

2011 - 2012 Free and Reduced School Meals Family Application

Akron Public Schools

Call Child Nutrition Help Line:
330-761-1335 if you have questions

1 HOMELESS, MIGRANT, RUNAWAY If the child you are applying for is homeless (H), migrant (M), or a runaway (R), place an X in the appropriate box and call Child Nutrition Services at 330-761-1335.

H M R

2 LIST THE SNAP (Food Stamp) or OWF 10 digit case # FOR ANY HOUSEHOLD MEMBER (including adults). Continue to part 3.

3 CHILDREN IN SCHOOL LIST ALL STUDENTS ATTENDING AKRON PUBLIC SCHOOLS . Print Neatly with BLACK INK name, birth date, grade, and income of EACH ENROLLED child if any.

School Code (Office Use Only)	First Name	MI	Last Name	Date of Birth			Grade	Check if student is a foster child	STUDENT'S Monthly Income. If Any
				MM	DD	YY			
								<input type="checkbox"/>	\$ _____ . _____
								<input type="checkbox"/>	\$ _____ . _____
								<input type="checkbox"/>	\$ _____ . _____
								<input type="checkbox"/>	\$ _____ . _____
								<input type="checkbox"/>	\$ _____ . _____
								<input type="checkbox"/>	\$ _____ . _____
								<input type="checkbox"/>	\$ _____ . _____

4 HOUSEHOLD MEMBERS. DO NOT INCLUDE Students already Listed. GROSS MONTHLY INCOME BEFORE DEDUCTIONS. If you wrote a SNAP or OWF number in Part 2, skip Parts 4 and 5 below, and go to Part 6.

Print first and last name of all adults and children not listed above	No Income	Earnings from Work Before Deductions (Monthly)	Welfare Payments, Child Support, Alimony (Monthly)	Pension, Retirement, Social Security (Monthly)	Any Other Income Including Temporary Income (Monthly)
	<input type="checkbox"/>	\$ _____ . _____	\$ _____ . _____	\$ _____ . _____	\$ _____ . _____
	<input type="checkbox"/>	\$ _____ . _____	\$ _____ . _____	\$ _____ . _____	\$ _____ . _____
	<input type="checkbox"/>	\$ _____ . _____	\$ _____ . _____	\$ _____ . _____	\$ _____ . _____
	<input type="checkbox"/>	\$ _____ . _____	\$ _____ . _____	\$ _____ . _____	\$ _____ . _____
	<input type="checkbox"/>	\$ _____ . _____	\$ _____ . _____	\$ _____ . _____	\$ _____ . _____
	<input type="checkbox"/>	\$ _____ . _____	\$ _____ . _____	\$ _____ . _____	\$ _____ . _____

To Determine Monthly Income: Multiply Weekly by 52 and divide by 12, Every Two Weeks by 26 and divide by 12, Twice Monthly by 2 or Yearly divided by 12

5 **ENTER THE TOTAL HOUSEHOLD MEMBERS (Add the Names listed in Parts 3 & 4)**

8 Mailing Address _____ Apt # _____ City _____ State _____ Zip Code _____

Home Telephone Number _____ Cell Phone Number _____ Work Telephone Number _____

9 Race Identity (Optional) Asian White Black or African American American Indian or Alaska Native Native Hawaiian or Other Pacific Islander Other **Ethnic Identity (Optional)** Hispanic or Latino NOT Hispanic or Latino

6 An adult household member must sign the application. If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "X here if you do not have a Social Security Number" box. (See Privacy Act Statement on the instructions.)

ADULT Social Security Number (last 4 digits)
XXX - XX - X here if You DO NOT have a SSN

CERTIFICATION: 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.

ADULT SIGNATURE REQUIRED

Sign Here

Print First Name

Print Last Name

DATE SIGNED

7 FREE HEALTH CARE: Families with children eligible for school meals may be eligible for FREE health care coverage through Ohio's Healthy Start & Healthy Families programs. These programs include coverage for doctor visits, immunizations, physicals, prescriptions, dental, vision, mental health, substance abuse and more. Please call 1-800-324-8680 for more information or to request an application. Information can also be found on the web at www.state.oh.us/odifs/ohp/bcps/hshf/index.stm. *Please Note: If you already have an Ohio Medicaid Card, you are already getting these services.