

Meal Benefit Application for Free and Reduced-Price School Meals

July 1, 2022 – June 30, 2023

Apply online: www.smcps.org/dss/food-services

Complete one application per household.

For more information, read **Instructions for Applying** or call: 301-475-4256 ext. 5

Step 1 List all enrolled children (if more spaces are required for additional names, attach another sheet of paper).

Children in Foster Care and children who meet the definition of Homeless, Migrant, Runaway, Head Start, Early Head Start or Even Start are eligible for free meals. If all enrolled children meet the definition of Homeless, Migrant, Runaway, Head Start, Early Head Start or Even Start, complete Step 1 then skip to Step 4.

First and Last Names of All ENROLLED Children	Check (✓) all that apply:						School Name	Grade
	Foster Child	Homeless	Migrant	Runaway	Head Start Early Head Start	Even Start		

Step 2 Do any Household Members (including you) currently participate in one or more of the following assistance programs: Supplemental Nutrition Assistance Program (SNAP) or Temporary Cash Assistance (TCA)?
Circle one: Yes No

If you answered NO, complete Step 3.

If you answered YES, provide a 9-digit case number then go to Step 4

Case Number:

Step 3 Report Income for ALL Household Members (skip this step if you answered YES to Step 2)

List all Household Members (including yourself) even those who do not receive income. For each Household Member who receives income, report total income and how often for each source in whole dollars only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank you are certifying (promising) that there is no income to report.

How often = Weekly, Bi-Weekly, Twice a Month, Monthly, Yearly.

First and Last Names of ALL Household Members	Earnings from Work		Child Support, Alimony, Public Assistance		Pensions, Retirement, Other Income	
	Income	How Often?	Income	How Often?	Income	How Often?

Total Household Members (Children and Adults):

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member:

Check if No SSN:

Step 4 Contact information and Adult Signature

I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and federal laws. I understand my child's eligibility status may be shared as allowed by law.

Printed Name:	Signature:
Street Address:	
Date:	Phone #:

Step 5 OPTIONAL: Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section does not affect your children's eligibility for free or reduced-price meals.

Ethnicity (Check One):

Hispanic or Latino
 Not Hispanic or Latino

Race (Check one or more):

American Indian or Alaskan Native
 Asian

Black or African American
 Native Hawaiian or Other Pacific Islander

White

Step 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 SNAP or the Women, Infants, and Children (WIC) Program. Your decision will not change whether your children receive free or reduced-price meals. If you want information shared with SNAP or WIC, check (✓) YES or NO below. You may be contacted about submitting an application for the SNAP or WIC.

____ YES ____ NO

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.

____ NO

DO NOT FILL OUT THIS SECTION. SCHOOL USE ONLY

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

Total Income (Children and Adults): \$ _____ Weekly Every 2 Weeks Twice a Month Monthly Yearly

Eligibility: Free Categorically Eligible Reduced Paid

Determining Official's Signature: _____

Date: _____

Confirming Official's Signature: _____

Date: _____

Verifying Official's Signature: _____

Date: _____