**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)

**STEP 2**

**If NO** > Go to STEP 3.

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

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)

**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?

How often?

How often?

**$**

**$**

**$**

**$**

**$**

**$**

**$**

**$**

**$**

**$**

**$**

**$**

**$**

**$**

**$**

**Total Household Members (Children and Adults)**

**Check if no SSN**

“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.”

Prescribed by State Board of Accounts

School Form No. 521/2021

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.

**[Insert School Corporation Name]**

**2021-2022 Household Application for Free and Reduced Price School Meals**

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

☐

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

Pensions/Retirement/
All Other Income

**X X X**

**X X**

Public Assistance/
Child Support/Alimony

Only Students:

**Name of School Building**

Living with parent or caretaker relative?

Yes No

Only Students:

**Grade**

Only Students:

**Birthdate**

Student?

Yes No

**Child’s Last Name**

**MI**

**Child’s First Name**

Foster Child

Homeless, Migrant, Runaway

1

2

3

**Check all that apply**

4

5

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

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

How often?

Daytime Phone and Email (optional)

Zip

State

City

Apt #

Street Address (if available)

Printed name of adult completing the form

Today’s date

Signature of adult completing the form

**Contact information and adult signature. Mail Completed Form To: [INSERT YOUR SCHOOL MAILING ADDRESS HERE] Turn for Textbook Benefits**

Are you unsure what to do here?

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.

**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.

2

1

3

4

5

Name of Adult Household Members (First and Last)

**$**

 Weekly Every 2 Wks 2x Month Monthly

**STEP 4**

 Weekly Every 2 Wks 2x Month Monthly

 Weekly Every 2 Wks 2x Month Monthly

Earnings from Work Weekly Every 2 Wks 2x Month Monthly

**5**

**Other Benefits – This section does not need to be completed to receive free or reduced price meal benefits.**

**STEP 5**

School Use Only:

 € Approved

 € Denied

 € Not Applicable

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.

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

Yes

No

If yes, **sign to the right**

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,](http://www.ascr.usda.gov/complaint_%EF%AC%81ling_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

This institution is an equal opportunity provider.

**ELIGIBILITY DETERMINATION**

Income Eligibility: Total Household Size:\_\_\_\_\_\_ Total Income:$\_\_\_\_\_\_\_\_\_\_\_ per: Weekly Every 2 Weeks Twice a Month Monthly 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 AppealDate Hearing Requested:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hearing Decision: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Verifying Official's Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **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 |

**Race (check one or more):**

Native Hawaiian or Other Pacific Islander

White

☐

☐

☐

☐

☐

American Indian or Alaskan Native

Asian

Black or African American

☐

☐

Hispanic or Latino

Not Hispanic or Latino

**Ethnicity (check one):**

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.

**OPTIONAL**

**Children's Racial and Ethnic Identities**

**For information about Hoosier Healthwise health insurance,**

**call 1-800-889-9949.**

Today’s date

Signature of adult completing the form

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.

Signature of adult completing the form

Today’s date