St. Francis Area Schools
Nutrition Services
4111 Ambassador Blvd NW, St. Francis MN 55070
763-753-7015 • www.isd15.org • nutrition.office@isd15.org

Angel Fund Meal Account Request

Date: _____

Name of parent/guardian _____ Telephone _____

Name of Student(s):

Name _____ School _____ Grade _____

Name _____ School _____ Grade _____

Name _____ School _____ Grade _____

I am requesting the following help from the angel fund:

☐ Matching funds: I have enclosed meal account payment of $_____ and I am requesting Angel Fund Meal Account matching funds for the same amount, up to the outstanding balance.

☐ I have applied for Educational Benefits and need help of the Angel Fund to wipe out my existing outstanding balance.

☐ I am requesting help due to temporary financial difficulties.

Justification for request:

I acknowledge the above information to be true and accurate.

Parent Signature _____

Please return this form to Nutrition Services.

Mail to: Nutrition Services
4111 Ambassador Blvd NW
St. Francis MN 55070

Fax to: 763-753-7709

Email to: nutrition.office@isd15.org

Nutrition Services Office use only: Amount Approved_____ Amount Disapproved_____

Signature _____