

Milk Fund Application

Family Resources Community Action

245 Main Street
Woonsocket, RI 02895
766-0900

Please attach proof of income and birth certificates to this application.

Date of Application: _____ Current Recipient? Yes No

Referred By: Self Family Resources Community Action Head Start Other:

Last Name: _____ First Name: _____

Social Security # _____ Date of Birth: _____

Spouse Name: _____ Date of Birth: _____

Address: _____ Apt # _____

City/Town: _____ State: _____ Zip: _____

Telephone: _____

If you have no phone please provide the name and phone number of someone we can contact if we need to reach you.

Contact Name: _____ Contact Phone: _____

Please provide the following information for all other members of your household

Name	Age	Date of Birth	Gender
			<input type="checkbox"/> M <input type="checkbox"/> F
			<input type="checkbox"/> M <input type="checkbox"/> F
			<input type="checkbox"/> M <input type="checkbox"/> F
			<input type="checkbox"/> M <input type="checkbox"/> F
			<input type="checkbox"/> M <input type="checkbox"/> F
			<input type="checkbox"/> M <input type="checkbox"/> F
			<input type="checkbox"/> M <input type="checkbox"/> F
			<input type="checkbox"/> M <input type="checkbox"/> F
			<input type="checkbox"/> M <input type="checkbox"/> F

Milk Fund application

Do you receive?:

Income from work	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Unemployment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	FIP Payments	Yes <input type="checkbox"/> No <input type="checkbox"/>
Social Security	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Income from Owning Property	Yes <input type="checkbox"/> No <input type="checkbox"/>
SSI Payments	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other:	Yes <input type="checkbox"/> No <input type="checkbox"/>
SSDI Payments	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Please specify Other:	
GPA Payments	Yes <input type="checkbox"/>	No <input type="checkbox"/>		_____

What is your household income? \$ _____ Every Week
 Every Two Weeks
 Every Month

Does anyone in your household have a medical condition that requires supplemental milk?
Yes No

If Yes please provide:

<u>Name</u>	<u>Condition</u>
_____	_____
_____	_____
_____	_____

I give my permission for Family Resources Community Action representatives to discuss my case with whomever it is necessary to ensure the accuracy of the information I have provided. This release expires upon my termination from the Milk Fund.

Benefits are not guaranteed to all who are accepted. I understand that benefits are subject to the availability of funds to pay for the program. If there are any questions, call Family Resources Community Action at 766-0900.

Signature: _____ Date: _____

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| Eligibility requirements and priorities established by the Board of Directors of Milk Fund, Inc. |
| <ol style="list-style-type: none">1. Children of working low income families.2. Children of low income families where the wage earner is recently unemployed.3. Elderly (age 60 and older), with health or nutritional needs.4. Children of families supported by a pension or SSI. |