Application # _____

2017-2018 CONFIDENTIAL FAMILY APPLICATION FOR FREE & REDUCED MEALS

NOTICE:

- If you received an ELIGIBILITY NOTIFICATION – FREE MEALS from the school district **do not** complete this application.
- See **Application Instructions** on back of form.

1 HOUSEHOLD INFORMATION

Print name of person completing this application (Last name, First name)

_____
Name **Print**

_____
Mailing Address – Apt #

_____
City State Zip

Home Phone or Cell Phone or Work (Circle One)
_____

Email address
_____

➔ Number living in this household _____
(Write names of **all** household members on part 2 and/or part 4 of this form)

2 STUDENT INFORMATION

Child's Name (Legal Last name, First name)	School	Grade (optional)	Birth Date (optional)	Check if Foster Child
1. _____	_____	_____	_____	❑
2. _____	_____	_____	_____	❑
3. _____	_____	_____	_____	❑
4. _____	_____	_____	_____	❑
5. _____	_____	_____	_____	❑

3 BENEFITS

If any member of your household receives SNAP or TANF, provide the name and case number of the member receiving benefits

Name _____ ❑ SNAP ❑ TANF Case Number _____ Go to Part 5 below

Does this household receive FDPIR (Food Distribution on Indian Reservations) ☐ Yes (Go Part 5 and complete)

4 HOUSEHOLD MEMBERS & GROSS MONTHLY INCOME – if not monthly, see back for conversions

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
List **all** household members, including children not attending school, and income. Do not include students listed in part 2, unless they receive regular income. (*Last name, first name*)	MONTHLY INCOME (Total earnings & wages before deductions)	MONTHLY CHILD SUPPORT, WELFARE, ALIMONY RECEIVED	MONTHLY PENSIONS, SOCIAL SECURITY, RETIREMENT	OTHER MONTHLY INCOME -Including unemployment and workers comp.	Check if No Income
1. _____	_____	_____	_____	_____	❑
2. _____	_____	_____	_____	_____	❑
3. _____	_____	_____	_____	_____	❑
4. _____	_____	_____	_____	_____	❑

5 SIGNATURE, DATE and Last four numbers of SOCIAL SECURITY NUMBER (Adult must sign)

I certify (promise) that all of the information on this application is true (correct) 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 give purposely false information, my children may lose meal benefits and I may be prosecuted.

Signature of Adult Household Member X_____

Date Signed _____ Month/day/year

Social Security Number (See privacy statement on back) XXX-XX -__ __ __ __

☐ **I do not have a Social Security Number.**

6 RACIAL OR ETHNIC GROUP (OPTIONAL)

Mark one ethnic identity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Mark one or more racial identities:
☐ Asian
☐ American Indian & Alaskan Native
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American
☐ White, not of Hispanic origin
☐ Other

I prefer all written correspondence in ☐Spanish ☐ Russian ☐ Other _____

7 I do not want my information shared with State children's health insurance programs. Sign here:_____

I have a child (or children) who does not have any kind of health coverage – neither private health insurance nor Oregon Health Plan/Healthy Kids. I am interested in free or reduced cost health coverage for at least one of my children. ☐ Yes ☐ No

SCHOOL USE ONLY - DO NOT WRITE BELOW THIS LINE

Total Income:_____ Number in household:_____ **Date Withdrawn:**_____

☐ **Free based on:**
- ☐ SNAP/TANF/FDPIR
- ☐ Foster child categorical
- ☐ household income

☐ **Reduced based on:**
- ☐ household income

☐ **Denied – Reason:**
- ☐ income too high
- ☐ incomplete application

Determining Official's Signature :_____ Date_____

 SEE IMPORTANT INFORMATION ON REVERSE SIDE

Application Instructions

- If your household receives **SNAP, TANF or FDPIR**, complete parts 1, 2, 3 and 5; parts 6 and 7 are optional.
- If you do not receive these benefits and your **income** is below the guidelines, complete parts 1, 2, 4, 5; parts 6 and 7 are optional.
- If you are a household with a **FOSTER CHILD**, complete parts 1, 2, 4, and 5; parts 6 and 7 are optional.

Any income fields left blank will be counted as zeros. Please be careful that you meant to leave income fields blank.

DETERMINING MONTHLY INCOME FOR EARNINGS & WAGES

Monthly income for all household members must be reported in Part 4 of this application. Income means any money regularly received from work, child support, alimony, pensions, retirements, social security or any other source. Exclude student/school loans.

Household members who are not paid monthly should change earnings into monthly income by doing the following:

Household members who are paid every week: Multiply total earnings and wages for one pay period, before deductions, by 52. Then divide by 12. The resulting amount is the total monthly income.

Household members who are paid every 2 weeks: Multiply total earnings and wages for one pay period, before deductions, by 26. Then divide by 12. The resulting amount is the total monthly income.

Household members who are paid twice a month: Multiply total earnings and wages for one pay period, before deductions, by 24 then divide by 12. The resulting amount is the total monthly income.

Household members who are seasonal workers or work less than 12 months: Project annual rate of income to accurately represent actual circumstances then divide by 12. The resulting amount is the projected monthly income.

Note: Money received from a business or farm owned by you should be reported as "net income." *Net Income is defined as the total income left after business and farm operating expenses are subtracted from gross receipts.*

FEDERAL INCOME GUIDELINES

Your children may qualify at least for reduced price meals if your household income is at or below the limits of this chart.

	Reduced Price Meals				
Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
-1-	22,311	1,860	930	859	430
-2-	30,044	2,504	1,252	1,156	578
-3-	37,777	3,149	1,575	1,453	727
-4-	45,510	3,793	1,897	1,751	876
-5-	53,243	4,437	2,219	2,048	1,024
-6-	60,976	5,082	2,541	2,346	1,173
-7-	68,709	5,726	2,863	2,643	1,322
-8-	76,442	6,371	3,186	2,941	1,471
For each additional family member add	7,733	645	323	298	149

PRIVACY STATEMENT - SOCIAL SECURITY NUMBERS and OTHER INFORMATION

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 4 digits of the social security number of the adult household member who signs the application. The last 4 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. We may share the information on this form with Medicaid or the State Children's Health Insurance Program (SCHIP), unless you tell us not to. The information, if disclosed, will only be used to identify eligible children and seek to enroll them in Medicaid or SCHIP.

NON-DISCRIMINATION STATEMENT

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: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov
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