Instructions for
2024 Summer Electronic Benefit Transfer (EBT) Application
ar.gov/summerebt

The Arkansas Department of Human Services has partnered with the Arkansas Department of Education to provide summer food benefits (S-EBT) to certain households. These benefits can help families buy food to provide meals for their children during the summer and will be available on an Electronic Benefit Transfer (EBT) card and can be used like SNAP benefits. Each *approved* child will receive a one-time issuance of $120.00 for the summer of 2024. A S-EBT card will be issued for each approved child.

PART 1. ALL HOUSEHOLD MEMBERS

- List parents/guardians and child(ren)
- Do not list anyone outside of the immediate family unless they are the guardian over the child(ren) and reside within the home.
- Grade Level will be for the most recent school year, not the grade your child(ren) will be going into next year

PART 2. BENEFITS

- If any child(ren) listed in Part 1 received SNAP or TEA in the past year, include your SNAP or TEA Case Number
- This will assist in determining eligibility for S-EBT benefits

PART 3. TOTAL HOUSEHOLD GROSS INCOME

- List income from work/employers for all HH members.
- Enter the gross amount of all income before deductions.
- List all earned or unearned income received by all HH members.

PART 4. OPTIONAL - CONSENT FOR AUTHORIZED REPRESENTATIVE

- This section is optional
- If you would like for another adult, not listed in Part 1, to act on the behalf of your household, include their information in this section

PART 5. SIGNATURE AND CONTACT INFORMATION

- The adult household member completing this form must enter their information and sign this section
- Please include a phone number and email address in case the worker has any questions

Important guidelines to apply for S-EBT benefits

- When you apply, and verification of any item(s) is requested and not provided by the deadline, you will have to reapply.
- You may reapply until August 26, 2024, ONLY if you are denied AND your circumstances change.
- If you previously opted out of S-EBT benefits and want to opt back in, please mail or email (at the addresses below) a written signed statement, with ALL HH members name and DOB, asking to opt back in to SEBT program.
- This application and any information associated with this application will not be viewable on your Access Arkansas account.
- If approved keep your SEBT card. The same SEBT card will be used each year, if eligible.
- Once approved for Summer EBT this year, no changes need to be reported.
- Unspent benefits will automatically expire after 122 days from the date they became available on the S-EBT card.
- You cannot apply online or over the phone. Please submit the application to:
    - Any DHS office
    - Scan and email to: SummerEBT@dhs.arkansas.gov
    - Mail to:

        Arkansas Department of Human Services
        Mississippi Scanning Center
        P.O. Box 2630
        Blytheville, AR 72315

Summer Operational Period:
May 24, 2024 – August 26, 2024

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May 24, 2024 – August 26, 2024

ARKANSAS DEPARTMENT OF HUMAN SERVICES

2024 Summer Electronic Benefit Transfer (EBT) Application

Please see cover sheet for instructions on how to submit your application.

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PART 1. ALL HOUSEHOLD MEMBERS (Please attach an additional sheet for more than four household members)

Names of all people living in your household, including adults and children (First, Middle Initial, Last)	Date of Birth	Grade Level	School District Name & School Name the child attends Indicate "NA" if not in school	Gender	SSN (OPTIONAL)	Check the appropriate box for each school aged child if any apply: Foster Care	Migrant	Homeless	Runaway	Check if No income
						☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐

PART 2. BENEFITS - If any member of your household receives SNAP or TEA, provide the name and case number or identifier for the person who receives benefits. If no one receives SNAP or TEA, skip this section.

NAME: **SNAP/TEA CASE NUMBER:**

PART 3. TOTAL HOUSEHOLD GROSS INCOME (before deductions.) List all income on the same line as the person who receives it. Check the box for how often it is received. Record each income only once.

1. NAME (List only household members with income)	2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED															
	Earnings from work before deductions.	Weekly	Every 2 Weeks	Twice Monthly	Monthly	TEA, child support, alimony	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Pensions, retirement, Social Security, SSI, VA benefits	Weekly	Every 2 Weeks	Twice Monthly	Monthly	All Other Income (indicate frequency, such as "weekly," "every 2weeks," or "monthly")
(Example) Jane Smith	$ 200	X	☐	☐	☐	$ 150	X	☐	☐	☐	$	☐	☐	☐	☐	$ 50.00 / monthly
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$ /
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$ /
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$ /

PART 4. OPTIONAL - CONSENT FOR AUTHORIZED REPRESENTATIVE -- This person can apply for benefits, provide interview assistance, get notices, report changes, and make inquiries. Your household will be held liable for any over issuance that results from the representative providing incorrect information.

FULL NAME: **MAILING ADDRESS:**

PHONE #: **EMAIL:** **DOB:**

PART 5. SIGNATURE (ADULT HOUSEHOLD MEMBER MUST SIGN) AND CONTACT INFORMATION

Under penalties of perjury, I state that I have reviewed this application, and to the best of my knowledge and belief, the answers I gave within this application are true. I affirm that none of the children on this application have already been approved or received SEBT in Arkansas or in another state for 2024. I understand the federal 2024 Summer EBT funds received are based on the information provided. I understand that I may have to provide proof that what I've told the Department is true. I understand that if I purposely give false information, my child(ren) may lose benefits. I understand that anyone knowingly providing false information may be prosecuted under applicable federal and state statutes.

