

Iowa Eligibility Application

FFY 10-11

Complete one application per household. Each foster child is a household of one.

School Year 10-11

Part 1. Check all applicable boxes:

- | | | |
|---|--|---|
| <input type="checkbox"/> school meals | <input type="checkbox"/> children in center | <input type="checkbox"/> children in home child care (HP) |
| <input type="checkbox"/> special milk (restrictions apply) | <input type="checkbox"/> Tier I home provider (HP) | Provider name: _____ |
| <input type="checkbox"/> foster child (ONE APPLICATION PER CHILD) | <input type="checkbox"/> Head Start/Even Start | |

Part 2. Children enrolled. REQUIRED OF ALL APPLICANTS. If applicable, list FIP or Food Assistance Case Number.

List name(s) of all enrolled child(ren) in your household. Children's Racial and Ethnic identities are optional. Provide one or more if you choose (see code).

| | | | |
|---|---|-----------------------------|---|
| Ethnicity: H=Hispanic or Latino, N=Non Hispanic or Latino | Race: A=Asian P=Native Hawaiian or other Pacific Islander | B=Black or African American | I=American Indian or Alaska Native W=White |
|---|---|-----------------------------|---|

FIP or Food Assistance Eligible: Enter the FIP or Food Assistance Case Number for ANY household member as listed in the Notice of Decision. NOTE: Medicaid, Title XIX, FIP card number and EBT card numbers are not acceptable.

| Name of household member with Case Number | | | | List Case Number | | | | |
|---|------------|------------------------|----------------------------|------------------|-------|-----------|------|---|
| Last Name | First Name | Middle Name or Initial | Check box for FOSTER child | Date of Birth | Grade | OPTIONAL | | Name of School/Head Start/Child Care Center |
| | | | | | | ETHNICITY | RACE | |
| 1. | | | <input type="checkbox"/> | | | | | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |

Part 3. Total Household Gross Income. DO NOT COMPLETE THIS PART IF YOU LISTED A FIP OR FOOD ASSISTANCE NUMBER IN PART 2. Report the gross income received by EACH household member in the correct column: weekly, every 2 weeks, twice a month or monthly. Gross income is the amount earned before taxes and other deductions, not take-home pay. Report all other monthly income received. Self-employed persons, see the worksheet on reverse side.

| List the names of everyone living in your household, including the children listed in Part 2. Attach a separate page if more space is needed. For FOSTER children, include only money available for child's personal use or child's own income. | | | | | Gross Income: Report income by how often the household member is paid. | | | | Other Monthly Payments or Income Received. | | |
|---|------------|-----|--------------------------|------------------------------|--|-------------------------------------|-------------------------------|---|---|------------------|--|
| Last Name | First Name | Age | Check if N/A | Gross amount received weekly | Gross amount received every 2 weeks | Gross amount received twice a month | Gross amount received monthly | Welfare, child support, alimony, adoption subsidies | Pension, retirement, social security, SSI, VA | All other income | |
| 1. | | | <input type="checkbox"/> | | | | | | | | |
| 2. | | | <input type="checkbox"/> | | | | | | | | |
| 3. | | | <input type="checkbox"/> | | | | | | | | |
| 4. | | | <input type="checkbox"/> | | | | | | | | |
| 5. | | | <input type="checkbox"/> | | | | | | | | |
| 6. | | | <input type="checkbox"/> | | | | | | | | |

My Social Security Number: _____ I do not have a Social Security Number.
 If Part 3 is completed, the adult signing the form must also list his or her Social Security Number or mark the "I do not have a Social Security Number" box. Foster parents completing this application for a foster child are not required to provide their Social Security Numbers. For all other applicants, providing Social Security Numbers is voluntary. **See Privacy Act Statement in the parent letter.**

Part 4. Certification and Signature. REQUIRED OF ALL APPLICANTS.

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

Signature of Adult Completing Form _____ Printed Name of Adult Completing Form _____ Date Signed _____

Address of Adult Completing Form _____ Town _____ ZIP Code _____ Work Phone _____ Home Phone _____ Cell Phone _____

Part 5. DO NOT WRITE BELOW THIS LINE. FOR ADMINISTRATIVE USE ONLY.

