**[Insert District Name] 20\_\_-20\_\_ Application for Free and Reduced Price School Meals** **AND Family Economic Data Survey**

In schools **participating in the Community Eligibility Program (CEP),** receipt of school meals does not depend on households returning this form. **In non-CEP schools,** this form will be used to determine eligibility for school meals. Complete one application per household. **Sections required to be completed for students in CEP and/or non-CEP schools are outlined below**. Please use a black or blue pen (no pencil).

**List ALL Students’ attending [Insert District Name] (if more spaces are required for additional names, attach another sheet of paper)**

Foster Head

Child Start Runaway Homeless Migrant

Birth Date

M M D D Y Y

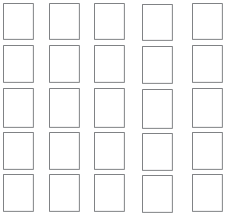
**STEP 1**

Grade

MI

Student’s Last Name

Student’s First Name



Check all that apply. Read **How to Apply for Free and Reduced Price School Meals** for more information.

**If any household members (including you) currently receive assistance from any of the following programs: SNAP, TANF or FDPIR list the case number below.**

**STEP 2**

Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF/Colorado Works – Basic Cash Assistance or State Diversion), or Food Distribution Program on Indian Reservations (FDPIR). **Provide case number and skip to Step 4.**



TANF Case Number

SNAP Case Number

FDPIR Case Number

**Report income for ALL household members (skip this step if you provided a case number in STEP 2)**

**STEP 3**

How Often?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Weekly | Bi-Weekly | 2x Month | Monthly | Annually |
|  | | | | |

**$**

**$**

**$**

**$**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Weekly | Bi-Weekly | 2x Month | Monthly | Annually |
|  | | | | |

**$**

**$**

**$**

**$**

**$**

**$**

**$**

**$**

Earnings from Work

Student Income

$

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Weekly | Bi-Weekly | 2x Month | Monthly | Annually |
|  | | | | | |

1. **Student Income**

Please include the **TOTAL** income, if any, received by all students’ listed above.

1. **All Other Household Members (including yourself)**

List all other household members not listed in Step 1 (including yourself) even if they do not receive income. For each household member listed, if they do receive income, report **TOTAL GROSS (BEFORE TAXES AND OTHER DEDUCTIONS)** for each source in whole dollars (no cents) only. If they do not receive income from any source, write ‘0’. If you enter ‘0’ or leave any fields blank, you are certifying that there is no income to report.

How Often?

How Often?

How Often?

**Names of All Other Household Members**

(First and Last)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Weekly | Bi-Weekly | 2x Month | Monthly | Annually |
|  | | | | |

Public Assistance/

Child Support/Alimony

Pensions/Retirement/

All Other Income

**Check if no SSN**

**XXX-XX-**

Last four digits of Social Security Number (SSN) of adult signing this form or mark ‘NO SSN’

**ONLY if Step 3B has been completed. This element is not required for CEP only schools.**

**Total Household Members**

(Students’ and Adults from Steps 1 and 3)

**STEP 4 Contact information and adult signature. Mail signed and completed application to: [Insert School/District Mailing Address]**

“I certify (promise) that all information on this application is true and that all income is reported. I understand that the information provide may be used in connection with federal and state educational programs. Specifically, I understand the school district may get additional federal and/or state funding based on the information I have provided. By signing below I agree that my child(ren)’s eligibility status may be shared for these specific purposes and as allowed by law without specific notice and/or consent. I understand that if this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws.”

Apt. # or Lot #

City

CO

Zip Code

Email Address

Phone

**SIGNATURE** of Adult Household Member

Printed First and Last Name of Signer

Today’s Date

Mailing Address or PO Box

**STEP 5 Release of Information**

The information provided on this application will be used in conjunction with state educational programs and may be shared with Medicaid or State Children’s Health Insurance Program (SCHIP) offices. Please check the box to opt out:

To save you time and effort, the information you gave on this form may be shared with other programs for which your children may qualify. For the following programs, we must have your permission to share your information. Completing this section of the form will not change whether your children get free or reduced price meals. ***Your information WILL NOT be shared unless you check one of the boxes below:***

Please share my information with the following programs I have checked:

Advanced Placement (AP) Exam and/or (AP) Book Fees

Accelerate College Opportunity Exam and/or Book Fees

List Specific Program

List Specific Program

**DO NOT** share information with Medicaid/SCHIP

See back of application

**OPTIONAL Children’s Racial and Ethnic Identities**

Text, letter

Description automatically generated

**You may also qualify for the Supplemental Nutrition Assistance Program! See more information below.**



|  |  |
| --- | --- |
| DISTRICT USE ONLY. DO NOT WRITE BELOW THIS LINE. | |
| **Annual Income Conversion: Weekly x 52; Bi-Weekly x 26; 2 Times per Month x 24; Monthly x 12** | |
| Application Type:   Total Household Income: $ Household Size:\_  Household Income Frequency -  Weekly  Bi-Weekly  2x/Month Monthly Annually  Categorical Eligibility - SNAP FDPIR TANF Foster  Homeless/Migrant/Runaway/Head Start | Application Status:  Approved - Free Reduced  Denied - Over Income Guidelines Incomplete/Missing: Notes: |
| Determining Official Signature: Approval/Denial Date: Notification Sent: | |

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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 submit all needed information, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the primary wage earner or other 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 Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier 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.

**Colorado PEAK** is an online service for Coloradans to screen and apply for medical, food and cash assistance programs.

Visit **coloradopeak.force.com** to learn more.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA’s TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant’s name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. mail:

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:

(833) 256-1665 or (202) 690-7442; or

3. email:

program.intake@usda.gov

This institution is an equal opportunity provider.