Victoria Learning Center
402 Washington St.
Cambridge, MD 21613

FREE AND REDUCED-PRICE MEAL BENEFIT APPLICATION
CHILD CARE CENTERS: July 1, 2010 - June 30, 2011

Please complete this form so that we may receive reimbursement for meals served to children in our program.
For help call (410) 228-0706

PART 1. ENROLLED CHILDREN INFORMATION

	Last Name	First Name
1.		
2.		
3.		
4.		
5.		
6.		

PART 2. CASE NUMBER

If applicable, give a Food Supplement Program (FSP) or Temporary Cash Assistance (TCA) case number for **any** member of the household.

_ _ _ _ _ _ _ _ _ _

If completed, skip to Part 6.

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. FOSTER CHILD If this application is for a child who is the legal responsibility of the Department of Social Services or court, check this box ☐ and then list the amount of the child's personal use monthly income: $_____. ☐ Check if no income. *Skip to Part 6.* Use a separate form for each foster child.

PART 5. 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	Frequency	Income	Frequency	Income	Frequency	
1.	$.		$.		$.		☐
2.	$.		$.		$.		☐
3.	$.		$.		$.		☐
4.	$.		$.		$.		☐
5.	$.		$.		$.		☐
6.	$.		$.		$.		☐

PART 6. SIGNATURE AND SOCIAL SECURITY NUMBER (ADULT MUST SIGN)

An adult household member must sign the application. **If Part 5 is completed, the adult signing the form also must list 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 get Federal funds based on the information I give. I understand that officials may verify (check) the information. I understand that if I purposely give false information, I may be prosecuted.

Sign here: _____ Print name: _____ Date: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____
Social Security Number: ___ ___ - ___ ___ - ___ ___ ___ ___ ☐ I do not have a Social Security Number

PART 7. 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 8. SHARING INFORMATION WITH OTHER PROGRAMS

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

If your children are eligible for free meals they may also be able to get free or low-cost health insurance through Medicaid or the MD Children's Health Insurance Program (MCHIP). Your family may also be eligible to receive food assistance benefits under the Food Supplement Program (FSP), formerly known as the Food Stamp Program or the Women, Infants, and Children (WIC) Program.

You may be contacted about submitting an application for the FSP or WIC if you selected **"Yes"**:
__ **Yes, I want** information shared from the Free and Reduced-Price Meal Benefit Application with the Food Supplement Program.
__ **Yes, I want** information shared from the Free and Reduced-Price Meal Benefit Application with the Women, Infants, and Children Program.

If you do not want information shared with Medicaid or the MD Children's Health Insurance Program (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: _____