

**2023-2024 Iowa Application for Free and Reduced Price School Meals/Milk** Complete one application per household. Use a pen (not a pencil).  
 Please read "How to Apply for Free and Reduced Price School Meals" for more information on completing this application.

<b>STEP 1</b>	List ALL Household Members who are infants, children, and students up grade 12 (if more spaces are required for additional names, attach the supplemental worksheet)											
Definition of <b>Household Member</b> : "Anyone who is living with you and shares income and expenses, even if not related." Children in <b>Foster care</b> and children who meet the definition of <b>Homeless, Migrant</b> or <b>Runaway</b> are eligible for free meals. We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community.	<b>Child's First Name</b>	<b>MI</b>	<b>Child's Last Name</b>	<b>Date of Birth</b>	<b>Student</b>		<b>Child's School</b>	<b>Grade</b>	<b>Foster Child</b>	<b>Homeless, Migrant, Runaway</b>	<b>OPTIONAL</b> Responding to this section is optional and does not affect your children's eligibility for free/reduced price meals.	
					Yes	No			<b>Ethnicity</b>		<b>Race</b>	
	Check all that apply		H=Hispanic or Latino N=Non-Hispanic/Latino		A=Asian W=White I=American Indian/Alaskan Native B=Black/African American P=Native Hawaiian/Other Pacific Islander							

<b>STEP 2</b>	Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP, FIP or FDIPIR? If No, go to STEP 3. If you answered Yes, write a case number here then go to STEP 4 (Do not complete STEP 3).
Write only one case number in this space. Medicaid and EBT card numbers are <b>NOT</b> acceptable.	
Case Number:	_____ - ____ - ____

<b>STEP 3</b>	Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)	
<b>A. Total Number of All Household Members</b> (Children + Adults)	<b>B. Last Four Digits of Social Security Number (SSN) of Adult Household Member (last 4 digits)</b> XXX-XX-_____	<b>C. Check No SSN</b> (adult): <input type="checkbox"/>

**D. All Adult Household Members (include yourself):** List all Household Members not listed in STEP 1 even if they do not receive income. If they do not receive income from any source, enter '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report. Applications with blank income fields will be processed as complete. **If more spaces are required for additional names, attach the supplemental worksheet.** The sources of income for adults section will help you with the adult income. Report all income in whole dollar amounts before deductions or taxes.

Names of All Adult Household Members	Gross Earnings from Work/All Other Income					Gross Public Assistance/Child Support/Alimony				Gross Pension/Retirement					
	How Often? (mark "X" in box)														
	Weekly	Bi-weekly	2x Month	Monthly	Yearly	Weekly	Bi-weekly	2x Month	Monthly	Weekly	Bi-weekly	2x Month	Monthly		
First and Last Names. Include children who are temporarily away at school or in college.	\$					\$					\$				
	\$					\$					\$				
	\$					\$					\$				
	\$					\$					\$				

<b>E. Child Income:</b> Sometimes children in the household earn or receive income. Please include the TOTAL gross earned income by all Children listed in STEP 1 here. The sources of income for children section will help you with the Child Income.	<b>Total Income Received by All Children</b>	How Often? (mark "X" in box)				
	\$	Weekly	Bi-weekly	2x Month	Monthly	Yearly

**STEP 4**      **Contact Information and Adult Signature**      **PAGE TWO CONTAINS MORE INFORMATION**

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Signature of adult completing the form	Printed name of adult completing the form	Today's Date
--	---	--------------

Street Address (if available)	Apt. #	City	State	Zip	Daytime Phone (optional)	Email (optional)
-------------------------------	--------	------	-------	-----	--------------------------	------------------

<b>DO NOT WRITE BELOW THIS LINE. FOR SCHOOL ADMINISTRATIVE USE ONLY</b>	Return completed form to: <b>Bosco Catholic School System, P.O. Box 106, Gilbertville, Ia 50634</b>
---	---

