



**WE HAVE CHECKED YOUR CACFP MEAL BENEFIT
INCOME ELIGIBILITY FORM INFORMATION**

Center/Sponsoring Organization: [**Name**]

[**Date**:]

Dear [**Name**]:

We checked the information you sent us to prove that [**name(s) of participant**] is eligible for free or reduced price meal benefits at our facility and have decided that:

- The participant's eligibility has not changed.
- Starting [**date**], the participant's eligibility for meal benefits will be changed **from reduced price to free** because the verified income is within the free meal eligibility limits. The participant will receive meals at no cost.
- Starting [**date**], the participant's eligibility for meals will be changed **from free to reduced price** because the verified income is over the limit.
- Starting [**date**], **the participant is no longer eligible** for free or reduced price meals for the following reason(s):
 - ___ Records show that you did not receive Food Stamps, TANF, FDPIR, SSI, or Medicaid.
 - ___ Your income is over the limit for free or reduced price meals.
 - ___ You did not provide: _____
 - ___ You did not respond to our request.

If your household income goes down or your household size goes up, you may complete another CACFP Meal Benefit Income Eligibility Form. If you did not provide proof of current eligibility, you will be asked to do so if you reapply.

If you disagree with this decision, you may discuss it with [**name**] at [**phone**]. You also have the right to a fair hearing. If you request a hearing by [**date**], the participant will continue to receive free or reduced price meals until the decision of the hearing official is made. You may request a hearing by calling or writing to: [**name**], [**address**], [**phone number**].

Sincerely,

[**signature**]

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