IF THE AUTHORIZED REPRESENTATIVE SECTION HAS BEEN COMPLETED:

I certify that the individual(s) designated above is (are) allowed to act on my behalf. I understand my household will be held liable for any over issuance that results from the authorized representative providing incorrect information. I understand that the power to act as an authorized representative is valid until I modify the authorization or notify the agency that the representative is no longer authorized to act on my behalf, or the authorized representative informs the agency that he or she is no longer acting in such capacity, or there is a change in the legal authority upon which the individual or organization's authority was based.

ADULT HOUSEHOLD MEMBER'S PRINTED NAME:	*SIGNATURE:	DATE:	
MAILING ADDRESS:	CITY:	STATE:	ZIP:
PHONE #: TYPE: ☐ HOME ☐ WORK ☐ CELL	EMAIL:		

See important information on Reverse.

DO NOT FILL OUT THIS PART. THIS IS FOR 2024 SUMMER EBT USE ONLY.

TOTAL INCOME: $ | **PER (check one):** ☐ **WEEKLY** ☐ **EVERY 2 WEEKS** ☐ **TWICE A MONTH** ☐ **MONTHLY** ☐ **YEARLY** | **HOUSEHOLD SIZE:**

SUMMER EBT ELIGIBILITY DETERMINATION: ☐ **YES/ELIGIBLE** ☐ **NO/NOT ELIGIBLE**

DETERMINING OFFICIAL'S PRINTED NAME AND SIGNATURE: **DATE:**

*By printing your name in this box, you are submitting your electronic signature as of this date to apply for Summer EBT for the child(ren) named herein, and affirm that everything is true and correct to the best of your knowledge.

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We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for Summer EBT benefits.

ETHNICITY (check one): ☐ **HISPANIC OR LATINO** ☐ **NOT HISPANIC OR LATINO**

RACE (circle one or more): **AMERICAN INDIAN OR NATIVE AMERICAN** **ASIAN** **BLACK OR AFRICAN AMERICAN** **NATIVE HAWAIIAN OR PACIFIC ISLANDER** **WHITE**

CATEGORICAL ELIGIBILITY

IMPORTANT NOTICES ABOUT YOUR RIGHTS AND RESPONSIBILITIES

Certain categories of school-aged students are categorically eligible for free meals and free milk, and for the Summer 2024 S-EBT Program.

Categorically eligible children are those in Foster Care, Homeless, are a member of a Migrant family, are a Runaway, or are currently enrolled in Head Start.

USE OF INFORMATION/INFORMATION DISCLOSURE

The Richard B. Russell National School Lunch Act requires that we use information from this application to determine who qualifies for Summer EBT benefits. We can only approve complete forms. We may share your eligibility information with education, health, and nutrition programs to help them deliver program benefits to your household. Inspectors and law enforcement may also use your information to make sure that program rules are met. Some children qualify for Summer EBT without an application. Please contact your school to get Summer EBT for a foster child, and children who are homeless, migrant, or runaway.

PRIVACY NOTICE

The PRIVACY ACT of 1974 requires the Ark. Department of Human Services (DHS) to tell you: (1) whether disclosure is voluntary or mandatory; (2) how DHS will use your SSN; and, (3) the law or regulation that allows DHS to ask you for the SSN. We are authorized to collect from your household certain information including the social security number (SSN) of each eligible household member. For the Supplemental Nutrition Assistance Program this authority is granted under the Food and Nutrition Act of 2008 as amended, 7 U.S.C. 2001-2036. For both the Medicaid Program and the TEA Program, this authority is granted under Federal laws codified at 42 U.S.C. §§1320b-7(a)(1) and 1320b-7(b)(2). This information may be verified through computer matching programs. We will use this information to determine program eligibility, to monitor compliance with program rules, and for program management. This information may be disclosed to other Federal and State agencies and to law enforcement officials. If a claim arises against your household, the information on this application, including all SSNs, may be provided to Federal or State officials or to private agencies for collection purposes.

NON-DISCRIMINATION STATEMENT

This institution is an equal opportunity provider.

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:

US Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights 1400
Independence Avenue, SW
Washington, D.C. 20250-9410; or (833)
Fax: 256-1665 or (202) 690-7442; or
Email: program.intake@usda.gov

Your Right to Appeal

If you think that DHS has made a mistake, you can appeal its decision. To appeal means to tell someone at DHS that you think the action was incorrect and that you want a fair review of the action. You can be represented in the process by someone other than yourself. You can request an appeal in the following ways:

In person: Talk to staff of any county DHS office.
By phone: You can call the Office of Appeals and Hearings at 501-682-8622 or you may call your local county office.
By email: DHS.Appeals@dhs.arkansas.gov
By US mail: Arkansas Department of Human Services Appeals and Hearings Section
P.O. Box 1437, Slot S101
Little Rock, AR 72203-1437

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