Hamza Academy
202 Stuart Avenue
Valley Stream, New York 11580
Phone: 516-285-1440 I Fax: 516-285-8580
administration@hamzaacademy.org

2020-2021 HAMZA ACADEMY NEW STUDENT REGISTRATION REQUIRED DOCUMENTS CHECKLIST

Student Name:	**Date of Birth:**

Document Title		**Office Use Only**	
Parents, please check off that you submitted the following items:		Submitted	Not Submitted
☐	$25.00 Application Fee		
☐	$400.00 Registration/Resource Fee		
☐	Passport Sized Photo of Student		
☐	Allergies List		
☐	Emergency Contact/Authorization for Pick-up List		
☐	Policies Contract		
☐	Records Release Form		
☐	Media Consent		
☐	Copy of Birth Certificate		
☐	2 Proof of Address		
☐	Racial & Ethnic Identification Home Language Questionnaire		
☐	Free/Reduced Lunch Income Eligibility 2019		
☐	Physical Form		
☐	Immunization Form		
☐	Dental Form		

Media Consent	
Allergies	

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Photo

New Student Registration Form 2020-2021

SECTION A - STUDENT INFORMATION		
Last Name:	First & Middle Name	Sex: [ ] Male [ ] Female
Date of Birth:	Country of Birth:	Ethnicity:
Home Address:	City & State:	Zip Code:
Home School District:	School Last Attended :	Last Attendance Date:
School Address	City, State, Zip code :	School Phone No:

SECTION B - HEALTH & WELLBEING	
Name of Current Doctor/Clinic:	Phone:
Allergies:	
Latest Vision Test Date:	Latest Dental Check Date:
Any Medical Issues:	Medication(s):
Any Behavioral Issues :	Special Considerations:
Please note: Hamza Academy staff is not permitted to administer daily medications to students	

SECTION C - SIBLING	
Please list your other children who are enrolled in Hamza Academy:	
Name:	Grade:
Name:	Grade:
Name:	Grade:
Name:	Grade:

For Office Use ONLY	**[ ] Accepted**	**[ ] Rejected**
Date Application Submitted:	Grade to be Enrolled:	Test/Interview Date:
Date of Enrollment:	Enrolled By:	Enrollment Fee Paid:
Director Signature:		Date:

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Section D - Family Information

Student Living with (please check one) : [ ] Parents [ ] Foster Parents [ ] Guardian/Other Relative		
Father or Primary Guardian's Information (If guardian, please specify relationship: _____):		
Last Name:	First & Middle Name:	
Address (if different than student):		
Mobile:	Work Phone:	Home Phone:
Email Address:		Occupation:
Mother or Second Guardian's Information (If guardian, please specify relationship: _____):		
Last Name:	First & Middle Name:	
Address (if different than student):		
Mobile:	Work Phone:	Home Phone:
Email Address:		Occupation:

Section E - Emergency Contacts/Pick-up List

If your child(ren) becomes ill while in Hamza Academy, but does not require emergency medical treatment, you will be called immediately. In the event you are not available, the number provided by you below will be called in. These emergency contacts (listed below) are authorized to pick up your child(ren). In the event, the child needs emergency medical treatment, 911 will be called in and the child will be taken to the nearest emergency room for treatment. In the event that you are not available, or unable to pick up your child(ren) from Hamza Academy at the time of dismissal, the person(s) listed below is/ are authorized to pick up your child(ren) in your place.

*** You MUST provide at-least 3 emergency/authorization for pick-up contacts besides parents/ guardians listed above***

Name	Relationship to child	Phone Number

I hereby give my consent to the staff at Hamza Academy to authorize emergency medical, surgical and/or dental treatment for my child if I cannot be reached. In consideration of the services provided to my child by Hamza Academy, I hereby agree to indemnify and hold harmless Hamza Academy, its directors, agents, employees or volunteers from any and all losses, liabilities, claims, damages, costs and expenses which may arise as a consequence or result of the release of my child to any of the aforementioned substitutes.

