

APPLICATION FOR FREE AND REDUCED PRICE SCHOOL LUNCHES

To apply for free or reduced price meals for your child, carefully complete, sign and return this application to the school. If you need help with this form, please call this telephone number. **534-0588**

Managers Use

Status Entered _____

Date _____

| | <u>DATE</u> | <u>SCHOOL</u> |
|-----|-------------|---------------|
| W/D | _____ | _____ |
| R/E | _____ | _____ |
| W/D | _____ | _____ |
| R/E | _____ | _____ |
| W/D | _____ | _____ |
| R/E | _____ | _____ |

PART 1 – Student Information

| <u>SCHOOL USE ONLY</u> | | |
|-------------------------|------------------------|-------------|
| <u>1721</u> School # | Last Name _____ | |
| Student # _____ | First Name _____ | M.I. _____ |
| | Lake Wales High School | Grade _____ |

DISTRICT USE ONLY

Food Stamp/TANF Eligibility _____

Determination Free Reduced Denied

If Denied, give reason _____

Change in status _____
Reason _____ Date _____

Temporary until: _____ Until _____

Household Size _____ Total Income \$ _____

Monthly Annual

Signature of Determining Official _____ Date _____

PART 2 – HOUSEHOLDS NOW GETTING FOOD STAMPS OR TANF FOR THEIR CHILDREN – Complete this part and skip to PART 5 DO NOT complete PART 4.

Food Stamp/TANF Case Number **Number**
NOTE: The food stamp case number is not the EBT (electronic benefits transfer) number or Social Security Number.

PART 3 – FOSTER CHILD: Complete this part and sign the application in PART 5.

If this is a foster child check this box List the child's monthly personal use income \$ _____

PART 4 – ALL OTHER HOUSEHOLDS – If you did not write a FOOD STAMP or TANF case number, complete this part and sign the application in PART 5.

| Total Household Income from Last Month - You must tell how much and how often | | | | | |
|---|---|---------------------------------|---------------------------------------|------------------|--------------------------|
| Name (List Everyone in household) | Last month's income and how often it was received Example: \$100/monthly \$100/twice a month \$100/every other week \$100/weekly | | | | Check if NO Income |
| | Earnings from work before deductions | Welfare, child support, alimony | Pensions, retirement, social security | Other | |
| Example Jane Smith | \$100/Week | \$150/week | \$100/month | \$ _____ / _____ | |
| | \$ _____ / _____ | \$ _____ / _____ | \$ _____ / _____ | \$ _____ / _____ | |
| | \$ _____ / _____ | \$ _____ / _____ | \$ _____ / _____ | \$ _____ / _____ | |
| | \$ _____ / _____ | \$ _____ / _____ | \$ _____ / _____ | \$ _____ / _____ | |
| | \$ _____ / _____ | \$ _____ / _____ | \$ _____ / _____ | \$ _____ / _____ | |
| | \$ _____ / _____ | \$ _____ / _____ | \$ _____ / _____ | \$ _____ / _____ | |
| | \$ _____ / _____ | \$ _____ / _____ | \$ _____ / _____ | \$ _____ / _____ | |

PART 5 – SIGNATURE: An adult household member must sign the application before it can be approved.

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and the food stamp or TANF number is current, correct, or that all income is reported. I understand that this information is being given for the receipt of Federal funds; that school officials may verify the information on the application ; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

SIGNATURE OF ADULT HOUSEHOLD MEMBER

Social Security Number **Number**
Write NONE if you do not have a Social Security Number

Printed Name _____ Home Phone No. _____ Work Phone No. _____

Mailing Address _____ Zip Code _____ Date Signed _____

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NAME OF STUDENT _____

PART 6 – OTHER BENEFITS – You do not have to complete this part to get free or reduced price school meals.

Low cost health insurance is now available to children through Medicaid or the State’s Children’s Health Insurance program. Many children who are eligible for meals through the National School Lunch and Breakfast Programs are also eligible for low cost insurance. We will forward the application on this application to the State Children’s Health Insurance program who will send you an application for insurance coverage. If you want information on this form to be shared with Medicaid or the State Children’s Health Insurance program check the box and sign here.

Signature of Parent or Guardian _____ Date _____

I DO NOT want this application used in duplication other benefits for my child.

PART 7 – RACE/ETHNIC IDENTITY OF CHILD: You are not required to answer this section:

Mark one or more racial identities

Asian Black or African American American Indian or Alaska Native Native Hawaiian or Other Pacific Islander

White

Mark one ethnic identity

Hispanic or Latino Not Hispanic or Latino

In accordance with Federal Law and the U.S. Department of discrimination(USDA) policy, prohibits discrimination in all of its programs and activities on the basis of race, color, national origin, gender, age, or diformation Persons with disabilities who require alternative means for communication of program information (Braille, large print, audio tape, etc.) should contact USDA’s TARGET Center at (202) 720-2600 (voice and TDD).

To file a complaint of discrimination, write the USDA, Director, Office of Civil Rights Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

Privacy Act Statement: Section 9 of the National School Lunch Act requires that, unless your child’s food stamp or TANF case number is provided or you are applying for a foster child, you must include the social security number of the adult household member signing the application or indicate that the household member does not have a social security number. You do not to list a social security number, but if a social security number is not given or an indication is not made that the signer does not have such a number, the application cannot be approved. The social security number may be used to identify the household member in verifying the correctness of the inrrectness stated on the application. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a food stamp or TANF office to determine current certification for receipt of food stamps or TANF benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by household members to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported. The social security number may also be disclosed to programs as authorized under the National School Lunch Act and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain Federal, State, and local education, health and nutrition programs.

Your children may qualify for free or reduced price meals if your household income falls within the limits on this chart.

REDUCED PRICE MEAL SCALE

| HOUSEHOLD SIZE | ANNUALY | MONTHLY | WEEKLY |
|--|---------|---------|--------|
| 1 | 17,224 | 1,436 | 332 |
| 2 | 23,107 | 1,926 | 445 |
| 3 | 28,990 | 2,416 | 558 |
| 4 | 34,873 | 2,907 | 671 |
| 5 | 40,756 | 3,397 | 784 |
| 6 | 46,639 | 3,887 | 897 |
| 7 | 52,522 | 4,377 | 1,011 |
| 8 | 58,405 | 4,868 | 1,124 |
| For each additionl family member, add: | 5,883 | 491 | 114 |

To determine monthly income:

- If you receive the income every week, multiply the total gross income by 4.33.
- If you receive the income every two weeks, multiply the total gross income by 2.15.
- If you receive the income twice a month, multiply the total gross income by 2

Remember:

The total income before taxes, social security, health benefits, union dues or other deductions must be reported.