

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.

Part 7. RACE AND ETHNICITY:

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:

- Asian
- Black or African American
- American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander
- White

Mark one ethnic identity:

- Hispanic or Latino
- 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 Supplemental Nutrition Assistance Program (SNAP) or 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.

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.

FOR SCHOOL USE ONLY – DO NOT WRITE BELOW THIS LINE

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

ELIGIBILITY DETERMINATION

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Date Withdrawn: _____				

VERIFICATION

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