Parent Name:	*Signature:*	*Date:*

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SECTION F - HAMZA ACADEMY POLICIES CONTRACT (Please initial your name)

- ____I understand that I will familiarize myself with school rules and policies and require my child to follow them at all times.
- ____I understand that I am responsible for the enrollment fees during the time of registration which are refundable if my child is not accepted.
- ____I understand that I am responsible for paying each month's tuition on time. I understand that I have to fulfill all financial agreements, including the daily $10 service fee for overdue tuition. I understand that If I plan to go away for a month (or more) during the school year, I am still responsible for the remaining balance. My child may need to be discharged and re-enrolled upon our return. I understand that this may impact my child's academic standing.
- **____I understand that, per our family handbook, my child/ren will be discharged from the school, if 2 payments are missed for the upcoming school year.**
- ____I understand that Hamza Academy reserves the right to discharge a student at any time (due to safety, behavioral, academic reasons or non-payment of fees). Hamza Academy reserves the right to request parents to enroll a special needs student at another facility, in order for the student to receive professional special needs services that Hamza Academy cannot provide. Hamza Academy reserves the right for academic/behavioral or other screening of any student. If further evaluation is recommended, the school district and/or parents will be notified.
- ____I understand that If I must follow the school parking lot policy during school hours. This includes not blocking the exit points during the school drop off or pick up timings and no loitering, waiting, or socializing during the parking lot/playground during school hours.
- ____I understand that parents and students must abide by all school rules and regulations (e.g. uniform, I.D., etc.). The school reserves the right to fail any student who do not meet school standards.
- ____I understand that tuition is non refundable or transferable for any reason such as suspensions, expulsions, or school closings. In order to re-register, all previous accounts must be paid in full. Parents who withdraw their children anytime during the school year are responsible for ONE MONTH tuition due to our penalty withdrawal policy. Upon withdrawal from the school, all payments must be paid in cash or money order (no checks). School transcripts/records and all official letters will be held until all accounts are paid in full.
- ____I understand that my child's enrollment status and/or student records may be affected if 1) tuition and fees are not fulfilled by the given deadlines or 2) a school policy is broken, pending the decision of the School Director and Board. Fees are subject to change and you will be notified of any changes.
- ____I understand that returned/bounced checks due to "insufficient funds" will incur a fee of a minimum of $25 per check.
- ____Parents are responsible for paying for any lost/stolen textbooks. Parents are entitled to all workbooks.
- ____I understand that I give the school authorization for immediate medical care, in the event that my child needs immediate emergency attention.
- ____I understand that students must be picked up by dismissal time. They will only be released to their parents or an authorized person on the pick-up list. Students left by parents/guardians in the school building before/after school hours will not be the responsibility of the school. Students who are picked up after dismissal time will be charged a late pick-up fee of $25.00 daily.
- ____I understand that if deemed necessary by school personnel, I authorize Hamza Academy to initiate any evaluations through the School District office relating to my child's needs. I understand that initiating this process may result in services being provided in order to meet my child's needs. I will be informed prior to any actions taken regarding my child.
- ____I understand that my child may participate in interviews, the use of quotes, photographs, movies, and/or videos that may be published in print and/or electronically. Hamza Academy may use photographs of my child and his/her name for any lawful purposes, including publicity, school newsletter, school website, school brochure, school advertising, school web content, etc. I also hereby release Hamza Academy and its school's representatives and employees from all claims, demands, and liabilities whatsoever in connection with the above. (Parents may file written "do not photograph/do not record" statement with main office in the form of a letter)
- ____Hamza Academy cannot be held accountable for any liability resulting from student participation in field trips, except in case of its sole and gross negligence, for damage because of bodily injury, including death at any time resulting therefrom, sustained by any child or by any person or persons, or on account of damage to property arising out of such participation. A permission slip must be signed by parents for every trip separately.
- ____I Understand that Hamza Academy cannot be held accountable for any liability resulting from student participation in any physical activities provided by Hamza Academy including but not limited to gym, except in case of its sole and gross negligence,

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for damage because of bodily injury, including death at any time resulting therefrom, sustained by any child or by any person or persons, or on account of damage to property arising out of such participation. Parents may file written "non-participation" statement from student's doctor detailing temporary or permanent physical limitations due to a medical condition with school office.

