

Dear Parent/Guardian: **Provider Name** \_\_\_\_\_ **Provider Number** \_\_\_\_\_

Your child(ren) is enrolled for child care services with the home provider listed to the right. This provider has been approved to receive CACFP funding for meals served to children through Horizons.

This sponsoring organization is approved by WI Department of Public Instruction (DPI) for distributing CACFP meal reimbursement to providers issued from the United States Department of Agriculture (USDA). Higher meal reimbursement (Tier 1) rates may be paid to your provider for the meals they serve to your children when your household receives the specified benefits or meets the criteria listed below OR has a total income equal to or lower than the amount shown for your household size within the table below.

**Please complete and return the attached Household Size-Income Statement form (HSIS) for the sponsoring organization to determine which meal reimbursement rate will be paid to your provider for the meals they serve to your child(ren).**

Only one completed HSIS is required for all children in your household. If your household does not meet the eligibility criteria, we would appreciate you returning the HSIS with "N/A" written on it along with your signature and date.

If determined as eligible for Tier 1 meal rates, your children will remain eligible 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 will be kept confidential.

> **You are not required to return a completed HSIS for your children to participate in CACFP.**

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

Your provider will receive Tier 1 meal reimbursement rates they serve to your children if your household receives benefits from FoodShare WI the Supplemental Nutrition Assistance Program (SNAP), FDPIR (Food Distribution Program on Indian Reservations), WI Works Programs, WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children), Respite Care, and/or TEFAP (the Emergency Food Assistance Program).

Wisconsin Works Programs 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 WI Child Care Subsidy Program. WI Works Programs includes Trial Employment Match Program (TEMP), Community Service Jobs (CSJ), W-2 Transitions (W-2T), Case Management, Custodial Parent of an Infant (CMC), Minor Parents Services, Noncustodial Parents, and Pregnant Women, Learnfare and Emergency Payments.

**You must include the following information on the HSIS (a-c) for eligibility based on receiving benefits from FoodShare WI, FDPIR, WI Works Programs, WIC, Respite Care, or TEFAP:**

- (a) The names of your enrolled children;
  - (b) Checked box for the benefit your household receives and its case number; &
  - (c) The signature of an adult member in the household & signature date
- DO NOT list case numbers for: Medicaid, SSI, OR Wisconsin Child Care Subsidy program AND
  - DO NOT list 16-digit Quest Card number (starts with 5077) 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, 2023 to June 30, 2024)

Household Size	Annual Income Level (at or below)
1	\$ 26,973
2	\$ 36,482
3	\$ 45,991
4	\$ 55,500
5	\$ 65,009
6	\$ 74,518
7	\$ 84,027
8	\$ 93,536
For each additional Household Member, add:	+\$ 9,509

If your household earns a total income that is less than or equal to the income levels listed within this table, your children will be eligible for Tier 1 meal reimbursement rates.

**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) The signature of an adult member of the household and signature date; and
  - (e) The last four digits of the social security number of the adult household member signing the HSIS or an indication they 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 in Head Start, and Free/Reduced School lunch:** If your household does not meet the eligibility criteria specified within this letter, any child residing in your home who is a foster, runaway, homeless, or migrant child, in Head start, or qualifies for Reduced Price School Lunch/Breakfast will qualify for Tier 1 meal reimbursement rates when

the respective documentation listed below is provided. **These children's eligibility for Tier 1 meal reimbursement rates does not extend to any other children in your household:**

- **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.
- **Free/Reduced-Priced Eligible for National School Lunch or School Breakfast Programs:** copy of Free/Reduced-Priced eligibility determination letter from school.

**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, your children will not be eligible for Tier 1 meal rates. You must include the last four digits of the social security number of the household member signing the form unless: the HSIS is only for your foster child(ren); you list a case number for receiving benefits listed above; or when the household member signing the HSIS checks "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. 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, 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.

Refer to the [USDA Non-Discrimination Statement and Complaint Filing Procedure](#). This institution is an equal opportunity provider.

