CARMI-WHITE COUNTY C.U.S.D. NO.5

HOUSEHOLD AND INCOME FORM

2021-2022

To determine eligibility for various additional state and federal programs benefits that your child(ren) may qualify for, please complete, sign and return this application to_____.
(school name)

1. All Household Members

NAMES OF ALL HOUSEHOLD MEMBERS First, Middle Initial, Last	SCHOOL NAME (for student only)	GRADE (for student only)	SNAP OR TANF CASE NUMBER ONLY Skip to Part 4 if you list a SNAP or TANF case number. At least one SNAP/ TANF must be provided below. If you receive Medicaid and were not directly certified for free meals, you MUST apply based on household size and income.	Check if NO Income	Check if Foster Child*
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

*A foster child is the legal responsibility of a welfare agency or court.

2. Homeless, Migrant, Runaway, or Head Start

☐ Homeless ☐ Migrant ☐ Runaway ☐ Head Start

3. Total Household Gross Income (before deductions) You must tell us how much and how often.

A. NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT WAS RECEIVED (Example: $100/month; $100 /twice a month; $100/every other week; $100/week)							
	B. Earnings From Work (Before Deductions)		C. Welfare, Child Support, Alimony		D. Pensions, Retirement, Social Security		E. Worker's Comp., Unemployment, SSI, etc. (All other income)	
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	
iv.	$		$		$		$	
v.	$		$		$		$	

4. Signature

Date *Printed Name of Adult Household Member* *Signature of Adult Household Member*

5. Contact Information

Work Telephone Number (Include Area Code) *Home Telephone Number (Include Area Code)* *Home Address (Number, Street, City, State, Zip Code)*

SCHOOL USE ONLY

INITIAL DETERMINATION **Annual Income Conversion** Weekly X **52** Every 2 Weeks X **26** Twice a Month X **24** Once a Month X **12** Convert income only if different frequencies of pay are reported.

TOTAL INCOME $_____ **Per:** ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year **NUMBER IN HOUSEHOLD:** ____ **CHANGE IN STATUS:**_____ Date _____

Currently receive benefits based on:

☐ homeless ☐ SNAP or TANF
☐ migrant ☐ foster child
☐ runaway ☐ household's income
☐ Head Start

_____
Date Withdrawn

Signature of Determining Official _____ Date: _____

Privacy Act Statement: The Illinois State Board of Education is requesting schools to collect the information on this form to assist schools in reporting student's eligibility for state and federal benefits programs. You do not have to give this information, but if you do not, we cannot determine your child's eligibility for additional benefits under state and federal programs. We will hold the information you provide us as private and confidential to the extent required by law. However, we will share your socioeconomic status with various state and federal 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.

Non-discrimination Statement: In accordance with Federal Law and U.S. Department of Education policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write U.S. Department of Education, Office for Civil Rights, The Wanamaker Building, 100 Penn Square East, Suite 515, Philadelphia, PA 19107-3323 or call (215)656-8541 (Voice). Individuals who are hearing impaired or have speech disabilities may contact U.S. DOE through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). The U.S. Department of Education is an equal opportunity provider and employer.