Iowa Eligibility Application

FFY 11-12

Complete one application per household. School Year 2011-2012

Part 1. Check all applicable boxes:
☐ school meals
☐ special milk (restrictions apply)
☐ children in child care center
☐ Tier I home provider (HP)
☐ Head Start/Even Start
☐ children in child care home(HP)
Provider name:

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 B=Black or African American I=American Indian or Alaska Native P=Native Hawaiian or other Pacific Islander W=White

	Last Name	First Name	Middle Name or Initial	Check box for FOSTER child	Date of Birth	Grade	OPTIONAL ETHNICITY	OPTIONAL RACE	Name of School/Head Start/ Child Care Center/Home
1.				☐					
2.				☐					
3.				☐					
4.				☐					
5.				☐					

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 number are not acceptable.

Name of household member with Case Number ______________ **List Case Number** ______________

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.

	Last Name	First Name	Age	Check if NO Income	Gross Income: Gross amount earned weekly	Gross amount earned every 2 weeks	Gross amount earned twice a month	Gross amount earned monthly	Other Monthly Payments or Income Received: Welfare, child support, alimony, adoption subsidies	Pension, retirement, social security, SSI, VA benefits	All other income
1.				☐							
2.				☐							
3.				☐							
4.				☐							
5.				☐							
6.				☐							

My Social Security Number: X XX - X X - ___ ___ ___ ___ ☐ I do not have a Social Security Number.

If Part 3 is completed, the adult signing the form must provide the last 4 digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. **For further information refer to the 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: ☐ Income ☐ Foster Child (free) ☐ FIP/Food Assistance
☐ Head Start DOCUMENTATION REQUIRED ☐ Homeless/Migrant (Schools only)

Eligibility Determination: ☐ Temporary Approval (zero income) expires in 45 days on (Mo.)______(Day)______
☐ Free Meals ☐ Reduced Price Meals ☐ Free Milk

Application Denied: ☐ Incomplete ☐ Over income limits

CACFP HP ONLY:
☐ Tier 1 Area (Provider's own children)
☐ Tier 1 Income (All children)
☐ Tier 1 Child (Tier 2 mixed)

Confirming Official Signature (Schools only) **Date**

Determining Official Signature ______ **Effective Date** ______

Follow-Up Official Signature (Schools only) **Date**