

Silver Valley Unified School District

*******PLEASE USE BLACK OR BLUE INK AND PRINT NEATLY WITHIN BOXES*******

**Application for Free and Reduced-Price Meals
(Complete ONE Application per Household)**

Part 1. ALL HOUSEHOLD MEMBERS

List the names of **all** household members.

Full name (First, middle Initial, last)	Name of each child's school (Indicate "N/A" if not in school)	Mark "X" below if child is a foster child, homeless, migrant, runaway, or Head Start child. If each child attending school is a foster child, homeless, runaway, migrant, or in Head Start, skip to Part 5.					Mark "X" in the box below for each child with NO earned income.
		Foster	Homeless	Migrant	Runaway	Head Start	
1.							
2.							
3.							
4.							
5.							

Part 2. BENEFITS

If any member of your household receives CalFresh, California Work Opportunity and Responsibility to Kids (CalWORKs), Food Distribution Program on Indian Reservations (FDPIR), or Kinship Guardianship Assistance Payment (Kin-GAP) program benefits, provide their name and case number below and **skip to Part 4. If no one receives these benefits, skip to Part 3.**

Full name of household member	Check one	Enter benefit case number (Not EBT card number)
1.	<input type="checkbox"/> CalFresh <input type="checkbox"/> CalWORKs <input type="checkbox"/> FDPIR <input type="checkbox"/> Kin-GAP	
2.	<input type="checkbox"/> CalFresh <input type="checkbox"/> CalWORKs <input type="checkbox"/> FDPIR <input type="checkbox"/> Kin-GAP	
3.	<input type="checkbox"/> CalFresh <input type="checkbox"/> CalWORKs <input type="checkbox"/> FDPIR <input type="checkbox"/> Kin-GAP	
4.	<input type="checkbox"/> CalFresh <input type="checkbox"/> CalWORKs <input type="checkbox"/> FDPIR <input type="checkbox"/> Kin-GAP	
5.	<input type="checkbox"/> CalFresh <input type="checkbox"/> CalWORKs <input type="checkbox"/> FDPIR <input type="checkbox"/> Kin-GAP	

Part 3. TOTAL HOUSEHOLD GROSS INCOME (BEFORE DEDUCTIONS)

List all income on the same line as the person who receives it. Mark "X" in the column for how often it is received. Record each income only once.

Full Name (List only household members receiving income)	Enter gross income (total amount before taxes or deductions) and how often it is received.																			
	Work earnings (before deductions)	Weekly	Every Two Weeks	Twice Monthly	Monthly	Welfare, child support, alimony	Weekly	Every Two Weeks	Twice Monthly	Monthly	Supplemental Security Income, Social Security, veteran or disability benefits	Weekly	Every Two Weeks	Twice Monthly	Monthly	All other income (such as unemployment benefits)	Weekly	Every Two Weeks	Twice Monthly	Monthly
1.	\$					\$					\$					\$				
2.	\$					\$					\$					\$				
3.	\$					\$					\$					\$				
4.	\$					\$					\$					\$				

Part 4. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (MUST BE SIGNED BY AN ADULT)

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 attached page.)

California Education Code Section 49557(a): Applications for free and reduced-price meals may be submitted at any time during a school day. Children participating in the National School Lunch Program will NOT be overtly identified by the use of special tokens, tickets, or serving lines; separate entrances or dining areas; or by any other means.

I certify (promise) that all information on this application is true and that I have reported all income. I understand that the school will get Federal funds based on the information I provide. I understand that school officials may verify (check) this 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.

Printed Name of Adult:	Signature of Adult:	Date:
Address:	City:	State: ZIP:
Phone Number:	E-mail Address:	
Last four digits of Social Security Number: XXX-XX- ____ ____ ____	<input type="checkbox"/> I do not have a Social Security Number.	

Part 5. ETHNIC AND RACIAL IDENTITY (OPTIONAL)

Child's full name	Check one	Check one or more (regardless of ethnicity)			
1.	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Asian <input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> Black or African American	
2.	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Asian <input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> Black or African American	
3.	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Asian <input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> Black or African American	
4.	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Asian <input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> Black or African American	
5.	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Asian <input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> Black or African American	

DO NOT COMPLETE THE INFORMATION BELOW. IT IS FOR SCHOOL USE ONLY.

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

Household size: _____ Household Total Income: _____ Per: Week Every Two Weeks Twice A Month Month Year

Application Approved as:

Free based on:

- CalFresh
- CaWORKs
- FDPIR
- Kin-GAP

Reduced-price based on:

- Household Income

Application Denied based on:

- Income too high
- Application Incomplete

Directly Certified as: Homeless Migrant Runaway Head Start

Household Income

Zero Income

Foster Child Only

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 on this chart.

Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	\$ 21,775	\$ 1,815	\$ 908	\$ 838	\$ 419
2	29,471	2,456	1,228	1,134	567
3	37,167	3,098	1,549	1,430	715
4	44,863	3,739	1,870	1,726	863
5	52,559	4,380	2,190	2,022	1,011
6	60,255	5,022	2,511	2,318	1,159
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 family member, add:	\$ 7,696	\$ 642	\$ 321	\$ 296	\$ 148

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to provide the information, but if you do not, we cannot approve your child for free or reduced-price meals. If you are submitting an income-based application, 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 are not required when you apply on behalf of a foster child; list a CalFresh, CalWORKs, FDPIR, or Kin-GAP case number or other FDPIR identifier for your child; or indicate that the adult household member signing the application does not have a Social Security Number. We will use your household size and income 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.

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases 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.)

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

The USDA and the CDE are equal opportunity providers and employers.