

2022-2023 Household Application for Free and Reduced Price School Meals

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

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)

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.

Child's First Name	MI	Child's Last Name	Student?		Only Students: Name of School Building	Only Students: Birthdate	Only Students: Grade	Living with parent or caretaker relative?		Foster Child	Homeless, Migrant, Runaway
			Yes	No				Yes	No		
1			☐	☐				☐	☐	☐	☐
2			☐	☐				☐	☐	☐	☐
3			☐	☐				☐	☐	☐	☐
4			☐	☐				☐	☐	☐	☐
5			☐	☐				☐	☐	☐	☐

STEP 2 Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP (Food Stamp) or TANF?

If NO > Go to STEP 3. If YES > Write a case number here then go to STEP 4 (Do not complete STEP 3)

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

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)

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.

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.

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.

Child income

\$

How often?

Weekly	Every 2 Wks	2x Month	Monthly
☐	☐	☐	☐

Name of Adult Household Members (First and Last)

	Earnings from Work	How often?				Public Assistance/ Child Support/Alimony	How often?				Pensions/Retirement/ All Other Income	How often?			
		Weekly	Every 2 Wks	2x Month	Monthly		Weekly	Every 2 Wks	2x Month	Monthly		Weekly	Every 2 Wks	2x Month	Monthly
1	\$	☐	☐	☐	☐	\$	☐	☐	☐	☐	\$	☐	☐	☐	☐
2	\$	☐	☐	☐	☐	\$	☐	☐	☐	☐	\$	☐	☐	☐	☐
3	\$	☐	☐	☐	☐	\$	☐	☐	☐	☐	\$	☐	☐	☐	☐
4	\$	☐	☐	☐	☐	\$	☐	☐	☐	☐	\$	☐	☐	☐	☐
5	\$	☐	☐	☐	☐	\$	☐	☐	☐	☐	\$	☐	☐	☐	☐

Total Household Members (Children and Adults)

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

X X X X X X

Check if no SSN ☐

STEP 4 Contact information and adult signature. Mail Completed Form To: Turn for Textbook Benefits

"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."

Printed name of adult completing the form

Signature of adult completing the form

Today's date

Street Address (if available)

Apt #

City

State

Zip

Daytime Phone and Email (optional)

STEP 5**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
☐ No

If yes, **sign to the right** →

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.

Signature of adult completing the form

Today's date

School Use Only:

- ☐ Approved
☐ Denied
☐ Not Applicable

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

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

OPTIONAL Children's Racial and Ethnic Identities

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.

Ethnicity (check one):

- ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (check one or more):

- ☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

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, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a [Form AD-3027](#), USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or **fax:** (833) 256-1665 or (202) 690-7442; or **email:** program.intake@usda.gov

This institution is an equal opportunity provider.

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
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: _____	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 Response Due from Households: _____			Date Notice of Change Sent: _____
Date Second Notice Sent (or N/A): _____			Date Change Made: _____
Request for Appeal Date Hearing Requested: _____ Hearing Decision: _____		Verifying Official's Signature: _____ Date: _____	