**Meal Benefit Application for Adult Day Care Centers**

**July 1, 2017 – June 30, 2018**

For more information, read **Instructions for Completing** or call: Giggle Box LNP 410-238-3232

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| **Step 1** | **List all enrolled participants (if more spaces are required for additional names, attach another sheet of paper). If a Medicaid or SSI number is provided, skip to Step 4** |
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| **First and Last Names of All ENROLLED Participants** |  | **Provide participant’s Medicaid or SSI # if applicable** | |
|  | **Medicaid** | **SSI** |
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| **Step 2** | **If you or your spouse or your dependent children who reside with you receive Food Supplement Program (FSP) benefits or Temporary Cash Assistance (TCA), enter one case number here.** |

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| Case Number: |  |  |  |  |  |  |  |  |  |

If you answered **NO**, complete Step 3.

If you answered **YES**, provide a case number then go to Step 4

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| **Step 3** | **Report Income for Household Members (skip this step if you answered ‘Yes’ to Step 2)** |

List all Household Members (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes) for each source in whole dollars only. If they do not receive income from any source, enter ‘0’. If you enter ‘0’ or leave any fields blank you are certifying (promising) that there is no income to report.

**How Often = Weekly, Every 2 Weeks, Monthly, Twice a Month or Yearly**

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| **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?** |
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| 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: |  |

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| **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 officials may verify (check) the information. I am aware that if I purposely give false information, I may be prosecuted under applicable State and Federal laws. I understand my participant’s eligibility status may be shared as allowed by law.

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

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| **Step 5** | **OPTIONAL: Participant’s Racial and Ethnic Identities** |

We are required to ask for information about your participant’s race and ethnicity. This information is important and helps to make sure we are fully serving our community.

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| **Ethnicity (Check One):** | |  | | **Race (Check one or more):** | | | |  | |  | |  | |  | |
|  | Hispanic or Latino | |  | |  | American Indian or Alaskan Native | | |  | | Black or African American | |  | | White | |
|  | Not Hispanic or Latino | | | |  | Asian |  | |  | | Native Hawaiian or Other Pacific Islander | |  | |  | |

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| **DO NOT FILL OUT THIS SECTION. CENTER 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 |
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|  | **Eligibility:** | | |  | Free | |  | | Categorically | |  | Reduced |  | Paid |  |  |
|  |  |  |  | |  |  | |  | | Eligible |  |  |  |  |  |  |
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Determining Official’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Withdrawn: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_