

**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 <u>all</u> listed children are foster children, skip to Part 5.	If applicable, give a Food Supplement Program or Temporary Cash Assistance case number for <u>any</u> member of the household.
1.			If completed, skip to Part 5. Last four digits of Social Security Number are not needed.
2.			
3.			
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.	\$.		\$.		\$.		<input type="checkbox"/>
2.	\$.		\$.		\$.		<input type="checkbox"/>
3.	\$.		\$.		\$.		<input type="checkbox"/>
4.	\$.		\$.		\$.		<input type="checkbox"/>
5.	\$.		\$.		\$.		<input type="checkbox"/>
6.	\$.		\$.		\$.		<input type="checkbox"/>

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:	Choose one or more (regardless of ethnicity):
<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	<input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> 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: _____