



STATE OF MAINE  
DEPARTMENT OF EDUCATION  
23 STATE HOUSE STATION  
AUGUSTA, ME 04333-0023

JANET T. MILLS  
GOVERNOR

A. PENDER MAKIN  
COMMISSIONER

Adult Day Centers  
July 1, 2025 - June 30, 2026

Dear Household Member:

The Adult Day Care Center in which you are enrolling participates in the Child and Adult Care Food Program (CACFP) under the direction of the U.S. Department of Agriculture (USDA). This means the Center must serve meals and snacks that meet or exceed the nutritional requirements set forth by the U.S. Government.

In return for serving meals and supplements that meet these requirements, the Center receives payment from the USDA based on the income levels of the individuals or households it serves. The higher the number of adults served who are low income or who come from low-income households, the more the Center receives as payment for the meals and supplements it serves.

In order that the Center may comply with the requirements of the CACFP, please complete, sign, date, and return the attached enrollment form as soon as possible. This form must be placed in the Center's files and treated as confidential information.

In order to qualify the Center to receive either the "Free" or the "Reduced-Price" rate of reimbursement for the meals and supplements you receive, the enrollment form must be completed as follows:

Supplemental Nutrition Assistance Program (SNAP)/SSI/MEDICAID HOUSEHOLDS: If the person being enrolled currently receives SNAP (formerly known as Food Stamps), Supplemental Security Income (SSI), or Medicaid assistance, list that person's name, SNAP, SSI, or Medicaid case identification number and sign and date the application. Since income information has already been given to the officials responsible for these programs, the enrollees' eligibility can be confirmed.

ALL OTHER HOUSEHOLDS: If the gross income of the household in which the enrollee lives falls at or below the current eligibility guidelines for the number of persons in the household, the Center will qualify to receive either "Free" or "Reduced-Price" reimbursements for meals served to the enrollee. In order to make this determination, the following information must be included on the form:

--Household Members: List the names of the enrollee, their spouse, and/or any other individual(s) who reside with the enrollee and depend on the enrollee for economic support. These individuals make up a "household" for the purposes of the Child and Adult Care Food Program.

--Monthly Income: List the total monthly income (BEFORE deductions for taxes, social security, etc.) received by each household member during the most recent month. Also, list the sources of this income such as wages, self-employment, retirement, or welfare assistance. If any household member's income was higher or lower than usual, show that person's average monthly income.

--Signature: An adult member of the household must sign and date the application.

If a working member of the household becomes unemployed, and if this loss of income causes the total household income to fall within the CACFP eligibility guidelines, the enrollee may qualify the Center for "Free" or "Reduced-Price" reimbursements during this period of unemployment.

The following chart shows the income levels to be used for the **July 1, 2025-June 30, 2026**, period to determine what amount of payment the Center will be able to receive for the meals and snacks served to you.

**Eligibility Scale For "Reduced-Price" Meals**

<b>Family Size</b>	<b>Annual</b>	<b>Monthly</b>	<b>Twice Per Month</b>	<b>Every Two Weeks</b>	<b>Weekly</b>
1	28,953	2,413	1,207	1,114	557
2	39,128	3,261	1,631	1,505	753
3	49,303	4,109	2,055	1,897	949
4	59,478	4,957	2,479	2,288	1,144
5	69,653	5,805	2,903	2,679	1,340
6	79,828	6,653	3,327	3,071	1,536
7	90,003	7,501	3,751	3,462	1,731
8	100,178	8,349	4,175	3,853	1,927
<b>Each Additional Family Member</b>	10,175	848	424	392	196

Thank you for your time and cooperation in completing the enclosed forms. All participants in the Adult Day Care portion of the CACFP must complete one of these applications, even if they are in the "Paid" category, as the CACFP regulations require everyone in the Center to be so enrolled. At least the enrolled person's name, age, and the last four (4) digits of their Social Security number must be entered, and an adult must sign and date the application.

Thank you.

## **CHILD AND ADULT CARE FOOD PROGRAM ADULT DAY CARE**

This Adult Day Care Center is a participant in the Child and Adult Care Food Program (CACFP), a Federal program of the Food and Nutrition Service (FNS), U.S. Department of Agriculture (USDA).

The primary goal of the Child and Adult Care Food Program is to improve the diet of adults enrolled in Adult Day Care Centers.

Nutrition is an important part of good health. Proper nutrition is also an important part of a good Adult Day Care Food Program. Adults need well-balanced meals in order to meet their daily energy needs and to help them maintain strong bodies and minds. Through the CACFP, you can be assured that you are getting balanced, nutritious meals. As participants in the CACFP, adult day care organizations may serve up to three meals a day to each adult. If three meals are served, at least one of them must be a snack. All of the meals must follow patterns set by USDA.

