

The Liberty-Perry Community School Corporation SCHOOL CORPORATION	1895 CORP. NUMBER
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APPLICATION FOR FREE OR REDUCED PRICE MEALS AND OTHER BENEFITS

Effective July 1, 2005 - One Application per Household

Part 1. Children in school. To apply for free or reduced price meals and other benefits for your child(ren), carefully complete, sign, and return this application to the school. If you need help with this application, please call the school.

NAME OF CHILD (First Name, MI, Last Name)	LIVING WITH PARENT or CARETAKER RELATIVE	BIRTHDATE	SCHOOL	GRADE	TANF or Food Stamp Case # (If you receive both benefits, list the TANF Case #)
	YES - NO				
	YES - NO				
	YES - NO				
	YES - NO				

If ALL above children are Food stamp or TANF recipients – now skip to Part 5.

Part 2. If the child you are applying for is migrant, homeless, or a runaway, check the appropriate box and call [your school's homeless liaison, migrant coordinator] at [phone #].
 Migrant Homeless Runaway

NAME OF CHILD (First Name, Middle Initial, Last Name)	LIVING WITH PARENT or CARETAKER RELATIVE	BIRTHDATE	SCHOOL	GRADE	TANF or Food Stamp Case # (If you receive both benefits, list the TANF Case #) OR Monthly Personal Use Income (if zero, indicate as such)
	YES - NO				

ALL OTHER HOUSEHOLD TYPES

Part 4. LIST ALL HOUSEHOLD MEMBERS	GROSS (before deductions) HOUSEHOLD INCOME FROM ALL SOURCES <i>Examples: \$100 / month or \$100 / twice a month or \$100 / biweekly or \$100 / weekly</i>				
NAME	Earnings from Work Before Deductions	Welfare Payments, Child Support, Alimony	Pensions, Retirement, Social Security	All Other Income Received	Check if NO income
1.	\$ /	\$ /	\$ /	\$ /	<input type="checkbox"/>
2.	\$ /	\$ /	\$ /	\$ /	<input type="checkbox"/>
3.	\$ /	\$ /	\$ /	\$ /	<input type="checkbox"/>
4.	\$ /	\$ /	\$ /	\$ /	<input type="checkbox"/>
5.	\$ /	\$ /	\$ /	\$ /	<input type="checkbox"/>
6.	\$ /	\$ /	\$ /	\$ /	<input type="checkbox"/>
7.	\$ /	\$ /	\$ /	\$ /	<input type="checkbox"/>
8.	\$ /	\$ /	\$ /	\$ /	<input type="checkbox"/>
(Example) Jane Smith	\$200 / week	\$150 / week	\$100 / month		<input type="checkbox"/>

Part 5. SIGNATURE: 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.

X _____ X _____ - _____ - _____ No Social Security Number _____
 SIGNATURE OF ADULT HOUSEHOLD MEMBER Social Security Number Security Number Home Telephone # / Work Telephone #

 Printed Name of Adult Household Member Date Signed Home Address/Apt # Zip Code

Part 6. 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? <input type="checkbox"/> YES* <input type="checkbox"/> NO If, YES, SIGN TO THE RIGHT)	Check here if you want to receive this information. <input type="checkbox"/> Twenty-first Century Scholars (7 th & 8 th grade only) 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 to the programs I have checked. I give up my right of confidentiality for these purposes only. X _____ SIGNATURE OF PARENT/GUARDIAN DATE	SCHOOL USE ONLY: <input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Not Applicable
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*THIS APPLICATION INFORMATION WILL BE SHARED WITH FAMILY AND SOCIAL SERVICES ADMINISTRATION OFFICE 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.

SEE PAGE 2 IF YOU WANT THIS INFORMATION RELEASED FOR THE PURPOSE OF HOOSIER HEALTHWISE.

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.

X _____
Signature of Parent/Guardian _____ Date _____

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

Part 7. RACE AND ETHNICITY:

Optional - You are not required to answer this question. No child will be discriminated against because of race, color, sex, national origin, age, or disability.

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

Privacy Act Statement: This explains how we will use the information you give us.

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 social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list Food Stamp or TANF case number 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.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write to *USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410* or call (800) 795-3272 (voice) or (202) 720-6382 (TDD). USDA is an equal opportunity provider and employer.

FOR SCHOOL USE ONLY – DO NOT WRITE BELOW THIS LINE

ANNUAL INCOME CONVERSION:

WEEKLY INCOME X 52 BI WEEKLY X 26 TWICE A MONTH X 24 MONTHLY INCOME X 12

ELIGIBILITY DETERMINATION

Income Eligibility: Total Household Size: _____ Total Income: \$ _____ per: Week Month Annual
 OR Categorical Eligibility: Food Stamp TANF Migrant Homeless Runaway
 Eligibility Determination: Approved Free Approved Reduced price Denied
 Reason for Denial: Income Too High Incomplete Application Other(Reason) _____
 Temporary: Free Reduced Time Period: _____ (expires after _____ days)
 Signature of Determining Official: _____ Date: _____
 Date Withdrawn: _____

VERIFICATION

Confirmation Review Official: _____				
Date Verification Notice Sent: _____	Approval Based On: <input type="checkbox"/> Food Stamp/ TANF Case Number <input type="checkbox"/> Household Size and Income <input type="checkbox"/> Other _____	Verification Results: <input type="checkbox"/> No Change <input type="checkbox"/> Free to Reduced <input type="checkbox"/> Free to Paid <input type="checkbox"/> Reduced to Free <input type="checkbox"/> Reduced to Paid	Reason for Change: <input type="checkbox"/> Income: _____ <input type="checkbox"/> Household Size: _____ <input type="checkbox"/> Change in Food Stamp/TANF <input type="checkbox"/> Did not respond <input type="checkbox"/> Other: _____	Date Notice of Change Sent: _____ Date Change Made: _____
Date Response Due from Households: _____				
Date Second Notice Sent (or N/A): _____				
Date Hearing Requested: _____		Verifying Official's Signature: _____		
Hearing Decision: _____		Date: _____		