**Submitting Completed HSIS for Eligibility Determination:** You must submit your completed HSIS for the sponsor to make an eligibility determination. Your provider may offer to collect the completed HSIS from the families of their enrolled children and then forward them to the sponsor for making eligibility determinations. If the provider offers to collect the completed HSIS, **you may choose to submit your completed HSIS by either:**

- **Giving your completed HSIS to the provider** with your consent (by initialing the household member consent statement in Part 3 of the HSIS) for them to forward your completed HSIS to the sponsor on your behalf; **OR**
- **Submitting the completed HSIS directly to the Sponsor** by email, regular mail, or fax to the sponsor at:

Name Horizons	Email horizonsfoodprogram1991@gmail.com	Address 225 E. 2nd St Kaukauna WI 54130	Fax 920 462 4871
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Horizons is not allowed to share any of your children's eligibility information or their eligibility determination with your provider. **If you have any questions or concerns, call** Jenna **with** Horizons **at** 920 462 4805

Jenna Van Den Wildenberg  
**Signature of Sponsor Representative**

HOUSEHOLD SIZE-INCOME STATEMENT (HSIS) **YELLOW FORM**

For Establishing Tier 1 Eligibility for Children Enrolled in Tier 2 Homes: An adult household member must return this completed form to the sponsoring organization or to the provider upon their consent (*Initial consent statement in Part 3*)

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

First and Last Name(s) of Enrolled Child(ren)	Sponsoring Organization	Provider Name/Number
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**PART 1: BENEFITS**

Do any household members currently participate in FoodShare WI, WI Works Programs, FDPIR, WIC, Respite Care, or TEFAP? If yes, check the program and write the corresponding case number below; then go to Part 3. If no, skip to Part 2.

<input type="checkbox"/> <b>FoodShare Wisconsin (10-digit case number)</b> DO NOT list a 16-digit Quest Card number: _____  <input type="checkbox"/> <b>FDPIR (9-digit case number):</b> _____	<input type="checkbox"/> <b>Wisconsin Works (W-2) Programs (10-digit case number):</b> Wisconsin Shares Child Care Subsidy benefits is NOT a W-2 Program. It does not qualify a child as Tier 1 eligible.  <input type="checkbox"/> <b>WIC</b> <input type="checkbox"/> <b>Respite Care</b> <input type="checkbox"/> <b>TEFAP</b> Case #: _____
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**PART 2: TOTAL HOUSEHOLD SIZE AND INCOME**

If you did not complete Part 1, complete a, b, and c below; then go to Part 3.

<b>a) Household Member Information:</b> List full names of all members in first column below, including yourself and all children	<b>b) Income:</b> <ul style="list-style-type: none"> <li>List all income on the same line as the household member who receives it.</li> <li>Check the box for how often each income source is received</li> <li>Record each income source only once</li> </ul>
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Household Member Names	Optional Age	Check if Foster Child	Check if No Income	Gross wages, net income (self-employed), tips, commission, bonuses, military pay & allowances, work comp, strike benefits, unemployment	Weekly				Every 2 Weeks				Twice per Month				Monthly				Annually				Retirement, Social Security, SSI, disability, VA benefits, child support, alimony	Weekly				Every 2 Weeks				Twice per Month				Monthly				Annually				Private pensions, trusts, annuities, investments, savings, other income	Weekly				Every 2 Weeks				Twice per Month				Monthly				Annually			
					Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually																																										
Household Member: anyone who is living with you and shares income and expenses, even if not related.		<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"/>	<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"/>	<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: Signature**

An adult household member must sign and date this form.

If Part 2 is completed, the adult signing the form must list the last four digits of their SS# OR check "None" if they do not have a SS#.

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, the home provider caring for my children may lose meal reimbursement, 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#) ***_**_ _____ <input type="checkbox"/> None
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\_\_\_\_\_ 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 to not 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.

Address	Daytime Phone Number	Email
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**FOR SPONSORING ORGANIZATION USE ONLY - Complete all 3 sections**

Section 1: Basis of Determining Eligibility (A or B)	Section 2: Eligibility Determination	Section 3: Determining Official's Initials/Approval Date and Effective Month of Determination
<b>A. Household Size &amp; Income</b> Total Household Size _____  *Total Income \$ _____ / _____ (\$ Amount) (Time Period)	<b>B. Benefits/Foster</b> <input type="checkbox"/> Receives ≥ 1 of 6 Qualifying Benefits <input type="checkbox"/> Foster Child(ren)	<input type="checkbox"/> Tier 1 Eligible  <input type="checkbox"/> Tier 2 Eligible  Initials/Date: _____  **Effective Month of Determination: _____ Month/Year

\*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.