Minnesota Department of Education

0011Application for Educational Benefits

Free and Reduced-Price School Meals • School Year 2012-13 • State and Federally Funded Programs

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**	**✓ If Foster Child ***	**Any Regular Income to Child** Example: SSI
	___/___/___			☐	$____ per____
	___/___/___			☐	$____ per____
	___/___/___			☐	$____ per____
	___/___/___			☐	$____ per____
	___/___/___			☐	$____ per____

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
☐ Minnesota Family Investment Program (MFIP)
☐ Supplemental Nutrition Assistance Program SNAP)
☐ Food Distribution Program on Indian Reservations (FDPIR)
- Medical Assistance and WIC do not qualify

* Child is the legal responsibility of a welfare agency or court. If all chil… lied for are foster children, skip Sections 3 and 4.

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 Incom ✓

Ho …Write in each gross income and how often it is received: **weekly (W)**, **bi-weekly** (every …**month (TM)**, **monthly (M)**. **Do *not* write in hourly pay**. If income fluctuates, write … Attach additional page if necessary.

…n, SSI,	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____	$____ 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 …
☐ 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 un… 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 h… …ty number
Address: _____ City _____ Zip_____ Home Phone: _____ …k Phone: _____

Total Household Size: _____ Total Incomes: $ _____ per _____
Approved (check all that apply): ☐Case Number - Free ☐Foster - Free
☐Income – Free ☐Income – Reduced-Price **Office Use Only**
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: _____