the appropriate Runaway and Homeless Youth Program, Migrant Education Program, or school official.

Use of Information Statement: The Richard B. Russell National School Lunch Act requires the information on this form. You are not required to provide this information, but if you do not, you cannot be approved as Tier 1 eligible. You must include the last four digits of your social security number when eligibility is based household size and income. The social security number is not required when: the HSIS is only for your foster child(ren); you list a case number for receiving benefits listed above; or when you check "None" for not having a SS#.

Sharing Eligibility Information: Children's meal eligibility information may be shared, in accordance with disclosure protection requirements without prior notification, with education, health, and nutrition programs to assess their eligibility for benefits. The law allows us to share your children's eligibility information with programs such as Medicaid or BadgerCare for ensuring their access to free or low cost health insurance, **unless you tell us not to.** This information may only be used for determining eligibility for their programs; if your children are eligible, they may contact you to offer their enrollment options. Please note that filling out this HSIS does not automatically enroll your children in these programs. **If you do not want your information to be shared with these programs, please notify us in writing. This notification will not change whether your children's meals are eligible for meal reimbursement.** Your eligibility information provided on the HSIS may also be shared with auditors for program reviews and law enforcement officials for the purpose of investigating violations of program rules.

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](http://www.ascr.usda.gov/complaint_filing_cust.html), (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.



Signature of Sponsor Representative

HOUSEHOLD SIZE-INCOME STATEMENT (HSIS)

For Establishing Provider's Tier 1 Status: Complete and return this form to your sponsor for establishing eligibility as a Tier I home, **along with documentation supporting** all listed sources of household income OR your household's eligibility for FoodShare WI, W-2 Cash Assistance, or FDPiR.

Refer to the accompanying *Provider Letter* for instructions on completing this form.

Provider's Name	Provider Number
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PART 1: BENEFITS

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

If any member of your household currently receives benefits from:	Check the box for the benefit received AND list the case number	<ul style="list-style-type: none"> • DO NOT list a 16 digit Quest Card number for FoodShare • Wisconsin Shares Child Care Subsidy benefits is NOT W-2 Cash Assistance.
FoodShare Wisconsin (10 digit #) <input type="checkbox"/>	_____	
Wisconsin Works(W-2) Cash Assistance (10 digit #) <input type="checkbox"/>	_____	
FDPiR (9 digit #) <input type="checkbox"/>	_____	

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.	b) List all income on the same line as the person who receives it.																				
Household Member: anyone who is living with you and shares income and expenses, even if not related.	<ul style="list-style-type: none"> • Record each income source only once. • Check the box for how often each income source is received. 																				
Household Members	(Optional) Age	Check if Foster Child	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
		<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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c) Record total # of household members: _____																					

PART 3: ALL HOUSEHOLDS

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, W-2 Cash Assistance, and/or FDPiR. 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, I may lose meal benefits and be prosecuted under applicable State and Federal laws.

Home Provider's Signature	Signature Date <i>Mo./Day/Yr.</i>	Last 4 digits of SS# (or check "None" if you do not have a SS#) ***_**_ _____ <input type="checkbox"/> None
Address	Daytime Phone Number	Email

FOR SPONSORING ORGANIZATION USE ONLY – Complete all 3 sections and the Effective Month of Determination

Section 1: Basis of Determining Eligibility (A or B)	Section 2: Eligibility Determination	Section 3: Determining Official's Initials & Approval Date
A. Household Size & Income Total Household Size _____ *Total Income \$ _____ / _____ (\$ Amount) (Time Period)	<input type="checkbox"/> Eligible <input type="checkbox"/> Not Eligible	_____ **Effective Month of Determination _____ Month/Year
B. Benefits/Foster <input type="checkbox"/> FoodShare WI <input type="checkbox"/> W-2 Cash Assistance <input type="checkbox"/> FDPiR <input type="checkbox"/> Foster Child(ren)		

*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

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