

Family Meal Benefit Form for Free and Reduced Price School Meals/After School Snacks

Colonial School District ■ SCHOOL NUTRITION ■ 318 E. Basin Road New Castle, DE 19720

July 2016

You only need to fill out ONE form per family.

For questions on how to complete this form call (302)323-2743.

Dear Parent or Guardian:

The Colonial School District takes part in the National School Lunch Program/School Breakfast Program/After School Snack Program. Nutritious meals are served every school day. All meals served must meet nutrition standards established by the U.S. Department of Agriculture. **All District students receive a breakfast at no cost. Elementary students may buy a second lunch for \$1.30. Gunning Bedford and William Penn students may buy lunch for \$1.60 and a second breakfast for 95 cents.** You may prepay for school meals. Please make checks payable to Colonial School Nutrition or visit www.parentonline.com and set up an account to pay on line.

Children from households that meet Federal Income guidelines are eligible for free meals or reduced price meals but may put money on their account for snacks. To apply for free or reduced price meals, complete and sign the form on the back of this paper as soon as possible, and return it to your child's **cafeteria** or to the Colonial School District office. **If your household qualifies for reduced meals there is no cost to you.**

If a child has been determined by a doctor to be disabled and the disability would prevent the child from eating the regular school meal, the school will make substitutions prescribed by the doctor. If a substitution is needed, there will be no additional charge for the meal. Substitutions can be arranged by contacting the School Nutrition Department.

APPEAL: If you do not agree with the District's decision on your form or the result of verification, you may wish to discuss it with school officials. You also may have the right to a fair hearing. This can be done by a written request to the Colonial School District Official:

Karen Gilbert, Director of Operations

Colonial School District ■ 318 E. Basin Road ■ New Castle, DE 19720

CONFIDENTIALITY: We will use the information on your form to decide if your child qualifies for free or reduced price meals. We may inform officials connected with other child nutrition, health and education programs of the information on your form to determine benefits for those programs or for funding and/or evaluation purposes, such as verify Title I eligibility.

REAPPLICATION: You may apply for benefits anytime during the school year. If you are not eligible now but have a decrease in household income, an increase in household size, become unemployed, or receive Supplemental Nutrition Assistance Program (SNAP) or Delaware Temporary Assistance for Needy Families (DE-TANF) for your child, fill out a form at that time.

You will be notified via letter when the meal benefit form is approved or denied.

Income Guidelines Reduced Price Meals Effective July 1, 2016 to June 30, 2017

Family Size	Yearly	Monthly	Twice Per Month	Every 2 weeks	Weekly
1	\$21,978	\$1,832	\$916	\$846	\$423
2	\$29,637	\$2,470	\$1,235	\$1,140	\$570
3	\$37,296	\$3,108	\$1,554	\$1,435	\$718
4	\$44,955	\$3,747	\$1,874	\$1,730	\$865
5	\$52,614	\$4,385	\$2,193	\$2,024	\$1,012
6	\$60,273	\$5,023	\$2,512	\$2,319	\$1,160
7	\$67,951	\$5,663	\$2,832	\$2,614	\$1,307
8	\$75,647	\$6,304	\$3,152	\$2,910	\$1,455
For each additional household member, add:	\$7,696	\$642	\$321	\$296	\$148

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, religious creed, disability, age, political beliefs, 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 for program information (e.g. Braille, large print, audiotape, 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: (1) mail: U.S. Department of Agriculture

Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

PRIVACY ACT STATEMENT:

Unless you list the child's SNAP, or DE-TANF case number or are applying for a foster/group home, homeless, migrant, or runaway child, Section 9 of the National School Lunch Act requires that you include the last four digits of your social security number of the household member signing the form or indicate that the household member signing the form does not have a social security number. You do not have to list a social security number, but if a social security number is not listed or an indication is not made that the adult household member signing the form does not have a social security number, we cannot approve the form. The social security number may be used to identify the household member in verifying the correctness of information stated on the form. This may include program reviews, audits, and investigations and may include contacting employers to determine income, contacting a SNAP, or DE-TANF office to determine current certification for SNAP, or DE-TANF benefits, contacting the State employment security office to determine the amount of benefits received and checking the administrative claims, or legal actions if incorrect information is reported. The social security number may also be disclosed to programs as authorized under the National School Lunch Act and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain Federal, State and local education, health and nutrition programs.

