MEAL BENEFIT APPLICATION
CHILD CARE CENTERS: July 1, 2015 – June 30, 2016

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

PART 1 – ENROLLED CHILDREN INFORMATION

Last Name	First Name	Check (✓) if foster child, homeless, migrant, runaway, or in head start. If **ALL** students listed are foster, homeless, migrant, runaway, or in Head Start, skip to Part 4.				
1.		Foster	Home	Migrant	Runaway	Head Start
2.						
3.						
4.						
5.						
6.						
7.						

PART 2 - CASE NUMBER - If applicable, give Food Supplement Program or Temporary Cash Assistance case number for **any** member of the household: ___ ___ ___ ___ ___ ___ ___ ___ ___. **If completed, skip to Part 4. Last four digits of Social Security Number are not needed.**

PART 3 - HOUSEHOLD MEMBERS AND GROSS INCOME. You must tell us how much and how often.

LIST NAMES OF ALL HOUSEHOLD MEMBERS Include the child(ren) 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 4 - SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN)

An adult household member must sign the application. **If Part 3 is completed, the adult signing the form must list the last four digits of his/her Social Security Number, or check (✓) the "I do not have a SSN" box below.**

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, I may be prosecuted. I understand my child's eligibility status may be shared as allowed by law.

Sign here: _____ Print name:_____ Date: _____

Address:_____ Phone Number:_____

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

PART 5 - (OPTIONAL) CHILDREN'S ETHNIC AND RACIAL IDENTITIES

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 6 - SHARING INFORMATION WITH OTHER PROGRAMS

The eligibility status of your children may be used for other authorized purposes, shared with local Title I officials, and used for National Assessment of Educational Progress analyses. Your family may also 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 receive free or reduced-price meals. If you want information shared with FSP or WIC, check (✓) the YES box below. You may be contacted about submitting an application for the FSP or WIC.

❑ **YES**, I want information shared from the Free and Reduced-Price Meal Benefit Application with ❑ FSP and/or ❑ 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 MCHIP, check (✓) ❑ No.

DO NOT FILL OUT THIS PART. 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: _____ Date Withdrawn: _____

Eligibility: Free ___ (Categorically Eligible: ___) Reduced ___ Denied ___ Reason: _____

Determining Official's Signature: _____ Date: _____