Minnesota Department of Education

Application for Educational Benefits – School Year 2016-17
School Meals • State and Federally Funded Programs

Please return form to: MANKATO AREA PUBLIC SCHOOLS
PO BOX 8741
MANKATO MN 56001
ATTN: FOOD SERVICE

Step 1 **List all infants, children and students through grade 12 in the household, even if they are not related.** If more space is needed, attach another sheet.

Child's First Name	MI	Child's Last Name	Birth Date	School	Grade	Foster Child? (An agency or court has legal responsibility for the child.) If yes, fill in the circle.
						○
						○
						○
						○
						○

Step 2 **Do any Household Members, including yourself, currently participate in any of the following assistance programs: SNAP, MFIP or FDPIR?** Circle one: **Yes** **No**

Medical Assistance and WIC do not qualify. If **No** > Go to STEP 3. If **Yes** > Write in the. **CASE NUMBER** here: _____ then go to STEP 4.

Step 3

A. List ALL Adult Household Members including yourself and report all incomes. (Skip STEP 3 if you answered "yes" to STEP 2 or if all participants are foster children.)

Adults - Full Name For the purpose of school meal benefits, the members of your household are "Anyone who is living with you and shares income and expenses, even if not related." List the full name of each household member not listed in Step 1 and their income(s) in whole dollars. If a person has no income, write in 0 or leave the section blank. This is your certification (promise) of no income to report. Include any college students temporarily away from home.	Gross Pay from Work *Do not write in an hourly wage.*					Farm or Self-Employment	Public Assistance, Child Support, Alimony					All Other Incomes				
	Gross pay before deductions (not take-home pay).	Weekly	Bi-Weekly	2x Month	Monthly	Net Income after business expenses. State if annual or monthly.	Payments received.	Weekly	Bi-Weekly	2x Month	Monthly	Pension, retirement, disability, unemployment, Veterans benefits, etc.	Weekly	Bi-Weekly	2x Month	Monthly
	$	○	○	○	○	$	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	$	○	○	○	○	$	○	○	○	○

B. Last four digits of signer's Social Security Number (SSN) or no SSN (required):

X X X – X X [ ][ ][ ][ ] – or ☐ I don't have a Social Security Number.
Security Number.

C. Do any of the children listed in Step 1 receive regular incomes such as SSI or wages?

Income of children, if any:

$	Weekly	Bi-Weekly	2x Month	Monthly
	○	○	○	○

Step 4 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 understand that if I purposely give false information, my children may lose benefits and I may be prosecuted under applicable federal and state laws. The information I provide may be shared with Minnesota Health Care Programs as allowed by state law, unless I have checked this box: ☐ Do *not* share my information with Minnesota Health Care Programs.

Signature of Adult Household Member (required) _____ Print Name: _____ Date:

Address: _____ City _____ Zip _____ Home Phone: _____ Work Phone: _____

Office Use Only Total Household Size: _____ Total Income: $ _____ per _____ Approved: ☐ Case Number – Free ☐ Foster – Free ☐ Income – Free ☐ Income – Reduced-Price Denied: ☐ Incomplete ☐ Income Too High Signature of Determining Official: _____ Date: _____

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 applications from households (*Community Eligibility Provision, Provision 2 or Provision 3*) or

(2) You were notified that your children have been directly certified for school meal benefits based on foster care status or 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.

Only authorized officials will have access to the information that you provide on this form. 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, with auditors for program reviews, and with law enforcement officials to help them look into violations of program rules. We require written consent from you before sharing information for other purposes.

Please provide the requested information about children's race and ethnic identity. This information is not required and does not affect approval for program benefits. We use the percentages of participants in each racial/ethnic category to check that our program is operated in a nondiscriminatory manner in compliance with federal civil rights laws

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.

Information provided on this form may be shared with Minnesota Health Care Programs, unless the person completing this form has checked the box in Step 4 to not share information for that purpose.

Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA *Program Discrimination Complaint Form* (AD-3027) found online at: *http://www.ascr.usda.gov/complaint_filing_cust.html*, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail to U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue SW, Washington, D.C. 20250-9410, or (2) fax to (202) 690-7442; or (3) email to *program.intake@usda.gov*. This institution is an equal opportunity provider.

Office Use Only: Verification

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 of Confirming Official: _____ Date: _____ Signature of Verifying Official: _____ Date: _____