

1. Check here if this is the first application at this school district or nonpublic school for any child listed below.

2. Names of all Children in Household including Foster Children
Attach additional page if necessary

Last Name	First Name	Date of Birth Month/Day/Year	Grade	School	<input checked="" type="checkbox"/> If Foster Child *	Any Regular Income to Child Example: SSI
		___/___/___			<input type="checkbox"/>	\$ _____ per
		___/___/___			<input type="checkbox"/>	\$ _____ per
		___/___/___			<input type="checkbox"/>	\$ _____ per
		___/___/___			<input type="checkbox"/>	\$ _____ per
		___/___/___			<input type="checkbox"/>	\$ _____ per

* 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: write in name of person and case number, check the appropriate box, and skip section 4.

Name	Case Number
<input type="checkbox"/> Minnesota Family Investment Program (MFIP)	
<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)	
<input type="checkbox"/> Food Distribution Program on Indian Reservations (FDPIR)	
- Medical Assistance and WIC do 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.

Last Name	First 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	Any Other Income, including net Farm/Self-Employment
			\$ _____ 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 Minnesota Health Care Food Programs to identify children who are eligible for Minnesota health insurance programs. Leave the box blank to allow sharing of information. See back page for more information.
 Do not share information with Minnesota Health Care Programs.

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) _____ Print Name: _____ Date: _____
Social Security number – last 4 digits (required if Section 4 is completed): _____ OR I don't have a Social Security number

Total Household Size: _____ Total Incomes: \$ _____ per _____
Approved (check all that apply): Case Number - Free Foster - Free Office Use Only
 Income – Free Income – Reduced-Price
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 Case number not verified Foster not verified
 Refused Cooperation Other: _____
Signature – Verifying Official: _____ Date: _____