

Instructions for Completing the Application for Educational Benefits

Complete an application if one or more of the following apply to your household:

- Any member of the household currently participates in any of these three programs: *Minnesota Family Investment Program (MFIP)*, *Food Support (SNAP)*, or *Food Distribution Program on Indian Reservations (FDPIR)*.
- One or more children in the household are *foster children* (a welfare agency or court has legal responsibility for the child).
- *Total household income* (gross earnings, *not* take-home pay) is within these guidelines:

Household Size	\$ Per Year	\$ Per Month	\$ Twice Per Month	\$ Per 2 Weeks	\$ Per Week
1	20,147	1,679	840	775	388
2	27,214	2,268	1,134	1,047	524
3	34,281	2,857	1,429	1,319	660
4	41,348	3,446	1,723	1,591	796
5	48,415	4,035	2,018	1,863	932
6	55,482	4,624	2,312	2,134	1,067
7	62,549	5,213	2,607	2,406	1,203
8	69,616	5,802	2,901	2,678	1,339
For each additional household member add:	7,067	589	295	272	136

Section 1 Check the box if this is the first time that you have applied for meal benefits for any of your children at this school district or nonpublic school.

Section 2 List all children in the household, including foster children, and provide the requested information for each child. List any regular incomes to children such as SSI payments or regular earnings. Do not list occasional earnings like babysitting.

Foster children: check the “foster child” box for each child who is a foster child (a welfare agency or court has legal responsibility for the child). If all children who need to be approved for school meal benefits are foster children, skip sections 3 and 4.

Section 3 If any member of the household receives public assistance from any of the following three programs, write in the person’s name and case number: *Minnesota Family Investment Program (MFIP)*, *Food Support (SNAP)*, or *Food Distribution Program on Indian Reservations (FDPIR)*. If section 3 is completed, skip section 4. A Medical Assistance number does *not* qualify for this purpose.

Section 4 Write in all adult household members and all incomes. Include all adult persons who live in the household whether related or not. Also include any persons who are temporarily away, such as a student away at college.

For earnings, list *gross income before taxes and other deductions*, not take home pay. You should be able to find your gross income on your pay stub. For *farm/self-*

employment income only, list net income after business expenses. Write in how often each income is received: Weekly (W), Bi-Weekly (every other month) (BW), Twice per Month (TM), or Monthly (M). Do *not* write in an hourly wage.

Examples of “other income” to include in the last column are farm or self-employment income, Veterans (VA) benefits, and disability benefits.

Do not include as income: foster care payments, federal education benefits, or assistance provided by MFIP, Food Support (SNAP), WIC or FDPIR. Military: Do *not* include income from the Military Privatized Housing Initiative or combat pay.

Section 5 Leave these boxes blank if you want to share your school meal eligibility status with these health benefit/insurance programs. Check the boxes if you do not want to share your eligibility status with these programs.

Section 6 The form must be signed by an adult household member. If section 4 of the application has been completed, the signer must provide the last four digits of their Social Security number unless they indicate that they do not have a Social Security number. Provide address and phone number to assist in processing your application.

Also please provide voluntary racial/ethnic information requested on the back page of the form.

1. Check here if this is the first school meal application at this school district or nonpublic school for any child listed below.

2. Names of all Children in Household <i>including Foster Children</i> Attach additional page if necessary Last Name First Name	Date of Birth Month/Day/Year	Grade	School	✓ if foster child *	Any Regular Income to Child (for example SSD)
				<input type="checkbox"/>	\$ _____ per _____
				<input type="checkbox"/>	\$ _____ per _____
				<input type="checkbox"/>	\$ _____ per _____
				<input type="checkbox"/>	\$ _____ per _____
				<input type="checkbox"/>	\$ _____ per _____

* The child is the legal responsibility of a welfare agency or court. If all children applied for are foster children, skip Sections 3 and 4.

3. Benefits (if applicable)
 If any household member receives benefits from a program listed below, check the applicable box and write in the name of the person receiving benefits and their case number. Skip section 4.

