APPLICATION FOR FREE MILK/MEAL AND REDUCED-PRICE MEALS—Complete One Application per Household Per School District. Instructions on back.

SCHOOL USE ONLY

☐ Check if Error Prone Application

1. All Household Members (Attach another sheet of paper if necessary.)

NAMES OF ALL HOUSEHOLD MEMBERS First, Middle Initial, Last	(for Student only) School Name	(for Student only) Grade	SNAP OR TANF CASE NUMBER Skip to Part 4 if you list a SNAP or TANF case number. At least one SNAP/TANF must be provided below.	Check If Foster Child*
			- -	☐
			- -	☐
			- -	☐
			- -	☐
			- -	☐
			- -	☐

* A foster child is the legal responsibility of a welfare agency or court.

2. Homeless, Migrant, Runaway, or Head Start (Categorically eligible)

☐ Homeless ☐ Migrant ☐ Runaway ☐ Head Start

Signature of Your School Homeless Liaison, Migrant Coordinator, or Head Start Director _____ Date _____

3. Total Household Gross Income (before deductions) You must tell us how much and how often.

A. NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT WAS RECEIVED (Example: $100/month; $100 /twice a month; $100/every other week; $100/week)							
	Earnings From Work (Before Deductions)		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp., Unemployment, SSI, etc. (All other income)	
	B. Amount	How often?	C. Amount	How often?	D. Amount	How often?	E. Amount	How often?
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	
iv.	$		$		$		$	
v.	$		$		$		$	

4. Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her social security number or mark the *I do not have a social security number* box.

X X X - X X - _ _ _ _ Social Security Number

☐ **I do not** have a social security number.

I certify (promise) all information on this application is true and all income is reported. I understand the school will get Federal funds based on the information I give. I understand school officials may verify (check) the information. I understand if I purposely give false information, my children may lose meal benefits and I may be prosecuted.

Date _____ *Printed Name of Adult Household Member* _____ *Signature of Adult Household Member* _____

5. Contact Information (Optional)

Work Telephone Number (Include Area Code) _____ *Home Telephone Number (Include Area Code)* _____ *Home Address (Number, Street, City, State, Zip Code)* _____

6. Children's Racial and Ethnic Identities (Optional)

Mark one ethnic identity:
☐ Hispanic/Latino
☐ Not Hispanic/Latino

Mark one or more racial identities:
☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ American Indian or Alaska Native

7. Sharing Application Information With *All Kids*—*All Kids* program is a complete healthcare program for every child in Illinois.

No! **I DO NOT** want information from my Household Eligibility Application shared with *All Kids*. *Sign here:* _____

– THE FOLLOWING SECTIONS ARE FOR SCHOOL USE ONLY –

INITIAL DETERMINATION

TOTAL INCOME $ _____ **Per:** ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year **NUMBER IN HOUSEHOLD:** _____ **CHANGE IN STATUS:** _____ Date _____

LEAs must annualize income only when multiple incomes, at varying frequencies, are reported.
Annual Income Conversion Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12

☐ **Free based on:**
- ☐ homeless
- ☐ migrant
- ☐ runaway
- ☐ Head Start
- ☐ SNAP or TANF
- ☐ foster child
- ☐ household's income

☐ **Reduced based on:**
- ☐ household's income

☐ **Denied—Reason:**
- ☐ income too high
- ☐ incomplete application
- ☐ Non-qualifying SNAP/TANF

Signature of Determining Official _____ Date Withdrawn: _____ Date: _____

THE FOLLOWING SECTIONS ARE NOT REQUIRED FOR SCHOOLS/DISTRICTS THAT ONLY PARTICIPATE IN ILLINOIS FREE AND/OR SPECIAL MILK PROGRAMS

CONFIRMATION *(Prior to verification and only for those applications selected for verification.)* Signature of Confirming Official _____ Date: _____

VERIFICATION

DIRECT VERIFICATION COMPLETED ☐

DATE VERIFICATION NOTICE SENT: _____

DATE RESPONSE DUE FROM HOUSEHOLD: _____ (recommend 10 calendar days)

DATE, METHOD, RESULTS OF FOLLOW-UP: _____ (recommend 3 business days)

INITIAL DETERMINATION
- ☐ Free based on SNAP/TANF case number
- ☐ Free based on income
- ☐ Reduced based on income

VERIFICATION RESULTS:
- ☐ No Change
- ☐ Free to Reduced
- ☐ Free to Paid
- ☐ Reduced to Free
- ☐ Reduced to Paid

REASON FOR CHANGE:
- ☐ Income: $ _____
- ☐ Household Size: _____
- ☐ Change in SNAP/TANF
- ☐ Did not respond
- ☐ Other: _____

DATE NOTICE OF STATUS CHANGE SENT: _____

EFFECTIVE DATE OF STATUS CHANGE : _____

☐ Mail ☐ Telephone ☐ Personal Contact Results

Verifying Official's Signature _____ Date: _____