Prescribed by State Board of Accounts School Form No. 521 / 2014

[West Washington School Corporation | [8220]

SCHOOL CORPORATION | CORP. NUMBER

APPLICATION FOR FREE OR REDUCED PRICE MEALS AND OTHER BENEFITS

Effective July 1, 2005 - One Application per **Household**

Part 1. Names of **all** household members (First, Middle Initial, Last)	Only for students: Check if living with parent or caretaker relative	Only for students: Name of each child's school	Only for students: Grade	Only for students: Birthdate	Only for students: Check if a Foster child	Check if no income
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If ALL children listed above are foster children, skip to Part 5 and sign.

Part 2. If any member of your household (student, adult or non-student) has a valid Food Stamp (SNAP) or TANF case number, please provide the name of the person who receives benefits, check the box indicating the benefit program, and enter the case number, then skip to Part 5. If no one receives these benefits, skip to Part 3.

Name: ______________________ **Food Stamp** ☐ **TANF** ☐ **Case Number:** ___/___/___/___/___/___/___/___/___/___

Part 3. If any child you are applying for is migrant, homeless, or runaway, check the appropriate box and call [Gerald W Jackson] at [812 755-4872].

Migrant ☐ **Homeless** ☐ **Runaway** ☐

Part 4.

Section 2

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.

GROSS INCOME and HOW OFTEN IT WAS RECEIVED

Examples: $100 / monthly or $100 / every 2 weeks or $100 / twice a month or $100 / weekly

Section 1 NAME (List **ONLY** household members with income)	Earnings from Work Before Deductions	Weekly	Every 2 wks.	Twice A Month	Monthly	Welfare, Child Support, Alimony	Weekly	Every 2 Wks.	Twice A Month	Monthly	Social Security, SSI, VA, Retirement Benefits	Weekly	Every 2 Wks.	Twice A Month	Monthly	All Other Income such as Unemployment	Weekly	Every 2 Wks	Twice A Month	Monthly
Example: Jane Smith	*$ 200*	☐	☒	☐	☐	*$ 150*	☒	☐	☐	☐	*$ 100*	☐	☐	☐	☒	*$ 50*	☐	☐	☐	☒
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
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	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

Part 5. SIGNATURE: An adult household member must sign the application. If Part 4 is completed, the adult signing the form also must list the last four digits of his or her Social Security Number or mark the "No Social Security Number" box. (See Statement on the back of this page).

I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will get Federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted. I understand my child's eligibility status may be shared as allowed by law.

X________________________ *** - ** - __ __ __ __ No Social Security Number ________________________

Signature of Adult Household Member | Social Security Number | Home Telephone # / Work Telephone #

________________________ ________________ ________________________

Printed Name of Adult Household Member | Date Signed | Home Address/Apt # | Zip Code

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Email Address

Part 6. 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 If, YES, **SIGN TO THE RIGHT**→

NO

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.

X________________________ __________

SIGNATURE OF PARENT/GUARDIAN | DATE

SCHOOL USE ONLY:

Approved

Denied

Not Applicable

Part 6. OTHER BENEFITS (Continued from Page 1)

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.

X_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

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

Part 7. RACE AND ETHNICITY: Optional - You are not required to answer this question. No child will be discriminated against because of race, color, sex, national origin, age, or disability.	Mark one or more (regardless of ethnicity): Asian; Black or African American; American Indian or Alaska Native; Native Hawaiian or Other Pacific Islander; White	Mark one ethnicity: Hispanic or Latino; Not Hispanic or Latino

Use of Information Statement: This explains how we will use the information you give us.

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.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

FOR SCHOOL USE ONLY – DO NOT WRITE BELOW THIS LINE

INCOME CONVERSION to YEARLY:	WEEKLY INCOME X 52	
EVERY 2 WEEKS X 26	TWICE A MONTH X 24	MONTHLY INCOME 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(Reason)_____

Signature of Determining Official:_____ Date:_____

Date Withdrawn: _____

VERIFICATION

Confirmation Review Official: _____

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

Date Hearing Requested:_____

Hearing Decision: _____

Verifying Official's Signature:_____

Date:_____