



# PEMBROKE PINES CHARTER SCHOOLS

## 2015-2016

### FREE AND REDUCED-PRICE SCHOOL MEALS FAMILY APPLICATION

#### PART 1. ALL HOUSEHOLD MEMBERS

Names of <u>all</u> household members (First, Middle Initial, Last)	Student ID	Place a check in the box below if child is a foster, homeless, migrant, runaway, or Head Start child. If each child attending school is a foster, homeless, runaway, migrant or in Head Start, skip to part 4 to sign this form.					Place a check in the box if NO income
		Foster	Homeless	Migrant	Runaway	Head Start	

#### PART 2. BENEFITS

IF ANY MEMBER OF YOUR HOUSEHOLD RECEIVES FL SNAP, FDPPIR OR FL TANF ASSISTANCE, PROVIDE THE NAME AND CASE NUMBER FOR THE PERSON WHO RECEIVES BENEFITS AND **SKIP TO PART 4. IF NO ONE RECEIVES THESE BENEFITS, SKIP TO PART 3.**

NAME: \_\_\_\_\_ PROGRAM NAME \_\_\_\_\_ CASE NUMBER: (NOT EBT CARD NUMBER) \_\_\_\_\_

**PART 3. TOTAL HOUSEHOLD GROSS INCOME (BEFORE DEDUCTIONS).** List all income on the same line as the person who receives it. Check the box for how often it is received. **RECORD EACH INCOME ONLY ONCE.**

1. NAME (LIST ONLY HOUSEHOLD MEMBERS WITH INCOME)	2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED																				
	Earnings from work before deductions.	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Welfare, child support, alimony	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Social Security, SSI, VA, retirement benefits	Weekly	Every 2 Weeks	Twice Monthly	Monthly	All other income (such as Unemployment) benefits	Weekly	Every 2 Weeks	Twice Monthly	Monthly	
<i>(Example) Jane Smith</i>	\$200	X				\$150		X			\$0					\$0					
	\$					\$					\$					\$					
	\$					\$					\$					\$					
	\$					\$					\$					\$					
	\$					\$					\$					\$					

#### PART 4. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN)

An adult household member must sign the application. **If Part 3 is completed, the adult signing the form also must list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Statement on the back of this page.)

*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 funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted. I understand my child's eligibility status may be shared as allowed by law.*

Signature: \_\_\_\_\_ Printed name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Last four digits of Social Security Number: \*\*\*-\*\*-\_\_\_\_  I do not have a Social Security Number

The information contained within this application may be shared with other Federal/Local health programs for which your child(ren) may qualify, however your permission is required. This will not affect your eligibility for school meals. May school officials share the information within this application with other programs?  No  Yes

#### PART 5. CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

Choose one ethnicity:

- Hispanic/Latino  
 Not Hispanic/Latino

Choose one or more (regardless of ethnicity):

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

**\*\*\*\*\*DO NOT FILL OUT THIS PART. THIS IS FOR SCHOOL USE ONLY\*\*\*\*\***

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24 Monthly x 12

Total Income: \_\_\_\_\_ Per:  Week,  Every 2 Weeks,  Twice A Month,  Month,  Year Household size: \_\_\_\_\_

Categorical Eligibility: \_\_\_\_\_ Eligibility: Free \_\_\_\_\_ Reduced \_\_\_\_\_ Denied \_\_\_\_\_ Date Withdrawn: \_\_\_\_\_

Reason for denial or withdrawal: \_\_\_\_\_  **Check if Error Prone Application**

Determining Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Confirming Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Verifying Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Your children may qualify for Free or Reduced price meals if your household income falls at or below the limits of this chart

FEDERAL ELIGIBILITY INCOME CHART For School Year <b>2015-2016</b>			
Household size	Yearly	Monthly	Weekly
1	21,775	1,815	419
2	29,471	2,456	567
3	37,167	3,098	715
4	44,863	3,739	863
5	52,559	4,380	1011
6	60,255	5,022	1,159
7	67,951	5,663	1,307
8	75,647	6,304	1,455
Each additional person:	+7,696	+642	+148

*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.*

*The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the basis of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)*

*If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202)690-7442 or email at [program.intake@usda.gov](mailto:program.intake@usda.gov).*

*Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service 800) 877-8339; or (800) 845-6136 (Spanish).*

*USDA is an equal opportunity provider and employer.*

Date of Contact	Staff Initials	Name of Household Member Contacted	Detailed Information Received