

SCHOOL DISTRICT OF UNIVERSITY CITY



Dear Parent/Guardian:

Attached you will find a 2011-2012 Free and Reduced Price School Meal Family Application for the new school year for your completion. **One application should be completed per family listing each child in the family that attends a University City School District school.** In order to be considered for a free or reduced price meal, the sections listed below must be completed. Any section found incomplete would delay the processing of your application and your child(ren) lunch prices. If you are not applying at this time, please simply write your child(ren)'s name along with the words "DECLINE" in Part 1.

***Part 1. CHILDREN IN SCHOOL**

This section must be completed by listing each child's first, middle initial and last name along with the name of their school name and grade level the child will attend. **One application should be completed per family.** *If you have another child in the family that attends a school outside the district, this child should be listed in Part 3. You must also list the income the child receives and how often.

STUDENT INCOME

This section should be completed if the child(ren) is receiving income. In addition by completing this section, you must also list how often the income is received.

FOSTER CHILD

If you are applying for a child who is considered the legal responsibility of the Division of Family Services (DFS) or a court.

***Part 2. BENEFITS**

This section should also be completed if your family is currently receiving Food Stamp (FA) or Temporary Assistance (TA). **If you are receiving FA or TA assistance, you must provide the name of the person who receives this benefit and the Department Case number(DCN).** Please note the FS or TA number is not considered any part of the 16 digit Electronic Benefit Transfer (EBT) card number and is NOT acceptable.

***Part 3. HOMELESS, MIGRANT, OR RUNAWAY – You must tell us how much and how often**

This section must include each person in your household, related or not (such as grandparents, other relatives, or friends) along with yourself and all children who live with you. Secondly, you must include each person's gross income and how often it is received. **Gross income is the amount earned before taxes and other deductions. For example if you are paid weekly and work 40 hours per week making \$12.50 per hour, your gross income would be \$500.00 per week.** If the adult member or child does not have any income, check the box "NO" income.

***Part 4.**

This section should also be completed with each person living in your household, related or not (such as grandparents, other relatives, or friends) including yourself. Next to each person's name, list each type of income received last month, and how often it was received. List the gross income each person earned from work (**Gross income is the amount earned before taxes and other deductions**); any welfare, child support, alimony, pensions, retirement, Social Security, unemployment, Veteran, and Supplemental Security Income(SSI). List any net income from self-owned business, farm or rental income. Exclude military combat pay received by service members during a deployment. If the person does not have any income, you must check the "No income" box. .

***Part 5. Signature and Social Security Number**

This section must include the parent/guardian who is responsible for the child(ren) signature along with the last four digits of your social security number, full address and contact telephone number. If you do not have a social security number, you must check the box "I do not have a Social Security Number".

All applications should be returned to your child's school secretary as soon as possible. If you are applying for multiple children, please return the single application to the oldest child's school secretary. If you find that you are unable to return the application in person, please mail it to Food and Nutrition Services, School District of University City, 8136 Groby Road, University City, MO 63130. If you have any questions, please do not hesitate to contact your child's school secretary or call the lunch application hotline at 314-290-4010.

Food and Nutritional Services
8136 Groby Road, University City, Missouri 63130
314-290-4010 Lunch Application Hotline
314-290-4068 Office

SCHOOL YEAR 2011-2012

FREE AND REDUCED PRICE SCHOOL MEALS FAMILY APPLICATION – ONE APPLICATION PER HOUSEHOLD

PART 1. CHILDREN IN SCHOOL

Names of all children in school (First, Middle Initial, Last)	Name of School	Grade	Student		Check if a foster child (legal responsibility of welfare agency or court)
			Income	How Often	
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>

PART 2. BENEFITS

If any member of your household receives Food Stamps or Temporary Assistance, provide the name and case number for the person who receives benefits and skip to part 5. If no one receives benefits go to part 3.

Name: _____ Case Number: 0 0 _ _ _ _ _

PART 3. HOMELESS, MIGRANT, OR RUNAWAY

If any child you are applying for is homeless, migrant, or a runaway contact the school/district Homeless Liaison/Migrant Coordinator at **[phone number of Homeless Liaison/Migrant Coordinator]**

PART 4. TOTAL HOUSEHOLD GROSS INCOME—YOU MUST TELL US HOW MUCH AND HOW OFTEN

1. Name (List Everyone in Household Not Listed in Part 1) Please attach an additional page if needed.	2. Gross income and how often it was received								3. Check if NO income
	Earnings from work before deductions		Welfare, child support, alimony		Pensions, retirement, Social Security, SSI, VA Benefits		All Other Income		
	Income	How Often	Income	How often	Income	How often	Income	How often	
									<input type="checkbox"/>
									<input type="checkbox"/>
									<input type="checkbox"/>
									<input type="checkbox"/>
									<input type="checkbox"/>
									<input type="checkbox"/>

PART 5. 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 application must also list his or her last four digits of their Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement.)