Income conversion factors for annual income: weekly X 52; two weeks X 26; twice a month X 24; monthly X 12
 Household Income: \$ _____ Weekly Every 2 Weeks Twice Monthly Monthly Annually Household Size _____

| | |
|--|---|
| Application Approved: <input type="checkbox"/> Income <input type="checkbox"/> Foster Child (income) <input type="checkbox"/> FIP/Food Assistance <input type="checkbox"/> Head Start DOCUMENTATION REQUIRED <input type="checkbox"/> Homeless/Migrant (Schools only) <input type="checkbox"/> Temporary Approval (zero income) expires in 45 days on (Mo.) _____ (Day) _____ Eligibility Determination: <input type="checkbox"/> Free Meals <input type="checkbox"/> Reduced Price Meals <input type="checkbox"/> Free Milk Application Denied: <input type="checkbox"/> Incomplete <input type="checkbox"/> Over income limits | CACFP HP ONLY: <input type="checkbox"/> Tier 1 Area (Provider's own children) <input type="checkbox"/> Tier 1 Income (All children) <input type="checkbox"/> Tier 1 Child (Tier 2 mixed) |
|--|---|

| | |
|--|---|
| Determining Official Signature _____ Effective Date _____ | Confirming Official Signature (Schools only) _____ Date _____ Follow-Up Official Signature (Schools only) _____ Date _____ |
|--|---|

hawk-i /Medicaid Information Form: Read this information and sign if you do not want your name released to hawk-i or Medicaid.

If your children do not have health insurance, you will be interested to know that many families getting free and reduced price meals can also get free or low-cost health insurance for their children.

The law now requires schools to share your free and reduced price meal eligibility information with Medicaid and *hawk-i*, the State's medical insurance program for children. Specifically, we will give them your child's name and your name and address. Medicaid and *hawk-i* can only use the information to identify children who may be eligible for free or low-cost health insurance and then to contact you. They are not allowed to use the information from your free and reduced meal application for any other purpose.

You are not required to allow us to share information from your children's free and reduced price meal application with Medicaid or the *hawk-i* program. It will not affect your children's eligibility for free and reduced price meals. If you do NOT want your information shared with Medicaid or *hawk-i*, you must tell us by completing the information below at the time you complete this eligibility application. If you want further information, you may call *hawk-i* at 1-800-257-8563.

I DO NOT want school/home sponsor/child care or Head Start center officials to share information from my free and reduced price meal application with Medicaid or hawk-i. Also, if you are already receiving Medicaid or hawk-i, please sign below. This will avoid another contact.

Child's Name: _____ School/Child Care/Head Start Center: _____

Child's Name: _____ School/Child Care/Head Start Center: _____

Child's Name: _____ School/Child Care/Head Start Center: _____

Parent/Guardian Name (Printed) _____ Signature _____ Date _____

Self-Employment Income Worksheet: This worksheet will assist you in calculating the amount to report if you engage in farming, are self employed or have income from other sources.

Persons who are engaged in farming or who operate other types of private businesses may experience variations in cash flow or monthly income throughout the year. These persons may use their income tax records from the preceding calendar year as a basis for applying for the free and reduced price meals. The income to be reported is income derived from the business venture less operating costs incurred in the generation of that income. Deductions for personal expenses such as medical expenses and other non-business deductions are not allowed in reducing gross business income.

If you have additional income from other kinds of employment, this income must be treated as separate and apart from the income generated from your business venture. USDA **DOES NOT** recognize income the same way as IRS. USDA does not permit a loss from a business venture to off-set earnings from wages or salary. Though your business may have suffered a net operational loss, for purposes of this application, it is not possible to have a negative income. **The least self employed income possible is zero (no income).** For example, if you operated a business at a net loss but held another job where you received wages, your income for purposes of applying for free or reduced price meals would be the income from your wages only. The loss from the business cannot be deducted from the amount of the income earned in the other job.

A prior year loss from farming or other private business operation cannot be used to reduce the current year net income for determining free and reduced price eligibility. Wages paid to a spouse or other family member in the operation of a farm or private business must be shown as household income in Part 3 of the application.

The least income possible is zero (no income).

Income from private business operations is to be taken from your most recent U.S. Individual Income Tax Return - Form 1040. Use the lines from the 1040 that are identified.

| | | |
|---|--------------|----------|
| Line 12 - Business income or (loss) | | \$ _____ |
| Line 13 - Capital gain or (loss) | | \$ _____ |
| Line 14 - Other gains or (losses) | | \$ _____ |
| Line 17 - Rental real estate, royalties, partnerships, S corporations, trusts, etc. | | \$ _____ |
| Line 18 - Farm income or (loss) | | \$ _____ |
| | Total | \$ _____ |
| | Total ÷12* = | _____ |

*Enter amount in the "All Other Income Last Month" column in Part 3 on the front of the Iowa Eligibility Application. **The least income possible is zero (no income).**

WAIVER STATEMENT

If your child(ren) qualifies for free or reduced price meals, you may also be eligible for other benefits. One of these benefits is school fees. If you sign this waiver, your child(ren) will be considered for a full or partial waiver of school fees. I understand that I will be releasing information that will show that I applied for free and reduced price school meals for my child(ren). I give up my rights to confidentiality for waiver of school fees **ONLY**.

I certify that I am the parent/guardian of the child(ren) for whom application is being made.

Signature of Parent/guardian _____ Date _____

YOU DO NOT HAVE TO COMPLETE THIS WAIVER TO GET FREE OR REDUCED PRICE SCHOOL MEALS.