

Application for Educational Benefits – School Year 2017-18
School Meals • State and Federally Funded Programs

Step 1 List all infants, children and students through grade 12 in the household, even if they are not related. If more space is needed, attach another sheet.

Child's First Name	Child's Last Name	Birthdate	Grade	Foster Child? (An agency or court has legal responsibility for the child.) If yes, fill in the circle.	Optional - Racial Identity * Fill in one or more circles for each child.					
					American Indian	Asian	African American	Pacific Islander	White	
MI	School			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* The full names of the racial categories are: American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander and White.

Step 2 Do any Household Members currently participate in any of these programs – SNAP, MFIP or FDPIR? (Medical Assistance and WIC do not qualify.) If No > Go to STEP 3. If Yes > Write in the CASE NUMBER here _____ and check the program SNAP MFIP FDPIR. Then go to STEP 4.

Step 3 A. List ALL Adult Household Members including yourself and report all incomes. (Skip STEP 3 if you answered "yes" to STEP 2 or if all participants are foster children.)

Adults - Full Name For the purpose of school meal benefits, the members of your household are "Anyone who is living with you and shares income and expenses, even if not related." List the full name of each household member not listed in Step 1 and their income(s) in whole dollars. If a person has no income, write in 0 or leave the section blank. This is your certification (promise) of no income to report. Include any college students temporarily away from home.	Gross Pay from Work Do not write in an hourly wage.				Net income from Farm or Self-Employment after business expenses. State if annual or monthly.	Public Assistance, Child Support, Alimony				All Other Incomes				
	Weekly	Bi-Weekly	2x Month	Monthly		Weekly	Bi-Weekly	2x Month	Monthly	Pension, retirement, disability, unemployment, Veterans benefits, etc.	Weekly	Bi-Weekly	2x Month	Monthly
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	

B. Do any of the children listed in Step 1 receive regular incomes such as SSI or wages? C. Last four digits of signer's Social Security Number (SSN) or no SSN (required):
 TOTAL incomes to children, if any: Weekly Bi-Weekly 2x Month Monthly
 - - - - Security number.

Step 4 I certify (promise) that all information on this application is true and correct and all household members and incomes are reported. I understand that this information is given in connection with receipt of federal and state funds and that school officials may verify (check) the information. I understand that if I purposely give false information, my children may lose benefits and I may be prosecuted under applicable federal and state laws. The information I provide may be shared with Minnesota Health Care Programs as allowed by state law, unless I have checked this box: Do not share my information with Minnesota Health Care Programs.

Signature of Adult Household Member (required) _____ Print Name: _____ Date: _____

Address: _____ City _____ Zip _____ Home Phone: _____ Work Phone: _____

Office Use Only Total Household Size: _____ Total Income: \$ _____ per _____ Approved: Case Number – Free Foster – Free Income – Free
 Income – Reduced-Price Denied: Incomplete Income Too High Signature of Determining Official: _____ Date: _____