

**SOLICITUD FAMILIAR CONFIDENCIAL 2018-2019 PARA COMIDAS GRATIS Y DE PRECIO REDUCIDO**

**AVISO:**

- Si ha recibido una NOTIFICACIÓN DE ELEGIBILIDAD PARA COMIDAS GRATIS del distrito escolar, **no complete** esta solicitud.
  - Vea las **Instrucciones para completar la solicitud** al dorso de este formulario.
- \* = *Requerido Todas las aplicaciones*; \*\* = *Requerido para aplicaciones de ingresos*; \*\*\* = *Requerido para aplicaciones SNAP*

**1 INFORMACIÓN DEL HOGAR\*** Nombre de la persona que completa esta solicitud (**Apellido, Primer nombre**) \_\_\_\_\_

Nombre Escriba \_\_\_\_\_

Dirección postal – Apt # \_\_\_\_\_

Ciudad Estado Código Postal \_\_\_\_\_

Teléfono particular o móvil (marque uno con un círculo) \_\_\_\_\_

Teléfono del trabajo \_\_\_\_\_

→ Número de integrantes del hogar \_\_\_\_\_  
(Escriba los nombres de todos los integrantes del hogar en las partes 2 y/o 4 de este formulario)

**2 INFORMACIÓN DE LOS ESTUDIANTES\***

Nombre del niño (Apellido, Primer nombre)	Escuela	Grado (Opcional)	Fecha de nacimiento (Opcional)	Comprobar si los niños de crianza temporal
1. _____	_____	_____	_____	<input type="checkbox"/>
2. _____	_____	_____	_____	<input type="checkbox"/>
3. _____	_____	_____	_____	<input type="checkbox"/>
4. _____	_____	_____	_____	<input type="checkbox"/>
5. _____	_____	_____	_____	<input type="checkbox"/>

**3 BENEFICIOS** Si algún miembro del hogar recibe SNAP o TANF\*\*\*, dé el nombre y número de caso del miembro que recibe los beneficios.

Nombre \*\*\* \_\_\_\_\_  SNAP Número de caso\*\*\* \_\_\_\_\_  TANF

Siga abajo en la Parte 5

¿Recibe este hogar FDPIR (Distribución de comida en reservaciones indígenas)  Sí

**4 MIEMBROS DEL HOGAR E INGRESO MENSUAL BRUTO\*\* – si no es mensual, vea las conversiones al dorso**

Columna 1	Columna 2	Columna 3	Columna 4	Columna 5	Columna 6
Liste <b>todos</b> los miembros del hogar, incluidos niños, que no asistan a la escuela, y el ingreso. No incluya a los estudiantes listados en la parte 2, a menos que reciban ingresos regulares. (Apellido, Primer nombre)	Ingreso mensual (Ganancias y sueldos totales antes de deducciones)	Manutención infantil, Asistencia social, Pensión alimenticia Recibidas por mes	Mensual pensiones, Retiro del Seguro Social por mes	Otro Ingreso mensual – Incluido Seguro de desempleo Y Compensación laboral	Marque si no hay ingreso
1. _____	_____	_____	_____	_____	<input type="checkbox"/>
2. _____	_____	_____	_____	_____	<input type="checkbox"/>
3. _____	_____	_____	_____	_____	<input type="checkbox"/>
4. _____	_____	_____	_____	_____	<input type="checkbox"/>

**5 FIRMA, FECHA Y últimos cuatro números del NÚMERO DE SEGURO SOCIAL (Un adulto debe firmar)**

Certifico (prometo) que toda la información en esta solicitud es verdadera (correcta) y que he informado todos los ingresos. Entiendo que la escuela obtendrá fondos federales en base a la información que proporcione. Entiendo que los funcionarios de la escuela pueden verificar (controlar) la información. Entiendo que si doy información deliberadamente falsa, mis hijos pueden perder los beneficios de comidas y se me puede procesar.

