FREE AND REDUCED-PRICE MEAL BENEFIT APPLICATION
CHILD CARE CENTERS: July 1, 2011 – June 30, 2012

Complete this form so that we may receive reimbursement for meals served to children in our program. For help call _____.

PART 1 – ENROLLED CHILDREN INFORMATION			**PART 2 - CASE NUMBER**
Last Name	First Name	Check (✓) if foster child If all listed children are foster children, skip to Part 5.	If applicable, give a Food Supplement Program or Temporary Cash Assistance case number for **any** member of the household.
1.			
2.			___ ___ ___ ___ ___ ___ ___ ___ ___
3.			**If completed, skip to Part 5. Last four digits of Social Security Number are not needed.**
4.			

PART 3 - IF ANY CHILD YOU ARE APPLYING FOR IS HOMELESS, MIGRANT, OR A RUNAWAY, CHECK THE APPROPRIATE BOX AND COMPLETE THE APPLICATION ❑ HOMELESS ❑ MIGRANT ❑ RUNAWAY

PART 4 - HOUSEHOLD MEMBERS AND GROSS INCOME. You must tell us how much and how often.

LIST NAMES OF ALL HOUSEHOLD MEMBERS Include the children named above.	**EARNINGS FROM WORK** (before deductions)		**ADDITIONAL INCOME** Child Support, Alimony, TCA, Pensions, Retirement, Social Security, SSI, VA Benefits		**ALL OTHER INCOME**		Check if **NO** income
	Income	How Often	Income	How Often	Income	How Often	
1.	$.		$.		$.		❑
2.	$.		$.		$.		❑
3.	$.		$.		$.		❑
4.	$.		$.		$.		❑
5.	$.		$.		$.		❑
6.	$.		$.		$.		❑

PART 5 - SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN)

An adult household member must sign the application. **If Part 4 is completed, the adult signing the form must list the last four digits of his/her Social Security Number, or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement)

I certify (promise) that all information on this application is true and that all income is reported. I understand that the center will receive Federal funds based on the information I give. I understand that center officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.

Sign here: _____ Print name:_____ Date: _____

Address:_____ Phone Number:_____

City:_____ State:_____ Zip Code:_____ Social Security Number: **XXX**-**XX**- __ __ __ __ ❑ I do not have a SSN

PART 6 - CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

Choose one ethnicity:

❑ Hispanic/Latino
❑ Not Hispanic/Latino

Choose one or more (regardless of ethnicity):

❑ Asian ❑ American Indian or Alaska Native ❑ Black or African American
❑ White ❑ Native Hawaiian or other Pacific Islander

PART 7 - SHARING INFORMATION WITH OTHER PROGRAMS

Information that you provide will be used to determine your children's eligibility for free or reduced-price meals. The eligibility status of your children may also be used for other authorized purposes..

Your family may be eligible to receive benefits under the Food Supplement Program (FSP) or the Women, Infants, and Children (WIC) Program. To share your information with these programs, ***we must have your permission***. Your decision will not change whether your children get free or reduced price meals. **If you want information shared with FSP or WIC check the "Yes," box.**

You may be contacted about submitting an application for the FSP or WIC if you select **Yes**:

__ **Yes, I want** information shared from the Free and Reduced-Price Meal Benefit Application with FSP.
__ **Yes, I want** information shared from the Free and Reduced-Price Meal Benefit Application with WIC.

Children eligible for free or reduced-price school meals may also be able to get free or low-cost health insurance through Medicaid or the MD Children's Health Insurance Program (MCHIP). The law allows us to inform Medicaid and MCHIP that your children are eligible for free or reduced price meals, ***unless you say no***. Your decision will not change whether your children receive free or reduced-price meals. **If you do not want information shared with Medicaid or the MCHIP, check the "No," box.**

If you do not want information shared with Medicaid or MCHIP, check the "**No**," box:

__ **No, I DO NOT** want information from my Free and Reduced-Price Meal Benefit Application shared with Medicaid or MCHIP.

DO NOT FILL OUT THIS PART. THIS IS FOR CENTER USE ONLY.

Annual Income Conversion: Weekly x 52 Every 2 Weeks x 26 Twice A Month x 24 Monthly x 12

Total Income: $_____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: ___ Date Withdrawn: _____Eligibility: Free___ Reduced___ Denied___ Reason: _____

Temporary: Free_____ Reduced_____ Time Period: _____ (expires after _____ days)

Determining Official's Signature: _____ Date: _____