MSD OF WABASH COUNTY
2016-2017 Household Application for Free and Reduced Price School Meals

Prescribed by State Board of Accounts
School Form No. 521/2016

Complete one application per household. Please use a pen (not a pencil).

STEP 1 List ALL infants, children, and students up to grade 12 who are members of your household (if more spaces are required for additional names, attach another sheet of paper)

Definition of Household Member: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals. Read How to Apply for Free and Reduced Price School Meals for more information.

	Child's First Name	MI	Child's Last Name	Student? Yes	Student? No	Only Students: Name of School Building	Only Students: Birthdate	Only Students: Grade	Living with parent or caretaker relative? Yes	Living with parent or caretaker relative? No	Foster Child	Homeless, Migrant, Runaway
1				☐	☐				☐	☐	☐	☐
2				☐	☐				☐	☐	☐	☐
3				☐	☐				☐	☐	☐	☐
4				☐	☐				☐	☐	☐	☐
5				☐	☐				☐	☐	☐	☐

Check all that apply

STEP 2 Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP (Food Stamp) or TANF?

If NO > Go to STEP 3.

If YES > Write a case number here then go to STEP 4 (Do not complete STEP 3)

Case Number: / / / / / / / / / /

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Please read How to Apply for Free and Reduced Price School Meals for more information.

The Sources of Income for Children section will help you with the Child Income question.

The Sources of Income for Adults section will help you with the All Adult Household Members section.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all children in household listed in STEP 1 here.

Child income $ ____

How often? ○ Weekly ○ Every 2 Wks ○ 2x Month ○ Monthly

B. All Adult Household Members (including yourself)

List all Household Members not listed in STEP 1 (including yourself) **even if they do not receive income.** For each Household Member listed, if they do receive income, report **total (gross) income before any taxes or deductions** for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

	Name of Adult Household Members (First and Last)	Earnings from Work	How often? Weekly / Every 2 Wks / 2x Month / Monthly	Public Assistance/ Child Support/Alimony	How often? Weekly / Every 2 Wks / 2x Month / Monthly	Pensions/Retirement/ All Other Income	How often? Weekly / Every 2 Wks / 2x Month / Monthly
1		$	○ ○ ○ ○	$	○ ○ ○ ○	$	○ ○ ○ ○
2		$	○ ○ ○ ○	$	○ ○ ○ ○	$	○ ○ ○ ○
3		$	○ ○ ○ ○	$	○ ○ ○ ○	$	○ ○ ○ ○
4		$	○ ○ ○ ○	$	○ ○ ○ ○	$	○ ○ ○ ○
5		$	○ ○ ○ ○	$	○ ○ ○ ○	$	○ ○ ○ ○

Total Household Members (Children and Adults) ____

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member X X X X X ____

Check if no SSN ☐

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 school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Street Address (if available) | Apt # | City | State | Zip | Daytime Phone and Email (optional)

Printed name of adult completing the form | Signature of adult completing the form | Today's date

STEP 5 Other Benefits -- This section does not need to be completed to receive free or reduced price meal benefits.

Do you want to receive **Textbook Assistance?**

◯ Yes
◯ No

If yes, **sign to the right** →

I certify that I am the parent/guardian of the child(ren) for whom application is being made. My signature below authorizes the release of information on this application for textbook assistance. I give up my right of confidentiality for this purpose only. This application information will be shared with the Indiana Family and Social Services Administration pursuant to I.C. 20-33-5-2 and I.C. 12-14-28-2, solely for purposes of complying with 45 C.F.R. Parts 260 and 265.

Signature of adult completing the form _____ Today's date _____

School Use Only:
Approved
Denied
Not Applicable

This application information may be shared with the Family and Social Services Administration for the purpose of identifying children who may qualify for free or low-cost health insurance under **Medicaid** or **Hoosier Healthwise.** If you want the application information shared for this purpose, please sign below. I certify I am the parent/guardian of the child(ren) for whom application is being made. I authorize the release of information for this purpose.

For information about Hoosier Healthwise health insurance, call 1-800-889-9949.

Signature of adult completing the form _____ Today's date _____

OPTIONAL Children's Racial and Ethnic Identities

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 free or reduced price meals.

Ethnicity (check one):

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (check one or more):

☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

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 last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child 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. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

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

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FOR SCHOOL USE ONLY – DO NOT WRITE BELOW THIS LINE

INCOME CONVERSION to YEARLY:

WEEKLY X 52	EVERY 2 WEEKS X 26	TWICE A MONTH X 24	MONTHLY X 12

ELIGIBILITY DETERMINATION

Income Eligibility: Total Household Size:_____ Total Income:$_____ per: Weekly Every 2 Weeks Monthly Twice a Month Yearly
OR Categorical Eligibility: Food Stamps/TANF Migrant Homeless Runaway Foster
Eligibility Determination: Approved Free Approved Reduced Price Denied
Reason for Denial: Income Too High Incomplete Application Other_____
Type of Eligibility Notification Provided (if denied, notification must be written): Verbal Written Date:_____
Signature of Determining Official: _____ Date:_____ Date Withdrawn: _____

VERIFICATION

Confirmation Review Official: _____ Application Direct Verified? Yes No

Date Verification Notice Sent:_____ Date Response Due from Households:_____ Date Second Notice Sent (or N/A): _____	Approval Based On: Food Stamps / TANF Case Number Household Size and Income Other _____	Verification Results: No Change Free to Reduced Free to Paid Reduced to Free Reduced to Paid	Reason for Change: Income:_____ Household Size: _____ Change in Food Stamps /TANF Did not respond Other: _____	Date Notice of Change Sent:_____ Date Change Made:_____
Request for Appeal Date Hearing Requested:_____ Hearing Decision: _____	Verifying Official's Signature:_____ Date:_____			