Annual Income Conversion	x52 Weekly	x26 Bi-Weekly	x24 2x Month	x12 Monthly	Yearly	Total Income: \$_____	Application #: _____	Date Received: _____
<b>Household Size:</b> _____						<input type="checkbox"/> ERROR PRONE APPLICATION		
Signature and Effective Date of Determining Official			Signature and Date of Confirming Official			Signature and Date of Verification Follow-Up		

Application	<input type="checkbox"/> Income <input type="checkbox"/> Foster Child <input type="checkbox"/> FIP/SNAP <input type="checkbox"/> Head Start (confirmation required) <input type="checkbox"/> Homeless/Migrant/Runaway-Local Official confirmation Required					
Eligibility Determination	<input type="checkbox"/> Free	<input type="checkbox"/> Reduced	<input type="checkbox"/> Free Milk	Application Denied	<input type="checkbox"/> Incomplete	<input type="checkbox"/> Over Income Limits

**Low-Cost Health Insurance for Children**

If your children do not have health insurance, many families getting free or reduced price meals can also get free or low-cost health insurance for their children. The law requires public schools to share your free and reduced price meal eligibility information with Medicaid and Hawki, the State's medical insurance program for children. Private schools, RCCIs and childcare organizations may choose to share this information. Specifically, we will give them your child's name, your name and address. Medicaid and Hawki can only use the information to identify children who may be eligible for free or low-cost health insurance and contact you. They are not allowed to use the information from your free and reduced meal application for any other purpose or to share it with any other entity or program. You are not required to allow us to share this information, it will not affect your child's eligibility for free or reduced price meals. **If you do NOT want your information shared with Medicaid or Hawki, you must tell us by completing the information below.** If you want further information, you may call Hawki at 1-800-257-8563. Also, if you are already receiving Medicaid or Hawki, please sign below. This will avoid another contact.

My signature below indicates I DO NOT want school officials to share information from my free and reduced price meal application with Medicaid or Hawki.

Parent/Guardian Name (Printed) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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 submit all needed information, 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), Family Investment Program (FIP) 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.

**USDA Nondiscrimination Statement:** In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

- \* mail:**  
U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410; or
- fax:**  
(833) 256-1665 or (202) 690-7442; or
- email:**  
[program.intake@usda.gov](mailto:program.intake@usda.gov)

**\*Do not mail applications to this address, only complaints of discrimination.**

**Iowa Non-Discrimination Statement:** "It is the policy of this CNP provider not to discriminate on the basis of race, creed, color, sex, sexual orientation, gender identity, national origin, disability, age, or religion in its programs, activities, or employment practices as required by the Iowa Code section 216.6, 216.7, and 216.9. If you have questions or grievances related to compliance with this policy by this CNP Provider, please contact the Iowa Civil Rights Commission, Grimes State Office building, 400 E. 14<sup>th</sup> St. Des Moines, IA 50319-1004; phone number 515-281-4121, 800-457-4416; website: <https://icrc.iowa.gov/>."

**Return completed form to:**  
**Bosco Catholic School System**  
**Stephanie Schulte**  
**P.O. Box 106**  
**Gilbeerville, Ia 50634**

This institution is an equal opportunity provider.

Translated applications are available at: <http://www.fns.usda.gov/school-meals/translated-applications>

**Waiver Information**

Sources of Child Income	Earnings from Work (Adult Income Sources)	Public Assistance/Alimony/Child Support (Adult Income Sources)	All Other Income (Adult Income Sources)
<ul style="list-style-type: none"> <li>Earnings from work</li> </ul>	<ul style="list-style-type: none"> <li>Salary, wages, cash bonuses (before deductions or taxes)</li> <li>Net income from self-employment (farm or business)</li> </ul>	<ul style="list-style-type: none"> <li>Cash Assistance from State/local government</li> <li>Supplemental Security Income</li> </ul>	<ul style="list-style-type: none"> <li>Social Security</li> <li>Disability benefits</li> </ul>

