

Prescribed by State Board of Accounts
School Form No. 521/2021Prescribed by State Board of Accounts
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List ALL infants, children, and students up to grade 12 who are members of your household (if more spaces are required for additional names, attach another sheet of paper)

Homeless
Migrant
Foster

Check all that apply

Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP (Food Stamp) or TANF?

Case Number: / / / / / / / /

Report income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Weekly	Every 2 Wks	2x Month	Monthly
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List all 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) income before any taxes or 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?

The Sources of Income for Adults section will help you with the All Adult Household Members section.

Contact Information and adult signature. Mail Completed Form To: 33 Muenich Court, Hammond, IN 46320

☐ Indicate date	☐ Indicate date
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[illegible]

STEP 5 Other Benefits – This section does not need to be completed to receive free or reduced price meal benefits.

Do you want to receive Textbook Assistance?

☐ Yes
☐ No
If yes, sign to the right →

I certify that I am the parent/guardian of the child(ren) for whom application is being made. My signature below authorizes the release of information on this application for textbook assistance. I give up my right of confidentiality for this purpose only. This application information will be shared with the Indiana Family and Social Services Administration pursuant to I.C. 20-33-5-2 and I.C. 12-14-28-2, solely for purposes of complying with 45 C.F.R. Parts 260 and 265.

Signature of adult completing the form

Today's date

School Use Only:
☐ Approved
☐ Denied
☐ Not Applicable

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.

For information about Hoosier Healthwise health insurance, call 1-800-889-9949.

Signature of adult completing the form

Today's date

OPTIONAL Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.

Ethnicity (check one):

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (check one or more):

☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

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 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 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.

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 (e.g. Braille, large print, audiotype, 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:

mail:

U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
fax: (202) 690-7442, or
email: program.intake@usda.gov

This institution is an equal opportunity provider.

FOR SCHOOL USE ONLY – DO NOT WRITE BELOW THIS LINE

WEEKLY X 52	EVERY 2 WEEKS X 26	TWICE A MONTH X 24	MONTHLY X 12
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ELIGIBILITY DETERMINATION

Income Eligibility: Total Household Size: _____ Total Income: \$_____ per: ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly
OR Categorical Eligibility: ☐ Food Stamps/TANF ☐ Migrant ☐ Homeless ☐ Runaway ☐ Foster
Eligibility Determination: ☐ Approved Free ☐ Approved Reduced Price ☐ Denied
Reason for Denial: ☐ Income Too High ☐ Incomplete Application ☐ Other _____
Type of Eligibility Notification Provided (if denied, notification must be written): ☐ Verbal ☐ Written
Signature of Determining Official: _____ Date: _____ Date Withdrawn: _____

VERIFICATION

Confirmation Review Official: _____ Application Direct Verified? Yes ☐ No ☐	
Date Verification Notice Sent: _____	Approval Based On: ☐ Food Stamps / TANF Case Number
Date Response Due from Households: _____	☐ Household Size and Income
Date Second Notice Sent (or N/A): _____	☐ Other _____
Request for Appeal	Verification Results: ☐ No Change ☐ Free to Reduced ☐ Free to Paid ☐ Reduced to Free ☐ Reduced to Paid
Date Hearing Requested: _____	Reason for Change: ☐ Income: _____ ☐ Household Size: _____ ☐ Change in Food Stamps / TANF ☐ Did not respond ☐ Other: _____
Hearing Decision: _____	Date Notice of Change Sent: _____ Date Change Made: _____
Verifying Official's Signature: _____	Date: _____