I certify (promise) that all information on this application 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: X _____ Print name: _____ Date: _____
 Address: _____ City: _____ Zip Code: _____
 Phone Number: _____ Last 4 digits of Social Security Number: *** - ** - _____ I do not have a Social Security Number

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. 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 is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your 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. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

PART 6. CHILDREN'S RACIAL AND ETHNIC IDENTITIES (OPTIONAL)

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

Mark one ethnic identity:
 Hispanic or Latino
 Not Hispanic or Latino

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

DO NOT FILL OUT THIS SECTION. THIS IS FOR SCHOOL USE ONLY.

ANNUAL INCOME CONVERSION: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12 (Use Only if Multiple Income Frequency)
 Total Income: _____ Per: Week, Every 2 Weeks, Twice A Month, Month, Year Household Size: _____
 Food Stamps/Temporary Assistance
 Eligibility: Free Reduced Denied Reason: _____ Date Withdrawn: _____
 Temporarily: Free Reduced Temporarily Approved Until: _____ (allow no more than 45 calendar days) Until: _____
 Determining Official's Signature: _____ Date Approved/Denied: _____
 Confirming Official's Signature (For verification purposes only): _____ Date: _____
 Verification Complete Date: _____ Signature: _____

INSTRUCTIONS FOR APPLYING

If your household gets FOOD STAMPS OR TEMPORARY ASSISTANCE, follow these instructions:

Part 1: List child(ren)'s name, school and grade.

Part 2: If any child or adult in the household is receiving Food Stamp or Temporary Assistance provide the name and case number. Food Stamp/Temporary Assistance number is a ten digit number and the first two digits currently are "00". A 16-digit Electronic Benefit Transfer (EBT) card number is NOT acceptable. Currently an EBT number starts with 5076. If you do not know your Food Stamp or Temporary Assistance number, call your local Family Support Division, Social Services office.

Part 3: Skip this part.

Part 4: Skip this part.

Part 5: Sign the form. A Social Security Number is not necessary.

Part 6: Answer this question if you chose to.

If you are applying for a FOSTER CHILD or a household with a foster child(ren), follow these instructions:

Part 1: List the child's name, school, grade, personal use income received (write "0" if no personal use income) and check box. List all non-foster children in household, name of school, grade and income.

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: If there are non-foster children in the household, follow directions in ALL OTHER HOUSEHOLDS, Part 4.

Part 5: Sign the form. If filling out for only foster children, a Social Security Number is not necessary. If additional non-foster children are in the household, list last four digits of Social Security Number of the adult signing the form or mark the box if he or she does not have one.

Part 6: Answer this question if you choose to.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List each child's name, school, grade and income if applicable.

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Follow these instructions to report total household income from last month.

Column 1—Name: List the first and last name of each person **not listed in Part 1**, living in your household, related or not (such as grandparents, other relatives, or friends) including yourself. Attach another sheet of paper if you need to.

Column 2—Gross income last month and how often it was received. Next to each person's name list each type of income received last month, and how often it was received. For example, *Earnings from work*: List the **gross income** each person earned from work. This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person received it (weekly, every other week, twice a month, or monthly). List the amount each person got last month from welfare, child support, alimony; pensions, retirement, Social Security; and all other income in the appropriate categories. In the other income column, include Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household, and ANY OTHER INCOME. Report net income for self-owned business, farm, or rental income. Next to the amount, write how often the person received it. If you are in the Military Housing Privatization Initiative do not include this housing allowance. Exclude military combat pay received by service members during a deployment.

Column 3—Check if no income: If the person does not have any income, check the box.

Part 5: An adult household member must sign the form and list his or her last four digits of Social Security Number of the adult signing the form, or mark the box if he or she doesn't have one.

Part 6: Answer this question if you choose to.

REQUEST FOR INFORMATION

(Complete one form per family)

Please answer the question below by checking the appropriate box. The following information is a request adopted by the General Assembly in 2010 requiring school districts to determine whether or not all children in a family have health insurance.

Does each child in your family have health care insurance?

YES

NO

MO HealthNet (Medicaid) is considered health care insurance.

If NO is checked the school district will provide a MO HealthNet for Kids application for the family.