The meal pattern set by USDA is as follows:

Breakfast	Lunch or Supper	Snack
Milk Juice, fruit, or vegetable Bread or bread alternate	Milk Meat or meat alternate Vegetables and/or fruits Bread or bread alternate	(Serve two of the following four foods. Juice may not be served when milk is served as the only other food.)  Milk Meat or meat alternate Fruit, vegetable, or juice Bread or bread alternate

An Adult Day Care Center is any public agency or nonprofit organization or any proprietary Title XIX or Title XX center which is licensed or approved by Federal, State, or local authorities to provide nonresidential adult day care services to functionally impaired adults or persons 60 years of age or older in a group setting outside their homes on a less than 24-hour basis. The regulation further specifies that adult day care centers provide a community-based program designed to meet the needs of functionally impaired adults through an individual plan of care. This program must be a structured, comprehensive program that provides a variety of health, social, and related support services to enrolled adult participants.

**CHILD AND ADULT CARE FOOD PROGRAM**  
**APPLICATION FOR MEALS IN ADULT DAY CARE CENTERS**

To apply for free and reduced-price meals in an Adult Day Care Center, carefully complete this form, sign it, and return it to the center. If you need help with this form, please call the center.

PART I: COMPLETE THIS PART ONLY IF THE INDIVIDUAL TO BE ENROLLED IN THE CENTER IS CURRENTLY A MEMBER OF A SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) HOUSEHOLD OR RECEIVES ASSISTANCE THROUGH THE SUPPLEMENTAL SECURITY INCOME (SSI) PROGRAM OR THROUGH MEDICAID. IF THIS PART IS COMPLETED, SKIP PART II, GO TO PART III.

Enrollee's Name: \_\_\_\_\_ Age: \_\_\_\_\_ (Check all that apply) Case Number: \_\_\_\_\_  
Medicaid: SSI: SNAP:  
\_\_\_\_\_ ☐ ☐ ☐

PART II: COMPLETE THIS PART ONLY IF PART I IS NOT APPLICABLE. (If more space is needed, please use a separate sheet of paper.)

Enrollee's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Under "NAME," you must list the name of the enrollee and of their spouse and/or any other individuals who reside with the enrollee and who depend on the enrollee for economic support. In the appropriate column, list ALL income received last month on the same line as the name of the person who received it. The GROSS income amount must be listed (the amount BEFORE deductions for taxes, Social Security, etc.). Please list the total income received for the month in the appropriate space at the bottom. The person who signs the form must understand that if the household income section of the form is left blank, that person is certifying that the household has zero income. The center staff will then consider the enrollee to be in that category of eligibility which qualifies the center to receive the highest level of payment for the meals and supplements that the enrollee will receive.

NAME: (Last, First)	Age:	Salary-Wages Before Deductions:	Welfare, Child Support & Alimony	All Other Income:
1.				
2.				
3.				
4.				
5.				
<b>(Note: Weekly Income x 4.333 weeks; Bi-weekly Income x 2.15 weeks)</b> <b>TOTAL MONTHLY HOUSEHOLD INCOME:</b>				

**PART III: IDENTIFYING INFORMATION AND CERTIFICATION OF DATA:**

**PENALTIES FOR MISREPRESENTATION:** I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given in relation to the receipt of Federal funds; that the information on the application may be verified; and that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

**SIGNATURE:** An adult **MUST** sign the application before it can be approved and the last four (4) digits of the Social Security number of the person signing the application must be provided\*.

PRINT NAME OF ADULT	LAST 4 DIGITS OF SS#	SIGNATURE OF ADULT	DATE
<input type="checkbox"/> I do not have a social security number.			
HOUSEHOLD ADDRESS OF ADULT		HOME PHONE	WORK PHONE
<b><u>ALL HOUSEHOLDS: Racial/Ethnic Identity**:</u></b>  The spouse/guardian is not required to answer this question, but the information <b><u>is requested</u></b> to ensure that everyone receives benefits on a fair basis.  1. Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		2. Race (mark one or more):  <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White	

**\*\*This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws. Your response will not affect consideration of your application.**

\*Section 9 of the National School Lunch Act requires that, unless a SNAP or TANF case number is provided, you must include the last four (4) digits of a Social Security number on the application. This must be the last four (4) digits of the Social Security number of the adult household member signing the application. If the adult household member signing the application does not possess a Social Security number, they must indicate so on the application. Provision of a Social Security number is not mandatory, but if the last four (4) digits of a Social Security number are not provided or an indication is not made that the adult household member signing the application does not have one, the application cannot be approved. This notice must be brought to the attention of the household member whose Social Security number is disclosed. The Social Security number may be used to identify the household member in carrying out efforts to verify the accuracy of information stated on the application. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a SNAP, Indian Tribal Organization, or Welfare Office to determine current certification for receipt of SNAP, FDPIR, or TANF benefits, contacting the State Employment Security Office to determine the amount of benefits received, and checking the documentation produced by household members to verify the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal action if incorrect information is reported.

**THIS PORTION MUST BE COMPLETED BY THE CENTER'S INTAKE PERSONNEL:**

**Enrollee's Eligibility Category (circle one):    Free            Reduced-Price            Paid**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Federal Non-Discrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible State or local Agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, *USDA Program Discrimination Complaint Form* which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or

**(2) fax:**

(833) 256-1665 or (202) 690-7442; or

**(3) email:**

[program.intake@usda.gov](mailto:program.intake@usda.gov)

This institution is an equal opportunity provider.