

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)**

1 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.	2 Child's First Name	3 Child's Last Name	4 Student?		5 Only Students: Only School Building		6 Only Students: Only Student's Birthdate		7 Age of child in years						
			Yes	No	Name of School Building	Grade	Mo	Da	Yr	Mo	Da	Yr			
			<input type="checkbox"/>	<input type="checkbox"/>											
			<input type="checkbox"/>	<input type="checkbox"/>											
			<input type="checkbox"/>	<input type="checkbox"/>											
			<input type="checkbox"/>	<input type="checkbox"/>											

**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: 1 1 1 1 1 1 1 1 1 1 1 1 1

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)**

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.

Name of Adult Household Members (First and Last)	Earnings from Work	How often? Weekly - Every 2 Wks - 2 Month - Monthly	Public Assistance/Child Support	How often? Weekly - Every 2 Wks - 2 Month - Monthly	Pensions/Retirement/All Other Income	How often? Weekly - Every 2 Wks - 2 Month - Monthly
	\$	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	\$	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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	\$	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	\$	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Total Household Members (Children and Adults)   Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member     Check if no SSN

**STEP 4 Contact information and adult signature. Mail Completed Form To: 700 N.A Street Richmond N 47374**

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) \_\_\_\_\_

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 \_\_\_\_\_

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 benefits, but you are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Information, but if you do not, we cannot approve your child for free or reduced price meals. You must Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

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 To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program Form, (AD-3027) found online at [http://www.asst.usda.gov/complaint\\_filing\\_cusl.html](http://www.asst.usda.gov/complaint_filing_cusl.html), and at any USDA Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or office, or write a letter addressed to USDA and provide in the letter all of the information requested in the when you indicate that the adult household member signing the application does not have a social security number from To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to We will use your information to determine if your child is eligible for free or reduced price meals, and for USDA by: U.S. Department of Agriculture  
 Office of the Assistant Secretary for Civil Rights  
 1400 Independence Avenue, SW  
 Washington, D.C. 20250-9410  
 (202) 690-7442, or  
 program.intake@usda.gov  
 This institution is an equal opportunity provider.

Persons with print, audio

**FOR SCHOOL USE ONLY - DO NOT WRITE BELOW THIS LINE**

WEEKLY X 52      EVERY 2 WEEKS X 26      INCOME CONVERSION TO YEARLY      TWICE A MONTH X 24      MONTHLY X 12

**ELIGIBILITY DETERMINATION**

Income Eligibility: Total Household Size: \_\_\_\_\_ Total Income: \$ \_\_\_\_\_  
 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  
 Signature of Determining Official: \_\_\_\_\_ Date: \_\_\_\_\_

**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 \_\_\_\_\_

Date Response Due from Households: \_\_\_\_\_  
 Date Second Notice Sent (or N/A): \_\_\_\_\_

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: \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_  
 Signature of School Official \_\_\_\_\_  
 Date: \_\_\_\_\_