HOUSEHOLD SIZE—INCOME STATEMENT (HSIS)

Child and Adult Care Food Program - For Establishing Tier 1 Eligibility for Children Enrolled in Tier 2 Homes - FFY 2027, Rev. 7/26

An adult household member must complete this form and return it to the sponsor or to the provider upon their consent. See part 3 below. Refer to the accompanying *Household Letter* for instructions on completing this form.

Sponsoring Organization: Western Dairyland EOC **Provider Name:** _____ **Provider Number:** _____

In the table below, list all children enrolled at the child care and specify their age. If any children are in foster care, check the box. If a member of the household does not currently participate in a benefits program listed in Part 1 below, provide the income children earn or receive and indicate frequency of pay. The "Sources of Income for Children" chart in the *Household Letter* will help you with this section. If more space is needed, attach another HSIS.

Ethnicity and Race Questions: Providing ethnic and racial information is optional. This is required by Federal law to ask for this information. Your answers are strictly for statistical reporting and will have no effect on determination of eligibility for benefits. Complete for both ethnicity and race.

									Ethnicity: Choose Yes / No *Optional*	**Race: Select all categories that apply to your child *Optional***				
Child Last Name	**Child First Name**	**Age**	**Child in Foster Care?**	**Income child earns or receives**	Weekly	Every 2 Weeks	2x Month	Monthly	**Ethnicity: Hispanic or Latino?**	**American Indian or Alaska Native**	**Asian**	**Black or African American**	**Native Hawaiian or Other Pacific Islander**	**White**
			☐	$	☐	☐	☐	☐	☐ Yes ☐ No	☐	☐	☐	☐	☐
			☐	$	☐	☐	☐	☐	☐ Yes ☐ No	☐	☐	☐	☐	☐
			☐	$	☐	☐	☐	☐	☐ Yes ☐ No	☐	☐	☐	☐	☐
			☐	$	☐	☐	☐	☐	☐ Yes ☐ No	☐	☐	☐	☐	☐
			☐	$	☐	☐	☐	☐	☐ Yes ☐ No	☐	☐	☐	☐	☐

PART 1: BENEFITS

Do any household members currently participate in FoodShare Wisconsin (WI), Wisconsin (WI) Works Programs, or Food Distribution Program on Indian Reservations (FDPIR)? If yes, check the program and write the corresponding case number below; then go to Part 3. If no, go to Part 2 on the next page.

☐ **FoodShare WI (10-digit case number):** _____ *DO NOT list a 16-digit Quest Card number or number that starts with 5077.*

☐ **WI Works Programs (10-digit case number):** _____ *DO NOT list a WI Childcare Subsidy number. This is NOT a WI Works Program and does not qualify a child as free in CACFP.*

☐ **FDPIR (9-digit case number):** _____

☐ **WIC** ☐ **Respite Care** ☐ **TEFAP (case number):** _____

If you completed Part 1, go to Part 3 on the next page. If you did not complete PART 1, complete Part 2 and Part 3 on the next page.

This institution is an equal opportunity provider.

HOUSEHOLD SIZE—INCOME STATEMENT (HSIS)

Child and Adult Care Food Program - Group Child Care and Outside of School Hours Centers - FFY 2027, Rev. 6/26

PART 2: HOUSEHOLD SIZE AND INCOME

If you did not complete PART 1, complete the table below then go to PART 3.

- List full names of all adults and children, not listed on page 1, who are living in the household, including yourself and people who do not receive income.
- 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 income is received. The "Sources of Income for Adults" and "Sources of Income for Children" charts in the *Household Letter* will help you with this section.

Name of Other Household Members List all adults and children, not listed on page 1, who are living in the household and share income and expenses, even if not related.	**Check if No Income**	Earnings from Work, Gross pay before taxes (not take-home pay)	Weekly	Every 2 Weeks	2x Month	Monthly	Annually	Public Assistance, Child Support, Alimony payments received	Weekly	Every 2 Weeks	2x Month	Monthly	Annually	All other income: Pension, disability, retirement, unemployment, Veterans benefits, etc.	Weekly	Every 2 Weeks	2x Month	Monthly	Annually
	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐

Last four digits of signer's Social Security Number (SSN) (or check 'None' if you do not have a SS#): ***-**- __ __ __ __ Check if no SSN ☐

PART 3: SIGNATURE

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 benefits, and I may be prosecuted under applicable State and Federal laws.

_____ _____ _____

Signature of Adult Household Member **Date (Mo/Day/Year)** **Address**

_____ _____

Daytime Phone Number **Email**

_____Initial here if you have provided consent to your provider for collecting and forwarding your completed HSIS to the sponsor with the understanding that the provider is not allowed to review your completed HSIS. If you choose not to provide this consent, email, mail, or fax your completed HSIS directly to the sponsor using the contact information listed in the Household Letter provided with this form.

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FOR SPONSRING ORGANIZATION USE ONLY

Basis for Eligibility (complete one):

- **Benefits/Foster:** ☐ **Receives one or more of the 6 Qualifying Benefits** ☐ **Foster Child(ren)**
- **Total Household Size (children and adults): _____ Total Income (children and adults): _____ / _____**
  Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, 2x Month x 24, Monthly x 12 Amount Frequency

Eligibility Determination: ☐ **Tier 1 Eligible** ☐ **Tier 2 Eligible**

Determining Official's Initials/Approval Date (Mo/Day/Year): _____ Effective Month of Determination (Month/Year): _____

Form expires one year from the Effective Month of Determination

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