



Dear Parent or Guardian:

I am pleased to inform you that we will be offering Free Breakfast and Free Lunch for the 2017-18 School Year for all Chillicothe City School Students. Our district has been able to provide free breakfast and free lunch to students for the last three school years due to successful participation in a federal program.

In order to continue this wonderful program, the district must reapply this school year. This means we must collect data to update our records and have included applications for all parents to complete. We are asking ALL parents/guardians to complete the 2017-2018 Federal Free and Reduced School Meal application. Please note, completing this application does NOT change your student's eligibility for free breakfast and lunch in the 2017-2018 school year. It does, however help our district ensure that we can continue to offer free breakfast and lunch in future years.

Our Food Service Program applications are also used for Federal Grant Funded Educational Programs. Accurate applications and records ensure our district receives the appropriate amount of federal dollars for programs such as tutoring, summer school, SHARP, and even certain field trips.

If you could please fill this application out and return it back to your student's teacher as prompt as possible it would be greatly appreciated. Please complete the application regardless of your income.

If you have any questions or if I can be of any further assistance, please contact me at 740-702-2287 Ext: 16308

Sincerely,

Mary Montgomery

Director of Food Services

The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at [www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at [program.intake@usda.gov](mailto:program.intake@usda.gov).

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

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# 2017-2018 FREE AND REDUCED PRICE SCHOOL MEALS FAMILY APPLICATION

## Part 1. ALL HOUSEHOLD MEMBERS

Names of <u>all</u> household members (First, Middle Initial, Last)	Name of school and school grade level for each child/or indicate "NA" if child is not in school. School _____ Grade _____	Check if a foster child (legal responsibility of welfare agency or court) *If all children listed below are foster children, skip to Part 5 to sign this form.	Check if No Income
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

**Part 2. BENEFITS:** If any member of your household receives Supplemental Nutrition Assistance Program (SNAP) or Ohio Works First (OWF) benefits, provide the name and 10-digit case number for the person who receives benefits and **skip to Part 5**. If no one receives these benefits, skip to Part 3.

NAME: \_\_\_\_\_ 10-DIGIT CASE NUMBER: \_\_\_\_\_

**Part 3. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call, Tabitha Muse, McKinney Vento Liaison 740-775-4250 Ext. 16407** Homeless  Migrant  Runaway

**Part 4. TOTAL HOUSEHOLD GROSS INCOME (before deductions).** List all income on the same line as the person who receives it. Check the box for how often it is received. Record each income only once.

1. NAME (List all household members with income)	2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED															
	Earnings from work before deductions	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Welfare, child support, alimony	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Pensions, retirement, Social Security, SSI, VA benefits	Weekly	Every 2 Weeks	Twice Monthly	Monthly	All Other Income (indicate frequency, such as "weekly" "monthly" "quarterly" "annually")
(Example) Jane Smith	\$200	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$150	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$0	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$50.00/quarterly
\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____ / _____
\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____ / _____
\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____ / _____
\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____ / _____

**Part 5. SCHOOL INSTRUCTIONAL FEE WAIVER ADULT CONSENT:** Your child(ren) may qualify for a waiver of their school instructional fees. We must have your permission to share your meal application information with school officials if your child(ren) qualifies for a fee waiver. Answering this question will not change whether your children will get free or reduced price meals.

Please check a box:  Yes I agree to have my meal application used to determine if my child(ren) qualify for a fee waiver.

No, I do not agree to have my meal application used to determine if my child(ren) qualify for a fee waiver.

Signature of Parent/Guardian for the Instructional Fee Waiver Question: \_\_\_\_\_ Date: \_\_\_\_\_

## Part 6. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN)

An adult household member must sign the application. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this page.)

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 deliberate misrepresentation of the information may cause my children to lose meal benefits and I may be subject to prosecution under State and Federal statutes.

Sign here: X \_\_\_\_\_ Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Last four digits of your Social Security Number: \_\_\_\_\_  I do not have a Social Security Number

## Part 7. Children's ethnic and racial identities (optional)

Choose one ethnicity:	Choose one or more (regardless of ethnicity):		
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Not Hispanic/Latino	<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or other Pacific Islander	

**Don't fill out this part. This is for school use only.**

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24 Monthly x 12

Total Income: \_\_\_\_\_ Per:  Week,  Every 2 Weeks,  Twice A Month,  Month,  Year Household size: \_\_\_\_\_  
 Categorical Eligibility: \_\_\_\_\_ Date Withdrawn: \_\_\_\_\_ Eligibility: Free \_\_\_\_\_ Reduced \_\_\_\_\_ Denied \_\_\_\_\_ Reason: \_\_\_\_\_  
 Determining/Approval Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Confirming Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Follow-up Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 If selected for Verification, Date Verification Notice Sent: \_\_\_\_\_ Response Date: \_\_\_\_\_ 2<sup>nd</sup> Notice Sent: \_\_\_\_\_ Results Sent: \_\_\_\_\_  
 Verification Result: No Change \_\_\_\_\_ Free to Reduced Price \_\_\_\_\_ Free to Paid \_\_\_\_\_ Reduced Price to Free \_\_\_\_\_ Reduced Price to Paid \_\_\_\_\_

**SHARING INFORMATION WITH MEDICAID/*Healthy Start, Healthy Families***

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Dear Parent/Guardian:

If your children get free or reduced price school meals, they may also be able to get free or low-cost health insurance through Medicaid or the State of Ohio Healthy Start, Healthy Families Program. Children with health insurance are more likely to get regular health care and are less likely to miss school because of sickness.

Because health insurance is so important to children's well-being, **the law allows us to tell Medicaid and *Healthy Start, Healthy Families* that your children are eligible for free or reduced price meals, unless you tell us not to.** Medicaid and *Healthy Start, Healthy Families* only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children. Filling out the Free and Reduced Price School Meals Application does not automatically enroll your children in health insurance.

If you do not want us to share your information with Medicaid or *Healthy Start, Healthy Families*, fill out the form below and send in (Sending in this form will not change whether your children get free or reduced price meals).

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**No! I DO NOT** want information from my Free and Reduced Price School Meals Application shared with Medicaid or the *Healthy Start, Healthy Families*.

**If you checked no, fill out the form below.**

Child's Name: \_\_\_\_\_ School: \_\_\_\_\_

Child's Name: \_\_\_\_\_ School: \_\_\_\_\_

Child's Name: \_\_\_\_\_ School: \_\_\_\_\_

Child's Name: \_\_\_\_\_ School: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Address: \_\_\_\_\_

For more information, you may call **Mary Montgomery** at **740-702-2287 Ex.t 16308**.  
**Return this form to your child's school as soon as possible or mail to 425 Yoctangee Pkwy.  
Chillicothe, Ohio 45601**

This institution is an equal opportunity provider.