Summer Food Program Income Application

FY 2010

(For Use by Camps and Closed Enrolled Sites)

1. **CHILD INFORMATION** (print)

2. **PROGRAM BENEFITS**

Name of Child	Date of Birth	Food Stamp#	K-TAP#	Foster Child fill in monthly personal income here

3. **HOUSEHOLD MEMBERS AND MONTHLY INCOME**: If you have a food stamp or K-TAP case number, go to Part 4.

NAMES OF HOUSEHOLD MEMBERS Including Children Not Listed Above LAST FIRST	GROSS MONTHLY Income From Work (Before Deductions)	MONTHLY Income From Welfare Payments, Child Support, Alimony	MONTHLY Income from Pensions Retirement Social Security	Any Other MONTHLY Income
1.	$	$	$	$
2.	$	$	$	$
3.	$	$	$	$
4.	$	$	$	$
5.	$	$	$	$

4. SIGNATURE: I certify that all of the above information is true and correct, that all income is reported and/or the food stamp or K-TAP case number is reported correctly. I understand that this information is being given for the receipt of federal funds; that school officials may verify the information on the application and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

X_____ _____ _____

Signature of Adult Household Member | Date | Social Security Number*

Home Telephone No. _____Work Telephone No. _____Printed Name _____

Street/Apt.No._____City/State/Zip_____

PART 5 - RACE AND ETHNICITY: (**You are not required to answer this question**.) Please check all categories that apply to the racial identity of your children. No child will be discriminated against because of race, color, sex, national origin, age or disability.	**ETHNICITY:** (Choose one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino	**RACE:** (Choose one) ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

PART 6 – Medicaid or K-CHIP Benefits – This section does not need to be completed to receive free or reduced price meals.

We may share your information with Medicaid or the Kentucky Children's Health Insurance Program (K-CHIP), unless you tell us not to. The information, if you choose to let us share it, may be used to determine if your children would qualify for Medicaid or K-CHIP benefits and officials from those programs may contact you with additional information. If you do not want us to share the information for that purpose, please check the box and put your signature and the date on the line below. ☐ **NO**

X _____ X _____

SIGNATURE OF PARENT/GUARDIAN | DATE

I certify that I am the parent/guardian of the child for whom this application is made. X _____

Signature of Parent/Guardian **Date**

PRIVACY ACT NOTICE: The National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security number of the adult household member who signed the application unless (1) you are applying for a foster child or (2)you list a Food Stamp or K-TAP number for your child or (3)when the adult who signed the application does not have a social security number. We will use the information to determine if your child is eligible for free or reduced price meals and for the operation and enforcement of the breakfast and lunch programs. We may share this eligibility information with (1) education, health and nutrition programs to help them evaluate, fund, or determine benefits for their programs; (2) auditors for program reviews; and (3) law enforcement officials to help them investigate violations of program rules.

FOR SPONSOR USE ONLY. DO NOT WRITE BELOW THIS LINE.

MONTHLY INCOME CONVERSION – WEEKLY X 4.33 **EVERY 2 WEEKS X 2.15** **TWICE A MONTH X 2**

☐ Food Stamp/K-TAP

☐ Income Household:

Total Household Monthly Income: _____

Household Size: _____

Application approved for:

☐ Qualified

☐ Non-Qualified

X_____ _____ _____ _____

Signature of Determining Official | Date | W/D Date | Re-enter Date