- ____I understand that my child's attendance at Hamza Academy is very important. We are concerned about the academic growth of your child. Hamza Academy is mandated by as well as compliance with New York State Law to monitor and report attendance. If your child is going to be absent, we ask that you call our school to notify us BEFORE 9:00 AM, and also provide the reason. If we do not hear from you, an office staff from Hamza Academy will call you. Additionally, according to New York State mandates, if your child has frequent absences in a week, you are required to provide a medical note from your child's primary physician. I understand that I am required to provide documentation from my child's primary physician for three consecutive days or more that my child has not been present at school. I understand that a notice of extended leave of absence form must be completed prior to traveling time and tuition installments must be fulfilled prior to leave.
- ____I understand that students are expected to attend school all day, and every day that school is in session. Parents are asked to cooperate with this expectation and not ask to have children leave before regular dismissal time (2:45 p.m.) Interruptions to the school day should be avoided. I understand that I should schedule any medical and dental appointments after school hours, so learning time is not disrupted.
- ____I understand that I will update the school with any changes with the information provided on the application.
- ____I understand that by registering and maintaining enrollment in all upcoming years, parents and students agree to abide by all school policies, terms, and conditions until the child is enrolled in Hamza Academy.

By signing below, I understand all of Hamza Academy terms and policies stipulated in the Family Handbook, which can be found online, and stated above.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Relationship to Student: _____ Date: _____

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SECTION G - RECORDS RELEASE AGREEMENT

Under the Family and Education Rights and Privacy Act (FERPA), schools have the right to disclose information records, without consent, to the following parties or under the following conditions (34 CFR § 99.31):

- School officials with legitimate educational interest;
- Other schools to which a student is transferring;
- Specified officials for audit or evaluation purposes;
- Appropriate parties in connection with financial aid to a student;
- Organizations conducting certain studies for or on behalf of the school;
- Accrediting organizations;
- To comply with a judicial order or lawfully issued subpoena;
- Appropriate officials in cases of health and safety emergencies; and
- State and local authorities, within a juvenile justice system, pursuant to specific State law.

I hereby authorize Hamza Academy to release any student records as necessary. I also hereby authorize Hamza Academy to obtain all _____'s student records from:

_____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date:_____

SECTION H - CUSTODY REQUIREMENTS

If you are legally separated or divorced, the law requires you to provide Hamza Academy with a copy of the child custody order or decree indicating full or joint (shared) custody and indicate the residential parent for school purposes. These papers must be court stamped and include the signature page. Also, whenever there is a modification of the order or decrees, the custodial parent/guardian shall provide the school with a copy of the updated order of decree that makes the modification. The order should be included with this form.

☐ I am the child's legal guardian.

☐ I have legal full or joint (shared) custody of the child as assigned by the courts.

☐ I do not have full or joint (shared) custody of the child as assigned by the courts. Please explain:

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Relationship to Student: _____ Date: _____

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PLEASE CIRCLE WHICH TUITION PLAN YOU AGREE TO FULFILL FOR 2020-2021

TUITION PLAN OPTIONS OVER 10 MONTHS

STuition Amount Annually $5,250 - 1 Child $10,130 - 2 Siblings $14,600 - 3 Siblings	PLAN 1 (5% Discount) Lump Sum Payment Plan $4,988 - 1 Child $9,624 - 2 Siblings $13,870 - 3 Siblings	PLAN 2 (2 % Discount) Bi-Annual Payment Plan $5,145 - 1 Child $9,927 - 2 Siblings $14,308 - 3 Siblings	PLAN 3 Monthly Payment Plan $5,250 - 1 Child $10,130 - 2 Siblings $14,600 - 3 Siblings
Payment Due On 8/24/20	$4,988 - 1 Child $9,626 - 2 Siblings $ 13,866 - 3 Siblings	$2,573 - 1 Child $4,964 - 2 Siblings $7,154 - 3 Siblings	$525 - 1 Child $1,013 - 2 Siblings $ 1,460 - 3 Siblings
TBD			$525 - 1 Child $1,013 - 2 Siblings $ 1,460 - 3 Siblings
TBD			$525 - 1 Child $1,013 - 2 Siblings $ 1,460 - 3 Siblings
TBD			$525 - 1 Child $1,013 - 2 Siblings $ 1,460 - 3 Siblings
TBD			$525 - 1 Child $1,013 - 2 Siblings $ 1,460 - 3 Siblings
TBD		$2,573 - 1 Child $4,964 - 2 Siblings $7,154 - 3 Siblings	$525 - 1 Child $1,013 - 2 Siblings $ 1,460 - 3 Siblings
TBD			$525 - 1 Child $1,013 - 2 Siblings $ 1,460 - 3 Siblings
TBD			$525 - 1 Child $1,013 - 2 Siblings $ 1,460 - 3 Siblings
TBD			$525 - 1 Child $1,013 - 2 Siblings $ 1,460 - 3 Siblings
TBD			$525 - 1 Child $1,013 - 2 Siblings $ 1,460 - 3 Siblings