Firma de un miembro adulto del hogar\* X \_\_\_\_\_ Firmado en\* \_\_\_\_\_ Mes/día/año

Número de Seguro Social \*\* (Ver declaración de privacidad al dorso) XXX-XX-\_\_\_\_-\_\_\_\_  No tengo número de Seguro Social\*\*

**6 GRUPO RACIAL O ÉTNICO (OPCIONAL)**

Marque una identidad étnica:  Hispano o latino  No hispano ni latino

Marque una o más identidades raciales:  Asiático  Indio americano y nativo de Alaska  Nativo de Hawai o de otra isla del Pacífico

Negro o afroamericano  Blanco, no de origen hispano  Otra

Prefiero recibir toda la correspondencia en  Español  Ruso  Otro \_\_\_\_\_

**7 No deseo que mi información se comparta con el programa de seguro de salud de niños del Estado** Firme aquí: \_\_\_\_\_

Tengo un hijo (o hijos) que no tienen ningún tipo de cobertura de salud – ni de seguro de salud privado ni de Oregon Health Plan / Healthy Kids. Estoy interesado en libre o reducción del coste de la cobertura de salud para al menos uno de mis hijos.  Sí  No

**SCHOOL USE ONLY - DO NOT WRITE BELOW THIS LINE**

Total Income: \_\_\_\_\_ Number in household: \_\_\_\_\_ Date Withdrawn: \_\_\_\_\_

Free based on:  SNAP/TANF/FDPIR  Foster child categorical  household income

Reduced based on:  household income

Denied – Reason:  income too high  incomplete application

Determining Official's Signature : \_\_\_\_\_ Date \_\_\_\_\_

- If your household receives **SNAP, TANF or FDPIR**, complete parts 1, 2, 3 and 5; parts 6 and 7 are optional.
  - If you do not receive these benefits and your **income** is below the guidelines, complete parts 1, 2, 4, 5; parts 6 and 7 are optional.
  - If you are a household with a **FOSTER CHILD**, complete parts 1, 2, 4, and 5; parts 6 and 7 are optional.
- Any income fields left blank will be counted as zeros. Please be careful that you meant to leave income fields blank.*

### DETERMINING MONTHLY INCOME FOR EARNINGS & WAGES

**Monthly income** for all household members must be reported in Part 4 of this application. Income means any money regularly received from work, child support, alimony, pensions, retirements, social security or any other source. Exclude student/school loans.

Household members who are not paid monthly should change earnings into monthly income by doing the following:

**Household members who are paid every week:** Multiply total earnings and wages for one pay period, before deductions, by 52. Then divide by 12. The resulting amount is the total monthly income.

**Household members who are paid every 2 weeks:** Multiply total earnings and wages for one pay period, before deductions, by 26. Then divide by 12. The resulting amount is the total monthly income.

**Household members who are paid twice a month:** Multiply total earnings and wages for one pay period, before deductions, by 24 then divide by 12. The resulting amount is the total monthly income.

**Household members who are seasonal workers or work less than 12 months:** Project annual rate of income to accurately represent actual circumstances then divide by 12. The resulting amount is the projected monthly income.

Note: Money received from a business or farm owned by you should be reported as "net income." *Net Income is defined as the total income left after business and farm operating expenses are subtracted from gross receipts.*

### FEDERAL INCOME GUIDELINES

Your children may qualify at least for reduced price meals if your household income is at or below the limits of this chart.

#### Reduced Price Meals

Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
-1-	22,459	1,872	936	864	432
-2-	30,451	2,538	1,269	1,172	586
-3-	38,443	3,204	1,602	1,479	740
-4-	46,435	3,870	1,935	1,786	893
-5-	54,427	4,536	2,268	2,094	1,047
-6-	62,419	5,202	2,601	2,401	1,201
-7-	70,411	5,868	2,934	2,709	1,355
-8-	78,403	6,534	3,267	3,016	1,508
For each additional family member add	7,992	666	333	308	154

### PRIVACY STATEMENT - SOCIAL SECURITY NUMBERS and OTHER INFORMATION

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 4 digits of the social security number of the adult household member who signs the application. The last 4 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. We may share the information on this form with Medicaid or the State Children's Health Insurance Program (SCHIP), unless you tell us not to. The information, if disclosed, will only be used to identify eligible children and seek to enroll them in Medicaid or SCHIP.

### NON-DISCRIMINATION STATEMENT

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov)  
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