



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.

<b>Part 7. RACE AND ETHNICITY:</b> 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: <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White	Mark one ethnic identity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> 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 a \*SNAP (Supplemental Nutrition Assistance Program) 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 (TTY). USDA is an equal opportunity provider and employer.

\* SNAP: Supplemental Nutrition Assistance Program (formerly the Food Stamp Program with USDA)

**FOR SCHOOL USE ONLY – DO NOT WRITE BELOW THIS LINE**

INCOME CONVERSION to ANNUAL:		
WEEKLY INCOME X 52	BI WEEKLY X 26	MONTHLY INCOME X 12

**ELIGIBILITY DETERMINATION**

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Date Withdrawn: _____

**VERIFICATION**

Confirmation Review Official: _____				
Date Verification Notice Sent: _____  Date Response Due from Households: _____  Date Second Notice Sent (or N/A): _____	Approval Based On: <input type="checkbox"/> Food Stamps / 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 Stamps /TANF <input type="checkbox"/> Did not respond <input type="checkbox"/> Other: _____	Date Notice of Change Sent: _____  Date Change Made: _____
Date Hearing Requested: _____		Verifying Official's Signature: _____		
Hearing Decision: _____		Date: _____		