

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 including Foster Children	Date of Birth	Grade	School	<input type="checkbox"/> if foster child *	Any Regular Income to Child (for example SSD)
Attach additional page if necessary	Month/Day/Year				
Last Name	First Name				
				<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 (MFIP)	Name _____ Case Number _____
<input type="checkbox"/> Food Support (SNAP)	
<input type="checkbox"/> Food Distribution Program on Indian Reservations	

- 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.

First Name	Last Name	Check if NO Income <input checked="" type="checkbox"/>	Household Incomes: 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 not 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
			\$ _____ 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: _____
 Print Name: _____

Total Household Size: _____ Total Incomes: \$ _____ per _____ Office Use Only
 Approved (check all that apply): Case Number - Free Foster - Free
 Income - Free Income - Reduced Price Temporary until _____
 Denied: Incomplete Income Too High Other: _____
 Signature - Determining Official: _____ Date: _____
 Change Status To: _____ Reason: _____ Withdrawn: _____

Signature - Confirming Official: _____ Date: _____
 Date Verification Sent: _____ Response Due: _____ 2nd Notice: _____
 Result: No Change Free to Reduced-Price Free to Paid Office Use Only
 Reduced-Price to Free Reduced-Price to Paid
 Reason for Change: Income Household Size Refused Cooperation
 Other: _____
 Signature - Verifying Official: _____ Date: _____

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), 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