

This Provider 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 to our office the attached Household Size-Income Statement form (HSIS) along with support documentation of all reported income or your household's participation in Benefits Programs. Once 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 will be 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 Wisconsin Works Programs and your household income is higher than the amount shown for your household size within the table below.

**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 WI Works Programs. **Wisconsin Works Programs** is Wisconsin's Temporary Assistance for Needy Families (TANF) program. **It provides 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:

- (a) The names of your own and/or other residential children; • DO NOT list case numbers for:
- (b) Checked box for the benefit your household receives and its case number; & Medicaid, SSI, OR Wisconsin Child Care Subsidy program AND
- (c) The signature of an adult member in the household & signature date • 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, 2024 to June 30, 2025)

Household Size	Annual Income Level (at or below)
1	\$ 27,861
2	\$ 37,814
3	\$ 47,767
4	\$ 57,720
5	\$ 67,673
6	\$ 77,626
7	\$ 87,579
8	\$ 97,532
For each additional Household Member, add:	+\$ 9,953

If your household earns a total income that is less than or equal to the income levels listed within this table, you will receive Tier 1 meal rates for all your enrolled 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) 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:**

If your household does not qualify you as a Tier 1 provider 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. **These children's Tier 1 eligibility status does not extend to your home or any other children in the household. 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 a Tier 1 eligible provider. 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 FoodShare WI, WI Works Programs, or FDPIR; 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.

  
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 1 provider, **along with documentation supporting** all listed sources of household income OR your household's participation in Benefits Programs. Refer to the accompanying *Provider Letter* for instructions on completing this form.

<b>Provider's Name</b>	<b>Provider Number</b>
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**PART 1: BENEFITS**

Do any household members currently participate in FoodShare WI, WI Works Programs, or FDPIR?  
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 or number that starts with 5077.  <input type="checkbox"/> <b>FDPIR (9-digit case number):</b>	<input type="checkbox"/> <b>Wisconsin Works Programs (10-digit case number):</b> DO NOT provide a WI Share Childcare Subsidy number. This is NOT a WI Works Program and does not qualify a child as free in CACFP.  
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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, Cash bonuses, Military pay & allowances, Work comp, strike benefits, Unemployment	Income				Retirement, Social Security, SSI, Disability, VA benefits, Child support, Alimony	Income				Private pensions, trusts, Annuities, Interest, Investments, Net rental income, Savings, Other income
					Weekly	Every 2 Weeks	Twice per Month	Monthly		Annually	Weekly	Every 2 Weeks	Twice per Month	
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"/>	<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"/>

**c) Record total number 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, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws.

Home Provider's Signature	Signature Date Mo./Day/Yr.	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**

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"/> FoodShare WI <input type="checkbox"/> W-2 Programs <input type="checkbox"/> FDPIR <input type="checkbox"/> Foster Child(ren)	<input type="checkbox"/> Eligible  <input type="checkbox"/> Not 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.