

**APPLICATION FOR FREE AND REDUCED PRICE MEALS FOR SCHOOL YEAR 2005-2006
ONLY ONE APPLICATION PER HOUSEHOLD**

Please complete and return this application to _____. This school meals application can also be used to apply for Medi-Cal. To apply for Medi-Cal for your child(ren), complete the back page (Section E). **You do not need to apply for Medi-Cal to apply for free or reduced-price meals.**

SECTION A. STUDENT INFORMATION: Complete this section by providing information for all of the children in your household.

STUDENT/CHILD INFORMATION				FOR SCHOOL USE ONLY	FOOD STAMPS, CALWORKS, KINGAP, OR FDIPIR BENEFITS		FOSTER CHILD (MUST HAVE SEPARATE APPLICATION)		CHILD'S MONTHLY INCOME
LAST NAME	FIRST NAME	CURRENT SCHOOL WRITE "NA" IF NOT IN SCHOOL	GRADE		WRITE "YES" OR "NO"	IF "YES," WRITE CASE NUMBER	WRITE "YES" OR "NO"	IF "YES," ENTER CHILD'S MONTHLY 'PERSONAL USE' INCOME	WAGES, SSI, ADOPTION ASSISTANCE PAYMENTS OR OTHER INCOME
1.									
2.									
3.									
4.									
5.									
6.									

If you entered a Food Stamp, CalWORKs, KinGap, or FDIPIR case number for each child in Section A, or if this application is for a Foster Child and you entered his/her monthly personal-use income, skip Section B and complete Section C.

SECTION B. HOUSEHOLD MEMBERS AND MONTHLY INCOME: List all adult household members, regardless of whether or not they have income. Indicate the amount and source of monthly income each household member received last month. If any amount last month was more or less than usual, enter the usual monthly income. Also, enter any income received by or for a child that has not been listed above in Section A from full-time or regular part-time employment, or for a child for SSI or Adoption Assistance payments.

LAST NAME	FIRST NAME	GROSS MONTHLY EARNINGS FROM WORK (BEFORE DEDUCTIONS) INCLUDE ALL JOBS	MONTHLY PENSION, RETIREMENT, SOCIAL SECURITY	MONTHLY WELFARE BENEFITS, CHILD SUPPORT, ALIMONY PAYMENTS	ANY OTHER MONTHLY INCOME (LIST SOURCE OF INCOME)	FOR SCHOOL USE ONLY: TOTAL MONTHLY INCOME
1.						
2.						
3.						
4.						

SECTION C. I certify that all of the above information is true and correct and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, that school officials may verify the information on the application at any time, and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

SIGNATURE OF ADULT HOUSEHOLD MEMBER COMPLETING THIS FORM		DAYTIME TELEPHONE NUMBER	TODAY'S DATE
PRINTED NAME OF ADULT HOUSEHOLD MEMBER COMPLETING THIS FORM		SOCIAL SECURITY NUMBER (WRITE "NONE" IF NO SOCIAL SECURITY NUMBER)	
MAILING ADDRESS	APT. #	CITY	ZIP CODE

This institution is an equal opportunity provider.

SECTION D. CHILDREN'S RACIAL and ETHNIC IDENTITIES (Optional): 1) Mark one or more racial identities below:

AMERICAN INDIAN OR ALASKAN NATIVE { } ASIAN { } BLACK OR AFRICAN AMERICAN { } NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER { } WHITE { }

2) Mark one ethnic identity:

OF HISPANIC OR LATIN ORIGIN { } NOT OF HISPANIC OR LATIN ORIGIN { }

California Education Code Section 49557 (a): Applications for free and reduced-price meals may be submitted at any time during the school day. Children participating in the National School Lunch Program will not be overtly identified by the use of special tokens, special tickets, special serving lines, separate entrances, separate dining areas, or any other means. **PRIVACY ACT STATEMENT:** National School Lunch Act (Section 9) requires that, unless your child's Food Stamp, CalWorks, KinGap, or FDIPIR case number is provided, you must include the social security number of the adult household member signing the application or indicate that the household member signing the application does not have a social security number. Provision of a social security number is not mandatory, but the application cannot be approved if a social security number is not provided or an indication is not made that the signer does not have such a number. The social security number may be used to identify the household member in carrying out efforts to verify correct information provided on the application. These verification efforts may be carried out through program reviews, audits, and investigations; and may include contacting employers to determine income, contacting the State's Employment Development Department or local welfare offices to determine the amount of benefits received, and checking the documentation produced by household members to prove the amount of income received. Reporting incorrect information may result in loss or reduction of the household's program benefits, or in administrative claims and/or legal actions against household members.

COMPLETE THE BACK PAGE OF THIS APPLICATION IF YOU WOULD LIKE TO APPLY FOR MEDI-CAL FOR ONE OR MORE OF YOUR CHILDREN.

STOP!! DO NOT COMPLETE THIS PAGE (Sec. E) IF YOUR CHILD(REN) ALREADY HAS MEDI-CAL OR HEALTHY FAMILIES COVERAGE.