Completion of this form is not a condition of determining meal eligibility. Submission of your Free and Reduced Price Meals Family Application will be reviewed regardless of your response to this Request for Information.

Submit this request with your Free and Reduced Price School Meal Family Application or return to your school/school district.

Printed name of parent/guardian: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____



Dear Parent/Guardian:

Your child may be eligible for affordable health insurance through the MO HealthNet for Kids (MHK), Missouri's Health Insurance Program. Now most families can get low-cost or free health insurance for their children.

Children with health insurance are more likely to receive needed vaccinations and receive treatment for illnesses. Without treatment, these illnesses can slow a child's learning and have lifelong effects.

If you currently receive MO HealthNet for Kids (formerly MC+ for Kids), it is not necessary to complete the attached application. Current participants can contact their local county Family Support Division office for questions regarding healthcare coverage.

If you are interested in applying for MHK, please complete the enclosed application and mail to:

St. Joseph Customer Service Center
 525 Jules St. #127
 St. Joseph, MO 64501

**HAVE QUESTIONS OR NEED HELP COMPLETING ATTACHED APPLICATION
 DIAL 1-888-275-5908**

MO HealthNet for Kids - Missouri's Health Insurance Program

Do Your Children Qualify?

	Maximum MONTHLY Family Income			
FAMILY SIZE <small>(Includes parents)</small>	2	3	4	5
INCOME <small>(Subject to change annually)</small>	\$3,678	\$4,633	\$5,588	\$6,543
Some families may be required to pay premiums. Income standards effective April 1, 2011				

Do your children need health care coverage? MO HealthNet for Kids is Missouri's health insurance program for uninsured children.

MO HealthNet for Kids

Complete in Ink

A. MAILING ADDRESS

FOR OFFICE USE ONLY

NAME (FIRST, MIDDLE, LAST)			DATE APPLIED
ADDRESS (HOUSE NO., STREET OR RURAL ROUTE, P.O. BOX NO.)	CITY, STATE, ZIP CODE	COUNTY	DCN
HOME PHONE NUMBER - -	WORK PHONE NUMBER - -	MESSAGE PHONE NUMBER - -	ELIGIBILITY SPECIALIST/SUPV/LOAD / /

INSTRUCTIONS: Please answer each question completely. Attach an additional sheet if more space is needed in any section.

B. HOUSEHOLD INFORMATION

(LIST ALL CHILDREN, PARENTS/GUARDIANS AND STEPPARENTS WHO LIVE IN YOUR HOME, YOURSELF FIRST.)

NAME (FIRST, MIDDLE, LAST)	RACE*/ SEX	HISPANIC Y/N	RELATIONSHIP TO PERSON a.	BIRTHDATE	PLACE OF BIRTH	SOCIAL SECURITY NUMBER	(X) APPLYING FOR MHK
a.			SELF			- -	<input type="checkbox"/>
b.						- -	<input type="checkbox"/>
c.						- -	<input type="checkbox"/>
d.						- -	<input type="checkbox"/>
e.						- -	<input type="checkbox"/>
f.						- -	<input type="checkbox"/>

*(1 - WHITE 2 - BLACK/AFRICAN AMERICAN 4 - AMERICAN INDIAN/ALASKAN NATIVE 5 - ASIAN 6 - NATIVE HAWAIIAN/PACIFIC ISLANDER)

1. Are both parents of all the children in the home? YES NO (If NO, complete section E.)
2. Are all of the persons applying for MHK U.S. citizens? YES NO If NO, list the following information for persons applying for MHK who are not U.S. citizens: Name, immigration status and registration number, date of entry: _____
3. You may qualify for coverage of unpaid bills for medical services received in the past three months. Did any of the persons listed above receive medical services in the past three months? YES NO If yes, who? _____
4. Is anyone in your household pregnant? YES NO If yes, who? _____ Expected due date? _____
5. Is your net worth (net worth is the value of everything you own minus any debt.): less than \$50,000 \$50,000-\$100,000
 \$100,000-\$150,000 \$150,000-\$200,000 \$200,000-\$250,000 above \$250,000
 Please list your assets (bank accounts, stocks/bonds, vehicles, home, real and personal property, etc.) _____

C. INCOME (Please attach verification; i.e. paycheck stub, note from employer, federal income tax return, award letter, etc.)

