

2023-2024 CONFIDENTIAL INCOME STATEMENT – Roseburg Public Schools

INSTRUCTIONS:

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

1 HOUSEHOLD INFORMATION

Print name of person completing this application (Last name, First name)

Name Print

Mailing Address – Apt #

City State Zip

Home Phone or Cell Phone (Circle One)

Work Phone

Number living in this household
(Write names of all household members on part 2 and/or part 4 of this form)

2 CHILD INFORMATION – (Names of Your Children Enrolled in Child Care)

Table with 4 columns: Child's Name, Birth Date, Age, Check if Foster Child. Includes rows for 1, 2, and 3 children.

3 PUBLIC BENEFITS Indicate which benefits your household currently receives, and list case number, if any:

- Name: Case Number:
SNAP (Supplemental Nutrition Assistance Program)
TANF (Temporary Assistance to Needy Families)
FDPIR (Food Distribution on Indian Reservations)

4 HOUSEHOLD MEMBERS & GROSS MONTHLY INCOME – if not monthly, see back for conversions

Table with 6 columns: Column 1 (List all household members), Column 2 (MONTHLY INCOME), Column 3 (MONTHLY CHILD SUPPORT), Column 4 (MONTHLY PENSIONS), Column 5 (OTHER MONTHLY INCOME), Column 6 (Check if No Income). Includes rows 1-7.

5 SIGNATURE, DATE and Last four numbers of SOCIAL SECURITY NUMBER (Adult must sign)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give.

Signature of Adult Household Member Date Signed Social Security Number
I do not have a Social Security Number.

6 RACIAL OR ETHNIC GROUP (OPTIONAL)

- Mark one ethnic identity: Hispanic or Latino, Not Hispanic or Latino
Mark one or more racial identities: Asian, American Indian & Alaskan Native, Native Hawaiian or Other Pacific Islander, Black or African American, White, Other

SPONSOR USE ONLY - DO NOT WRITE BELOW THIS LINE

Total Income: Number in Household:
Centers Eligibility: Free, Reduced Price, Above Scale
Eligibility based on: SNAP, TANF, FDPIR, Household Income, Foster Child
Notes:
Determining Official's Signature: Date
Second Check Signature: Date

DETERMINING MONTHLY INCOME FOR EARNINGS & WAGES

Monthly income for all household members must be reported in Section 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. 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.*

Homeless, migrant and runaway youth are categorically eligible for free meals.

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.

FEDERAL INCOME GUIDELINES

Participants may qualify at least for reduced price meals if your household income falls within the limits of this chart.

Household Size	Reduced Price Meals				
	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
-1-	26,973	2,248	1,124	1,038	519
-2-	36,482	3,041	1,521	1,404	702
-3-	45,991	3,883	1,917	1,769	885
-4-	55,500	4,625	2,313	2,135	1,068
-5-	65,009	5,418	2,709	2,501	1,251
-6-	74,518	6,210	3,105	2,867	1,434
-7-	84,027	7,003	3,502	3,232	1,616
-8-	93,536	7,795	3,898	3,598	1,799
For each additional family member add	9,509	793	397	366	183

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 case number or Food Distribution Program on Indian Reservations (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, unless you tell us not to. The information, if disclosed, will only be used to identify eligible participants and seek to enroll them in Medicaid.

NON-DISCRIMINATION 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/oascr/how-to-file-a-program-discrimination-complaint>, 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: 1. **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. This institution is an equal opportunity provider.