Sincerely,



A Paula Angelucci
School Nutrition Supervisor



COLONIAL SCHOOL DISTRICT 2016-2017 SCHOOL YEAR

FREE AND REDUCED PRICE SCHOOL MEALS FAMILY MEAL BENEFIT FORM

PART 1. Children in School Attach a second sheet of paper if needed for more names

Names of all children in the household, infant to grade 12 (First, Middle Initial, Last)	School Name or N/A	Grade	Birth Date	Enter DE-SNAP or DE-TANF case # (if any). Only one case # needs to be submitted per family and SKIP to Part 4. Please note that Medicaid numbers do not qualify your child(ren) for free meals. WIC participants may be eligible for free/reduced price meals. SNAP Hotline: 1-800-372-2022	<input checked="" type="checkbox"/> Check box if student(s) is/are foster child(ren) and SKIP to PART 4 if all children are foster
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>

PART 2. If the child you are applying for is Homeless, Migrant, or a Runaway check the appropriate box and call Colonial School District's homeless liaison, **Melanie Hoffmann at (302)429-4085** Homeless Migrant Runaway

PART 3. Total Household **Gross Income**—You must tell us the gross income amount of **each person** in the household and how often it is received. For household members receiving no income, please check the NO income box. **If you do not enter a "0" in the income field or do not check the NO income box, you are then certifying (promising) that there is no income to report.**

A. Name (List all adult household members and their income. If no income check the no income box) Include yourself	B. List Gross Income (Not Net Income) and Circle how often it was received				<input checked="" type="checkbox"/> Check if NO income
	Earnings from work before deductions	Welfare, child support, alimony	Pensions, retirement, Social Security SSI, VA benefits	All Other Income	
	Example: Monthly \$ 200 Weekly Yearly 2x/Month				
	Monthly Weekly Yearly 2x/Month Bi-weekly	Monthly Weekly Yearly 2x/Month Bi-weekly	Monthly Weekly Yearly 2x/Month Bi-weekly	Monthly Weekly Yearly 2x/Month Bi-weekly	<input type="checkbox"/>
	Monthly Weekly Yearly 2x/Month Bi-weekly	Monthly Weekly Yearly 2x/Month Bi-weekly	Monthly Weekly Yearly 2x/Month Bi-weekly	Monthly Weekly Yearly 2x/Month Bi-weekly	<input type="checkbox"/>
	Monthly Weekly Yearly 2x/Month Bi-weekly	Monthly Weekly Yearly 2x/Month Bi-weekly	Monthly Weekly Yearly 2x/Month Bi-weekly	Monthly Weekly Yearly 2x/Month Bi-weekly	<input type="checkbox"/>
	Monthly Weekly Yearly 2x/Month Bi-weekly	Monthly Weekly Yearly 2x/Month Bi-weekly	Monthly Weekly Yearly 2x/Month Bi-weekly	Monthly Weekly Yearly 2x/Month Bi-weekly	<input type="checkbox"/>
B. List all children with income. (wages, SS, etc.)	Amount Monthly Weekly Yearly 2x/Month Bi-weekly				<input type="checkbox"/> Check if no income for children.

Last four digits of Social Security Number of primary wage earner or Other Adult household member _____ I do not have a Social Security Number

PART 4. Signature and Social Security Number (Adult must sign) * Application will not be processed without SS# (last 4 digits)

An adult household member must sign the Form. If Part 3 is completed, the adult signing the form must also list his or her last 4 digits of the Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)

I certify (promise) that all information on this Form 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.

Sign here: _____ Print name: _____ Date: _____
 Address: _____ City: _____ State: _____ Zip: _____ PO Box: _____ Phone Number: _____

STOP **NO! I DO NOT want information from my Free and Reduced Price Meal Benefit Form shared with Medicaid or the State Children's Health Insurance Program (CHIP). For more information about DECHIP, call: 1-800-996-9969. IF YOU DO NOT CHECK THIS BOX, YOUR INFORMATION WILL BE SHARED WITH MEDICAID AND/OR DECHIP.**

PART 5. YES! I DO want information from my Free and Reduced Price Meal Benefit Form shared to determine eligibility to receive scholarships, Title I or other program benefits.

PART 6. Children's racial and ethnic identities (optional) We are required to ask for information about your childrens race and ethnicity. This information is important and helps to make sure that we are fully serving our community. Responding to this section does not affect your childrens eligibility for free or reduced price meals.

Asian Black or African American American Indian or Alaska Native Hispanic or Latino
 White Other Native Hawaiian or Other Pacific Islander Not Hispanic or Latino

DO NOT MARK IN THIS SECTION FOR SCHOOL USE ONLY!!

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12
 Total Annual Income: _____ Household size: _____
 Categorical Eligibility: _____ Date Withdrawn: _____ Eligibility: Free ___ Reduced ___ Denied ___ Reason: _____
 Temporary: Free ___ Reduced ___ Time Period: _____ (expires after ___ days)
 Determining Official's Signature: _____ Date: _____
 Confirming Official's Signature: _____ Date: _____ Follow-up Official's Signature: _____ Date: _____

