



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

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) (formerly Food Stamp) or Temporary Assistance (formerly AFDC, now funded by 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<br><input type="checkbox"/> | MONTHLY<br><input type="checkbox"/> | 2 X A MONTH<br><input type="checkbox"/> | EVERY 2 WEEKS<br><input type="checkbox"/> | WEEKLY<br><input type="checkbox"/> |
|-----------------------------|------------------------------------|-------------------------------------|---|---|------------------------------------|
| 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:  YES  NO

|       |  |                                   |   |   |                                   |
|-------|--|-----------------------------------|---|---|-----------------------------------|
| Race: | AMERICAN INDIAN OR ALASKA NATIVE<br><input type="checkbox"/> | ASIAN<br><input type="checkbox"/> | BLACK OR AFRICAN AMERICAN<br><input type="checkbox"/> | NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER<br><input type="checkbox"/> | WHITE<br><input type="checkbox"/> |
|-------|--|-----------------------------------|---|---|-----------------------------------|

**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 FAMILY MEMBER | SOCIAL SECURITY NUMBER | DATE         |
| 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):   | SNAP (Food Stamp)        | TEMPORARY ASSISTANCE     |
|                       |         | YEAR MONTH 2 X A MONTH EVERY 2 WEEKS WEEKLY  | <input type="checkbox"/> | <input type="checkbox"/> |
|                       |         | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |                          |                          |

Eligibility Determination:  Eligible  Ineligible

|                                    |      |
|------------------------------------|------|
| SIGNATURE OF CENTER REPRESENTATIVE | DATE |
|------------------------------------|------|

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:** U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410; or
2. **fax:** (833) 256-1665 or (202) 690-7442; or
3. **email:** [program.intake@usda.gov](mailto:program.intake@usda.gov)

This institution is an equal opportunity provider.