*****PAYMENTS DUE DATES SUBJECT TO CHANGE****

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:		
First	*Middle*	*Last*

DATE OF BIRTH:			GENDER:
Month	*Day*	*Year*	❑ Male ❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	*First Name*	*Relation to Student*

HOME LANGUAGE CODE _____

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other _____ *specify*	
2. What was the first language your child learned?	❑ English	❑ Other _____ *specify*	
3. What is the Home Language of each parent/guardian?	❑ Mother _____ *specify*	❑ Father _____ *specify*	❑ Guardian(s) _____ *specify*
4. What language(s) does your child understand?	❑ English	❑ Other _____ *specify*	
5. What language(s) does your child speak?	❑ English	❑ Other _____ *specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other _____ *specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other _____ *specify*	❑ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:		STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School	*Address*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes* ***No*** ***Not sure***
❑ ❑ ❑ ***If yes,** please explain:_____

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ❑ No ❑ Yes* **Please complete 10b below*

10b. **If referred for an evaluation,* has your child ever *received* any special education services in the past?
❑ No ❑ Yes – Type of services received:_____

Age at which services received *(Please check all that apply):*
❑ Birth to 3 years (Early Intervention) ❑ 3 to 5 years (Special Education) ❑ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ❑ No ❑ Yes

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

_____ Month: Day: Year:
Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ❑ Mother ❑ Father ❑ Other:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ **POSITION:** _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ **POSITION:** _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

****DATE OF INDIVIDUAL INTERVIEW:** _____ (MO DAY YR.)

OUTCOME OF INDIVIDUAL INTERVIEW:
❑ ADMINISTER NYSITELL
❑ ENGLISH PROFICIENT
❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ **POSITION:** _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly Press Hard

STUDENT ID NUMBER OSIS

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | **Sex** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* __ __ / __ __ / __ __ __ __

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other _____

City/Borough | State | Zip Code | School/Center/Camp Name | District Number __ __ __ | **Phone Numbers** *Home* _____ *Cell* _____ *Work* _____

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ **Parent/Guardian** Last Name | First Name | ☐ **Foster Parent**

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF/Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ **Other** *(specify)* _____

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

_____

_____

Dietary Restrictions

☐ None ☐ Yes *(list below)*

_____

PHYSICAL EXAMINATION

Height _____ **cm** (__ __ %ile)

Weight _____ **kg** (__ __ %ile)

BMI _____ **kg/m²** (__ __ %ile)

Head Circumference *(age ≤2 yrs)* _____ **cm** (__ __ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

	NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl
☐	☐	HEENT	☐	☐	Lymph nodes	☐	☐	Abdomen	☐	☐	Skin	☐	☐	Psychosocial Development
☐	☐	Dental	☐	☐	Lungs	☐	☐	Genitourinary	☐	☐	Neurological	☐	☐	Language
☐	☐	Neck	☐	☐	Cardiovascular	☐	☐	Extremities	☐	☐	Back/spine	☐	☐	Behavioral

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* _____

☐ Communication/Language _____

☐ Social/Emotional _____

☐ Adaptive/Self-Help _____

☐ Motor _____

SCREENING TESTS	*Date Done*	*Results*
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	__/__/__	_____ µg/dL
	__/__/__	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	__/__/__	☐ At risk *(do BLL)* ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	__/__/__	☐ Normal ☐ Abnormal
Head Start Only		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__/__/__	_____ g/dL _____ %

	Date Done	*Results*
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__/__/__	Induration _____mm
PPD/Mantoux *read*	__/__/__	☐ Neg ☐ Pos
Interferon Test	__/__/__	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__/__/__	☐ NI ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__/__/__ ☐ with glasses	Acuity *Right* ___ / ___ *Left* ___ / ___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child

Hep B	__/__/__	__/__/__	__/__/__	__/__/__
Rotavirus	__/__/__	__/__/__	__/__/__	__/__/__
DTP/DTaP/DT	__/__/__	__/__/__	__/__/__	__/__/__
	__/__/__	__/__/__	__/__/__	__/__/__
Hib	__/__/__	__/__/__	__/__/__	__/__/__
PCV	__/__/__	__/__/__	__/__/__	__/__/__
Polio	__/__/__	__/__/__	__/__/__	__/__/__

