2019-2020

FREE AND REDUCED-PRICE SCHOOL MEALS FAMILY APPLICATION

PART 1. ALL HOUSEHOLD MEMBERS **** RETURN THIS APPLICATION TO YOUR CHILD'S SCHOOL****

Names of all household members (First, Middle Initial, Last)	Please check this box for students enrolled in school	*Place a check in the box below if child is a foster, homeless, migrant, runaway, or Head Start child. If each child attending school is a foster, homeless, runaway, migrant or in Head Start, skip to part 4 to sign this form.*					*Place a check in the box if NO income*
		Foster	Homeless	Migrant	Runaway	Head Start	

PART 2. BENEFITS

IF ANY MEMBER OF YOUR HOUSEHOLD RECEIVES **[State SNAP], [FDPIR]** OR **[State TANF Assistance]**, PROVIDE THE NAME AND CASE NUMBER FOR THE PERSON WHO RECEIVES BENEFITS AND **SKIP TO PART 4. IF NO ONE RECEIVES THESE BENEFITS, SKIP TO PART 3.**

NAME:_____ PROGRAM NAME _____ CASE NUMBER: (NOT EBT CARD NUMBER)_____

PART 3. 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.

1. NAME (LIST **ONLY** HOUSEHOLD MEMBERS WITH INCOME)	2. **GROSS INCOME** AND HOW OFTEN IT WAS RECEIVED																			
	Earnings from work before deductions.	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Welfare, child support, alimony	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Social Security, SSI, VA, retirement benefits	Weekly	Every 2 Weeks	Twice Monthly	Monthly	All other income (such as Unemployment) benefits	Weekly	Every 2 Weeks	Twice Monthly	Monthly
(Example) Jane Smith	**$200**	X				**$150**		X			**$0**					**$0**				
	$					$					$					$				
	$					$					$					$				
	$					$					$					$				
	$					$					$					$				

PART 4. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN)

An adult household member must sign the application. **If Part 3 is completed, the adult signing the form also must list the last four digits of his or her Social Security Number or mark the "I do not have a 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.

Signature: _____ Printed name:_____ Date: _____

Address:_____ Phone Number: _____

Email:_____ City:_____ State:_____ Zip Code:_____

Last four digits of Social Security Number: ***-**-_____ ❑ I do not have a Social Security Number

The information contained within this application may be shared with other Federal/Local health programs for which your child(ren) may qualify, however your permission is required. This will not affect your eligibility for school meals. May school officials share the information within this application with other programs? ❑ No ❑ Yes Child(ren) may also qualify for free or low-cost health and dental insurance with Florida KidCare. Apply at floridakidcare.org or call 1-888-540-5437.

PART 5. CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

Choose one ethnicity:

❑ Hispanic/Latino
❑ Not Hispanic/Latino

Choose one or more (regardless of ethnicity):

❑ Asian ❑ American Indian or Alaska Native ❑ Black or African American
❑ White ❑ Native Hawaiian or other Pacific Islander

*****DO NOT FILL OUT THIS PART. THIS IS FOR SCHOOL USE ONLY*****

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24 Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: ____ Eligibility: Free_____ Reduced_____ Denied_____ Date Withdrawn:_____

Reason for denial or withdrawal: _____ ❑ **Check if Error Prone Application**

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Verifying Official's Signature: _____ Date: _____

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.*

This institution is an equal opportunity provider.

Date of Contact	Staff Initials	Name of Household Member Contacted	Detailed Information Received