**SECTION E. MEDI-CAL (optional): COMPLETE THE NEXT SECTION ONLY IF YOU WANT TO APPLY FOR MEDI-CAL BENEFITS FOR YOUR CHILD(REN).
You do not need to complete this section for your child(ren) to qualify for school meals.**

For School Use Only		MC FAMILY SIZE _____				
FREE _____	CHILD AGE	1	2	3	4	5
REDUCED _____	INCOME _____					
DENIED _____						

NAME OF CHILD/STUDENT FROM SECTION A		DO YOU WANT TO APPLY FOR MEDI-CAL FOR THIS CHILD? YES OR NO	CHILD'S DATE OF BIRTH (MO/DD/YR)	GENDER		MOTHER OR STEPMOTHER IN THE HOUSEHOLD CHECK MOTHER OR STEPMOTHER FOR EACH CHILD AND WRITE FULL NAME	FATHER OR STEPFATHER IN THE HOUSEHOLD CHECK FATHER OR STEPFATHER FOR EACH CHILD AND WRITE FULL NAME	IF NO/MOTHER/FATHER IN HOUSEHOLD, WRITE GUARDIAN'S NAME AND RELATIONSHIP TO CHILD
LAST	FIRST			MALE	FEMALE			
						<input type="checkbox"/> MOTHER <input type="checkbox"/> STEPMOTHER	<input type="checkbox"/> FATHER <input type="checkbox"/> STEPFATHER	
						<input type="checkbox"/> MOTHER <input type="checkbox"/> STEPMOTHER	<input type="checkbox"/> FATHER <input type="checkbox"/> STEPFATHER	
						<input type="checkbox"/> MOTHER <input type="checkbox"/> STEPMOTHER	<input type="checkbox"/> FATHER <input type="checkbox"/> STEPFATHER	
						<input type="checkbox"/> MOTHER <input type="checkbox"/> STEPMOTHER	<input type="checkbox"/> FATHER <input type="checkbox"/> STEPFATHER	
						<input type="checkbox"/> MOTHER <input type="checkbox"/> STEPMOTHER	<input type="checkbox"/> FATHER <input type="checkbox"/> STEPFATHER	
						<input type="checkbox"/> MOTHER <input type="checkbox"/> STEPMOTHER	<input type="checkbox"/> FATHER <input type="checkbox"/> STEPFATHER	
						<input type="checkbox"/> MOTHER <input type="checkbox"/> STEPMOTHER	<input type="checkbox"/> FATHER <input type="checkbox"/> STEPFATHER	

READ and SIGN below if you want to apply for MEDI-CAL BENEFITS for your child(ren). The parent/guardian for each child must sign below. If your child(ren) is not eligible for full-scope, no-cost Medi-Cal, the application may be sent to Healthy Families and/or Healthy Kids.

IF MY CHILD(REN) IS ELIGIBLE FOR FREE MEALS, I agree to the following: 1) The school will share the information on this meal application with Medi-Cal representatives for the purpose of applying for Medi-Cal. 2) The Medi-Cal program representative may contact the school to request assistance in helping me complete the Medi-Cal application process. 3) If my child(ren) is not eligible for full-scope, no-cost Medi-Cal, this application may be shared with Healthy Families and/or Healthy Kids health insurance programs for the purpose of applying for these programs. I understand that the information on the National School Lunch Program application is confidential and will not be shared with any other government agencies, except for the purpose of the administration of the Medi-Cal, Healthy Families, and/or Healthy Kids health insurance programs. I certify that I am the parent/guardian of the child(ren) listed on this application. I declare under penalty of perjury under the laws of the State of California that the declarations and information on this application for Medi-Cal, Healthy Families, and Healthy Kids purposes are true and correct to the best of my knowledge and belief.

SIGNATURE OF PARENT/GUARDIAN OF CHILDREN WANTING MEDI-CAL IN THIS HOUSEHOLD _____ **PRINTED NAME OF PARENT OR GUARDIAN SIGNING THIS SECTION** _____ **TODAY'S DATE** _____

* Do your children receive food stamps or FDPIR? If yes, please complete the following questions:

How many immediate family members, including the children, are living in the household? _____ What is the combined monthly income of the children and the birth/adoptive parent(s) living in the household? _____

IS THERE MORE THAN ONE FAMILY (PARENT/CHILD UNIT) IN THIS HOUSEHOLD? IF YES, WE NEED THE SIGNATURE OF THE PARENT/GUARDIAN FOR THE OTHER FAMILY.

SIGNATURE OF PARENT/GUARDIAN OF CHILDREN WANTING MEDI-CAL IN THIS HOUSEHOLD _____ **PRINTED NAME OF PARENT OR GUARDIAN SIGNING THIS SECTION** _____ **TODAY'S DATE** _____

* Do your children receive food stamps or FDPIR? If yes, please complete the following questions:

How many immediate family members, including the children, are living in the household? _____ What is the combined monthly income of the children and the birth/adoptive parent(s) living in the household? _____

FOR SCHOOL USE ONLY- ELIGIBILITY DETERMINATION				
Year Rd Track:	Household Size:	Household Income:	Determining Official:	Date:
<input type="checkbox"/> Zero Income, Temporary Free Until (45 Calendar Days From Date Of This Determination):			Direct Certified as: H M R	
<input type="checkbox"/> Free <input type="checkbox"/> Reduced <input type="checkbox"/> Denied <input type="checkbox"/> Categorically Free Due To Food Stamps, CalWORKs, Kin-Gap, or FDPIR Benefits			2 nd Review:	EP <input type="checkbox"/>
Verification Official:	Date:	Follow-up:		

