**Application for Educational Benefits**

**School Meal Benefits – School Year 2015-16 – State and Federally Funded Programs**

**Step 111List All Children in the Household** (infants through grade 12).Attach an additional page if necessary. Race and ethnicity questions are optional and do not affect approval for school meal benefits. For Hispanic/Latino ethnicity, choose yes or no for each child. For race, select all that apply for each child.

| Last Name | First Name | Birthdate | Grade | School | Foster Child?\*  If yes, fill in the circle. | Optional  Hispanic /  Latino Ethnicity? \*\* | | Optional  Racial Identity \*\*  Fill in one or more circles for each child | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Yes | No | American  Indian | Asian | African American | Pacific Islander | White |
|  |  |  |  |  | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
|  |  |  |  |  | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
|  |  |  |  |  | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
|  |  |  |  |  | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
|  |  |  |  |  | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

\* The child is the legal responsibility of a welfare agency or court. If all children who need meal benefits are foster children, skip Steps 2 and 3.

\*\* The full names of the racial categories are: American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, and White.

**Step 22 Assistance Program Case Number** (if applicable)

If any household member receives benefits from one of the assistance programs listed below: **Check the program and write in the case number.** S*kip Step 3*.

**□** Minnesota Family Investment Program (MFIP) **□** Supplemental Nutrition Assistance Program (SNAP) **□** Food Distribution Program on Indian Reservations

**Case Number** (Medical Assistance and WIC case numbers do not qualify for this purpose.)

**Step 33 List All Adult Household Members and Household Incomes** Include all household members not listed in Step 1, related or not, including yourself.

* If any children in the household have regular income, such as a part-time job or SSI, write in the total regular income for all children. Do not include occasional earnings such as babysitting or lawn mowing. **Total regular income to children**: $ \_\_\_\_\_\_\_\_ □ Weekly □ Bi-Weekly □ 2x month □ Monthly
* **Last 4 digits of the Social Security number** (SSN) of the person signing this application (required): **X X X – X X – \_\_ \_\_ \_\_ \_\_** *OR* **□** I don’t have an SSN
* **Adult Household Members / Incomes** Write in the name of each adult household member, their *gross* incomes *(before deductions)* in whole dollars, and how often the income is received. Include a household member who is temporarily away, such as a college student. If income fluctuates, write in the amount normally received (before deductions). For self-employment income only, write in net income after business deductions. For adults with no income to report, enter ‘0’ or leave the section blank – this is your certification (promise) that they have no income to report. Attach an additional page if necessary.

| Adults - Full Name  Include any college students. |  | Earnings from Work  Gross wages or net self-employment | How often? | | | | |  | Public Assistance, Child Support, Alimony | How often? | | | | |  | All Other Incomes  for example pension, retirement, disability, Veterans benefits, unemployment | How often? | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Weekly | Bi-Weekly | 2x  Month | Monthly | Annual |  | Weekly | Bi-Weekly | 2x  Month | | Monthly |  | Weekly | Bi-Weekly | 2x  Month | Monthly |
|  |  | $ | ○ | ○ | ○ | ○ | ○ |  | $ | ○ | ○ | ○ | ○ | |  | $ | ○ | ○ | ○ | ○ |
|  |  | $ | ○ | ○ | ○ | ○ | ○ |  | $ | ○ | ○ | ○ | ○ | |  | $ | ○ | ○ | ○ | ○ |
|  |  | $ | ○ | ○ | ○ | ○ | ○ |  | $ | ○ | ○ | ○ | ○ | |  | $ | ○ | ○ | ○ | ○ |

**Step 44** If your children are approved for school meal benefits, this information may be shared with Minnesota Health Care Programs to identify children who are eligible for Minnesota health insurance programs. Leave the box blank to allow sharing of information. **□** Do *not* share information for this purpose.

**Step 55 I certify (promise) that all information on this application is true and correct and all household members and incomes are reported. I understand that this information is given in connection with receipt of federal and state funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose benefits and I may be prosecuted under applicable federal and state laws.**

**Signature** of Adult Household Member(required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is this form required?** This form must be completed to apply for free or reduced-price school meals, unless:

(1) Your school provides free school meals to all students without application (*Community Eligibility Provision, Provision 2 or Provision 3*). However, at public schools, your completion of this form also helps the school qualify for other education funds and discounts even if not needed for school meals.

(2) You have been notified that your children have been directly certified for school meal benefits based on participation in the Supplemental Nutrition Assistance Program (SNAP), Minnesota Family Investment Program (MFIP), or Food Distribution Program on Indian Reservations (FDPIR).

**Privacy Act Statement / How Information Is Used**

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give this information but if you do not, we cannot approve your child for free or reduced-price school 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 are not required when you apply on behalf of a foster child, or you provide an MFIP, SNAP or FDPIR assistance number, or 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 qualifies for free school meals, and for administration and enforcement of the school meal programs. We *may* share your information with other 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.

Children who qualify for free or reduced-price school meals may qualify for Minnesota Health Care Programs. Your child’s status for school meals *may* be shared with Minnesota Health Care Programs unless you tell us not to share your information by checking the box in Step 4 of the application. You are not required to share information for this purpose and your decision will not affect approval for school meal benefits.

At public school districts, each student's school meal status also is recorded on a statewide computer system used to report student data to the Minnesota Department of Education (MDE) as required by state law. MDE uses this information to: (1) Administer state and federal programs, (2) Calculate compensatory revenue for public schools, and (3) Judge the quality of the state's educational program.

**Nondiscrimination Statement**

Civil Rights Survey (voluntary)

This information is requested solely for the purpose of determining compliance with federal civil rights laws, and will not affect your application. By providing this information, you will assist us in assuring that this program is administered in a nondiscriminatory manner.

**1. Ethnicity** (check one):

□ Hispanic or Latino □ Not Hispanic or Latino**2.** **Race** (check one or more):

□ American Indian or Alaskan Native □ Native Hawaiian or Other Pacific Islander

□ Asian □ White□ Black or African American

The U.S. Department of Agriculture (USDA) 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 USDA. (Not all prohibited bases will apply to all programs and/or employment activities.)

| **Office Use Only**  Total Household Size: \_\_\_\_\_ Total Income: $ \_\_\_\_\_\_\_\_\_\_ per \_\_\_\_\_\_\_\_  Approved (check all that apply):  Case Number – Free  Foster – Free  Income – Free  Income – Reduced-Price  Denied:  Incomplete  Income Too High  Signature – Determining Official: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_  Change Status To: \_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Withdrawn: \_\_\_ | **Office Use Only**  Date Verification Sent: \_\_\_\_\_ Response Due: \_\_\_\_\_ 2nd Notice: \_\_\_\_\_\_  Result:  No Change  Free to Reduced-Price  Free to Paid  Reduced-Price to Free  Reduced-Price to Paid  Reason for Change:  Income  Case number not verified  Foster not verified  Refused Cooperation  Other:\_\_\_\_\_\_\_\_\_\_\_  Signature – Verifying Official: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_  Signature – Confirming Official: Date: \_\_\_\_\_\_\_ |
| --- | --- |

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 and wish to file either an EEO or program complaint may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). Persons with disabilities who wish to file a program complaint, please see information above on how to contact us by mail directly or by email. If you require alternative means of communication for program information (e.g., Braille, large print, audiotape, etc.) please contact USDA’s TARGET Center at (202) 720-2600 (voice and TDD). USDA is an equal opportunity provider and employer.