<input type="checkbox"/> Minnesota Family Investment Program (MFIIP) <input type="checkbox"/> Food Support (SNAP) <input type="checkbox"/> Food Distribution Program on Indian Reservations	Name _____ Case Number _____ _____
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- Medical Assistance number does not qualify -

4. Names of all Adults in Household (all household members not listed in Section 2) Include all adults living in your household, related or not. Attach additional page if necessary.		Check if NO Income ✓	Household Income: Write in each gross income and how often it is received: weekly (W) , bi-weekly (every other week) (BW) , twice per month (TM) , monthly (M) . Do <i>not</i> write in hourly pay. If income fluctuates, write in the amount normally received. Attach additional page if necessary.	Gross Wages and Salaries - all jobs - before deductions -	Pension, SSI, Retirement, Social Security	Public Assistance, Child Support, Alimony	Unemployment, Worker's Comp, Strike Benefits	Any Other Income, including <i>net</i> Farm/ Self-Employment
First Name	Last Name			\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____
				\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____
				\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____

5. If your children are approved for school meal benefits, this information may be shared with MinnesotaCare and General Assistance Medical Care programs to identify children eligible for Minnesota health insurance programs. See back page for more information. Leave the boxes blank to allow sharing of information.
 Do not share information with the MinnesotaCare health insurance program. Do not share information with the General Assistance Medical Care program.

6. 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 and state funds based on the information I give. I understand that if I purposely give false information, my children may lose meal benefits and I may be prosecuted.

Signature of Adult Household Member (required) _____ Date: _____
 Social Security number – last 4 digits (required if Section 4 is completed): _____ OR I don't have a Social Security number
 Address: _____ City _____ Zip _____ Home Phone: _____ Work Phone: _____

Total Household Size: _____ Total Incomes: \$ _____ per _____ Approved (check all that apply): <input type="checkbox"/> Case Number - Free <input type="checkbox"/> Foster - Free <input type="checkbox"/> Income - Free <input type="checkbox"/> Income - Reduced Price <input type="checkbox"/> Temporary until _____ Denied: <input type="checkbox"/> Incomplete <input type="checkbox"/> Income Too High <input type="checkbox"/> Other: _____ Signature - Determining Official: _____ Date: _____ Change Status To: _____ Reason: _____ Withdrawn: _____	Office Use Only Signature – Confirming Official: _____ Date: _____ Date Verification Sent: _____ Response Due: _____ 2 nd Notice: _____ Result: <input type="checkbox"/> No Change <input type="checkbox"/> Free to Reduced-Price <input type="checkbox"/> Free to Paid <input type="checkbox"/> Reduced-Price to Free <input type="checkbox"/> Reduced-Price to Paid Reason for Change: <input type="checkbox"/> Income <input type="checkbox"/> Household Size <input type="checkbox"/> Refused Cooperation <input type="checkbox"/> Other: _____ Signature – Verifying Official: _____ Date: _____
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Privacy Act Statement / How Information Is Used

The National School Lunch Act requires that the household member signing the application must provide the last four digits of their Social Security Number unless an active Minnesota Family Investment Program (MFIP), Food Support (SNAP) or Food Distribution Program on Indian Reservations (FDPIR) assistance number is supplied for your child, or you are applying for a foster child, or you do not have a Social Security number. Provision of a Social Security number is not mandatory, 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.

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.

At public school districts, each student's eligibility status is also recorded on a statewide computer system used to report student data to the Minnesota Department of Education as required by state law. The Minnesota Department of Education 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.

Sharing Information with MinnesotaCare and General Assistance Medical Care Programs

Children who are eligible for free and reduced-price school meals may be eligible for Minnesota health insurance programs. Your child's eligibility status for school meals (qualified for free or reduced-price meals) may be shared with the MinnesotaCare and General Assistance Medical Care programs unless you tell us not to share your information by checking the boxes in section 5 of the application. You are not required to share information for this purpose and your decision will not affect approval for school meal benefits.

Nondiscrimination 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 USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

Children's Ethnic and Racial Identities (Optional)

Please provide the following information, which is used to determine the institution's compliance with civil rights laws. If the information is left blank, a representative of the institution is required to identify the ethnic and racial categories of participants for civil rights reporting.

1. Choose one ethnicity:

Hispanic/Latino Not Hispanic/Latino

2. Choose one or more (regardless of ethnicity):

Asian American Indian or Alaskan Native Black or African American
 Native Hawaiian or other Pacific Islander White