



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE (CFNA)
SUMMER FOOD SERVICE PROGRAM (SFSP)

INCOME ELIGIBILITY FORM FOR SUMMER FOOD SERVICE PROGRAM

To apply for free or reduced-price meal eligibility benefits for your child(ren), please fill out this form and return it to the program.

PART 1 CHILDREN ENROLLED IN THE PROGRAM

Complete information below for children enrolled at the camp/site. If child(ren) are receiving Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance (TANF), complete Parts 1, 3, and 4 only. Complete Parts 1, 2, 3, and 4 if you did not provide a SNAP case number or Temporary Assistance case number. ***In certain cases, foster children are eligible for free meals regardless of household income. If foster children live in your household, please contact the camp or site sponsor for more information.***

NAME (first and last)	BIRTH DATE	FOSTER CHILD	SNAP CASE NUMBER	TEMPORARY ASSISTANCE CASE NUMBER

PART 2 HOUSEHOLD AND INCOME INFORMATION

List all members of the household including the children listed in Part 1. Indicate source and amount of current income for all members of the household before deductions, such as taxes and social security. Where there are wage earners and self-employed adults, the income of the wage earner cannot be offset by the business losses of the self-employed adult. If last month's income does not accurately reflect your circumstances, you may provide a projection of your current annual income. Irregular self-employed income may be averaged over the prior 12 months.

INCOME BASED ON (CHECK ONE)	YEARLY ☐	MONTHLY ☐	2X A MONTH ☐	EVERY 2 WEEKS ☐	WEEKLY ☐
HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT SOCIAL SECURITY	OTHER	

PART 3 PARTICIPANT'S ETHNIC AND RACIAL INFORMATION (Optional)

Hispanic or Latino origin? ☐ YES ☐ NO

Race: AMERICAN INDIAN OR ALASKA NATIVE ☐ AISAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ WHITE ☐

PART 4 SIGNATURE

I hereby certify that all information provided is correct and true and that all income is reported. I understand that this information is being given in connection with the receipt of federal funds, that institution officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

SIGNATURE OF ADULT ENROLLEE OR GUARDIAN	SOCIAL SECURITY NUMBER (LAST FOUR DIGITS ONLY)	DATE SIGNED
PRINTED NAME OF ADULT	ADDRESS	PHONE NUMBER

The Richard B. Russell 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 signs the application. The social security number is not required when you apply on behalf of a foster child or you list a SNAP, Temporary Assistance (TA) Program case number for your household or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. These verification efforts may be carried out through program reviews and investigations, and may include contacting employers to determine income, contacting a SNAP or welfare office to determine current certification for receipt of SNAP or Temporary Assistance benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to provide the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

FOR SPONSOR USE ONLY

TOTAL HOUSEHOLD SIZE:	INCOME	INCOME BASED ON (CHECK ONE):	YEAR ☐	MONTH ☐	2X A MONTH ☐	EVERY 2 WEEKS ☐	WEEKLY ☐	SNAP(Food Stamps) ☐	TEMPORARY ASSISTANCE ☐
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Eligibility Determination: ☐ Eligible ☐ Ineligible

SIGNATURE OF CENTER REPRESENTATIVE	DATE
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