1. Are you employed? YES NO If YES, name of employer _____
 How much are you paid **before** taxes or deductions? _____ Weekly Every two weeks Twice monthly Monthly
2. Is anyone else in your home employed? YES NO If yes, who? _____
 Name of employer _____
 How much are they paid **before** taxes or deductions? _____ Weekly Every two weeks Twice monthly Monthly
3. Does anyone in your home operate their own business or are they otherwise self-employed? YES NO
 If yes, who? _____ Describe what type of self-employment (baby-sitting, farm income, other) and amount earned: _____ Weekly Monthly Yearly
4. Childcare costs may be an allowable income deduction for working families. Do you pay someone to care for your child?
 YES NO If yes, list names of children cared for: _____
 How much do you pay for child care? _____ Weekly Every two weeks Twice monthly Monthly

5. Does anyone in your home receive other income such as child support, alimony, Unemployment Compensation benefits, sick benefits, interest income, Social Security benefits, or other unearned income. YES NO If yes, complete the following:

PERSON RECEIVING	WHO PROVIDES THE MONEY?	AMOUNT RECEIVED?	HOW OFTEN RECEIVED?

D. HEALTH INSURANCE

1. Does anyone in your home have medical, hospital insurance or Medicare? YES NO

PERSONS INSURED	NAME OF COMPANY AND POLICY NUMBER	TYPE OF COVERAGE
		<input type="checkbox"/> Doctor <input type="checkbox"/> Hospital If limited coverage explain: _____
		<input type="checkbox"/> Doctor <input type="checkbox"/> Hospital If limited coverage explain: _____

2. Has anyone in your home lost **or dropped** health insurance within the past six months? YES NO If yes, provide name(s), date and reason coverage ended.

3. Is health insurance available for any member of your family through an employer or other group membership? YES NO
If yes, name of employer or group: _____
Is the insurance available for: Self Spouse Children How much is the premium for the children? \$ _____ per _____

4. Do any of your children have a medical condition that left untreated would result in death or serious physical injury of the child?
 YES NO If yes, provide name(s) of child(ren) _____

5. Is a third party responsible to pay for any of your medical care? YES NO If yes, who? _____

6. Please refer to the income guidelines sent with the application. If income and family size fall in the premium group, submit 2 quotes from private insurance companies of what they would charge for medical coverage for all of your children.
1. \$ _____ per mo. Company _____ 2. \$ _____ per mo. Company _____

E. ABSENT PARENT INFORMATION (Complete this section if a parent of any of the children is absent from the home.)

NAME (FIRST, MIDDLE, LAST)	(MAIDEN)	RACE/ SEX	SOCIAL SECURITY NUMBER	BIRTHDATE	PARENT OF WHICH CHILD?	LAST KNOWN ADDRESS
			- -			
			- -			

Do you have a good reason for not cooperating in obtaining support for medical care? YES NO If yes, please explain.

F. PLEASE READ CAREFULLY AND SIGN BELOW.

- I/We agree that I/we must provide Social Security Numbers of all persons applying for MHK as required by law. The Social Security Number is used to determine eligibility and verify information.
- I/We agree I/we must be evaluated for the Health Insurance Premium Payment Program (HIPP) if I or members of the household are employed or lost employment in the last 30 days and the employer or former employer offers group health insurance.
- I/We agree that my/our statements and information provided may be verified.
- I/We will report any changes in circumstances within TEN DAYS of when they happen.
- I/We know that it is against the law to obtain or attempt to obtain benefits to which I am/we are not entitled. Any false claim, statement or concealment of any material fact whatever, in whole or in part, may subject me/us to criminal and/or civil prosecution.
- I/We agree that by applying for (and being determined eligible for) MHK for a child who is deprived of parental support, I/we have assigned all rights to medical support to the State of Missouri, and that I/we must cooperate in establishing paternity and obtaining medical support, **unless I/we have good cause. Failure to cooperate does not affect a child's eligibility.**
- I/We understand healthcare benefits based on a person being age 65 and over, blind or disabled is not determined by completing this application. If I/we want eligibility for healthcare benefits explored on the basis of being age 65 or over, blind or disabled, I/we must complete a different application for these benefits.
- I/We agree that medical information about me and/or my family can be released if needed to administer this program.
- Provided I am/we are found to be eligible for MHK I/we know the State of Missouri will pay for covered services on my/our behalf and agree the state may collect payments from any third party (i.e., insurance, estate, etc.) for services paid by the state.

My/Our signature below certifies under penalty of perjury that all declarations made in this eligibility statement are true, accurate, and complete, to the best of my/our knowledge. I/we authorize insurers or employers to release any information on myself or my/our dependent(s) needed to determine eligibility for the HIPP program.

SIGNATURE/AFFIDAVIT	DATE	SIGNATURE OF SPOUSE/AFFIDAVIT	DATE
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