2026 Milk Fund Application
Community Care Alliance
PO Box 1700
Woonsocket, RI 02895
235-7000

Qualifying Income

Family Size	Monthly Income
1	$2,660.00
2	$3,606.67
3	$4,553.33
4	$5,500.00
5	$6,446.67

1. Children of working low income families.
2. Children of low income families where the wage earner is recently unemployed or family member is deployed in the military.
3. Elderly (age 60 and older), with health or nutritional needs.

Eligibility requirements and priorities established by the Board of Directors of Milk Fund, Inc. for the 2026 year are: 200%

Please attach copies of proof of income and birth certificates of children

Date of Application: _____ Current Recipient? Yes__ No__

Referred by: Self____ Community Care Alliance___ Head Start____ Other _____

Last Name: _____First Name: _____

Social Security #_____Date of Birth: _____

Spouse/Significant Other 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
			M F
			M F
			M F
			M F
			M F

Do you receive:

Income from Work	**Yes**	**No**			
Unemployment	**Yes**	**No**	RIW (Cash Assistance) Payments	**Yes**	**No**
Social Security	**Yes**	**No**	Income from Owning Property	**Yes**	**No**
SSI Payments	**Yes**	**No**	Other _____	**Yes**	**No**
SSDI Payments	**Yes**	**No**	Please specify Other:		
GPA Payments	**Yes**	**No**			

What is the total of your monthly **household** income? $_____

Does anyone in your household have a medical condition that requires supplemental milk?

YES **NO**

If Yes, please provide more information

Name _____ Condition _____

_____

_____

I give my permission for Community Care Alliance 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 Community Care Alliance at 235-7000.

Signature: _____ Date: _____