- Social Security (disability payments and survivor's benefits)
- Income from person outside the household
- Income from any other source

- If you are in the U.S. Military:
  - a. Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances)
  - b. Allowances for off-base housing, food and clothing

- Unemployment benefits
- Worker's compensation
- Alimony or child support payments
- Veteran's benefits
- Strike benefits

- Regular income from trusts or estates
- Annuities
- Investment income
- Rental income
- Regular cash payments from outside household

## Optional Supplemental Worksheet 2023-2024 Iowa Application for Free and Reduced Price School Meals/Milk

### Additional Children in Your Household (not listed on page 1)

Child's First Name	MI	Child's Last Name	Date of Birth	Student		Child's School	Grade	Foster Child	Homeless, Migrant, Runaway	<b>OPTIONAL</b>	
				YES	NO					Responding to this section is optional and does not affect your children's eligibility for free/reduced price meals.	
										Ethnicity	Race
										H=Hispanic or Latino N=Non-Hispanic/Latino	A=Asian W=White I=American Indian/Alaskan Native B=Black/African American P=Native Hawaiian/Other Pacific Islander
									Check all that apply		

Any income earned by the above listed children should be included under Step 3 D on the first page of the application.

### Additional Adults in Your Household (Not listed on page 1)

Names of All Adult Household Members	Gross Earnings from Work/ALL Other Income					Gross Public Assistance/Child Support/Alimony				Gross Pension/Retirement					
	How Often? (mark "X" in box)					How Often? (mark "X" in box)				How Often? (mark "X" in box)					
	Weekly	Bi-weekly	2x Month	Monthly	Yearly	Weekly	Bi-weekly	2x Month	Monthly	Weekly	Bi-weekly	2x Month	Monthly		
First and Last Names. Include children who are temporarily away at school or in college.	\$					\$					\$				
	\$					\$					\$				
	\$					\$					\$				
	\$					\$					\$				
	\$					\$					\$				
	\$					\$					\$				
	\$					\$					\$				

### Self-Employment Income Calculations

**This guidance will assist you in calculating the amount to report if you engage in farming, are self-employed or have income from other sources.**

Self-employed persons may use income tax records for the preceding calendar year as a base to project the current year's net income, unless the current monthly income provides a more accurate measure. Report income derived from the business venture less the operating costs incurred in the generation of that income. Deductions for personal expenses such as interest on home payments, medical expenses, and other similar non-business deductions are not allowed in reducing gross business income. Additional income from other kinds of employment must be treated as separate and apart from the income generated or lost from your business venture. For example, if you operated a business at a net loss, but held additional employment for which a salary was received, the income for purposes of applying for reduced price or free meals would be the income from the salary only. The loss from the business cannot be deducted from a positive income earned in other employment. For purposes of this application, it is not possible to report a negative income from any business venture. The least income possible is zero (no income). The necessary information for arriving at allowable income from private business operation may be taken from your most recent U.S. Individual Income Tax Return - Form 1040 or 1040-SR and Schedule 1. Add together the amounts reported on the following lines:

- Capital Gain or (Loss) Form 1040 or 1040-SR, LINE 7 \$ \_\_\_\_\_
- Business Income or (Loss) Schedule 1 Part 1, LINE 3 \$ \_\_\_\_\_
- Other Gains or (Losses) Schedule 1 Part 1, LINE 4 \$ \_\_\_\_\_
- Rental real estate, royalties, partnerships, S corporations, trusts, etc. Schedule 1 Part 1, LINE 5 \$ \_\_\_\_\_

Farm Income or (Loss) Schedule 1 Part 1, LINE 6

\$\_\_\_\_\_

TOTAL \$\_\_\_\_\_ Gross Annual Income Before Any Deductions. Report in Step 3 under All Other Income (**Computed Monthly Income** \$\_\_\_\_\_ Gross Annual Income ÷ 12)