Influenza	__/__/__	__/__/__	__/__/__	__/__/__
MMR	__/__/__	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__		
Td	__/__/__	__/__/__	__/__/__	__/__/__
Tdap __/__/__	Hep A	__/__/__	__/__/__	
Meningococcal	__/__/__	__/__/__		
HPV	__/__/__	__/__/__	__/__/__	
Other, *specify:* _____	__/__/__	_____	__/__/__	

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions *(specify)* _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __/__/__

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other _____

ASSESSMENT ☐ **Well Child** (V20.2) ☐ **Diagnoses/Problems** *(list)* **ICD-9 Code**

_____ __ __ __ __

_____ __ __ __ __

_____ __ __ __ __

Health Care Provider Signature | Date __ __ / __ __ / __ __

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (__ __ __) __ __ __ – __ __ __ __ | Fax (__ __ __) __ __ __ – __ __ __ __

DOHMH ONLY **PROVIDER I.D.**

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments

Date Reviewed: __/__/__ **I.D. NUMBER**

REVIEWER:

Copies: **White** School/Child Care/Early Intervention/Camp, **Canary** Health Care Provider, **Pink** Parent/Guardian

Date Withdrew_____ **Attachment Va** F ____R _____D_____

2019-2020 Application for Free and Reduced Price School Meals/Milk

To apply for free and reduced price meals for your children, read the instructions on the back, complete **only one** form for your household, sign your name and **return it to the address listed below.** Call ***(phone number),*** if you need help. Additional names may be listed on a separate paper.

Return Completed Applications to: **(School Name)**
(Street Name)
(City, State , Zip Code)

1. List all children in your household who attend school:

Student Name	School	Grade/Teacher	Foster Child	Homeless Migrant, Runaway
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

2. SNAP/TANF/FDPIR Benefits:
If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. **Skip to Part 4, and sign the application.**

Name: _____ CASE #: _____

3. Report all income for ALL Household Members (Skip this step if you answered 'yes' to step 2)

All Household Members (including yourself and all children that have income).
List all Household members not listed in Step 1 (including yourself) **even if they do not receive income**. For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any other source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of household member	Earnings from work before deductions ***Amount / How Often***	Child Support, Alimony ***Amount / How Often***	Pensions, Retirement Payments ***Amount / How Often***	Other Income, Social Security ***Amount / How Often***	No Income
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐

Total Household Members (Children and Adults) ☐☐

***Last Four Digits of Social Security Number:** XXX-XX- __ __ __ __ I do not have a SS# ☐

*When completing section 3, an adult household member must provide the last four digits of their Social Security Number (SS#), or mark the "I do not have a SS# box" before the application can be approved.

4. Signature: An adult household member must sign this application before it can be approved.
I certify (promise) that all the information on this application is true and that all income is reported. I understand that the information is being given so the school will get federal funds; the school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.
Signature: _____ **Date:** _____
Email Address: _____
Home Phone: _____ Work Phone: _____ Home Address:_____

5. Ethnicity and Race are optional; responding to this section does not affect your children's eligibility for free or reduced price meals.

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

Race (Check one or more) : ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Island ☐White

DO NOT WRITE BELOW THIS LINE – FOR SCHOOL USE ONLY

Annual Income Conversion (Only convert when multiple income frequencies are reported on application)
Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

☐ SNAP/TANF/Foster
☐ Income Household: Total Household Income/How Often: _____/_____ Household Size: _____
☐ Free Meals ☐ Reduced Price Meals ☐ Denied/Paid
Signature of Reviewing Official_____ Date Notice Sent:_____

APPLICATION INSTRUCTIONS

To apply for free and reduced price meals, complete only one application for your household using the instructions below. Sign the application and return the application to _____.
If you have a foster child in your household, you may include them on your application. A separate application is not needed. Call the school if you need help: _____. Ensure that all information is provided. Failure to do so may result in denial of benefits for your child or unnecessary delay in approving your application.

PART 1 ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE APPLICATION FOR YOUR HOUSEHOLD.

(1) Print the names of the children, including foster children, for whom you are applying on one application.
(2) List their grade and school.
(3) Check the box to indicate a foster child living in your household, or if you believe any child meets the description for homeless, migrant, runaway (a school staff will confirm this eligibility).

PART 2 HOUSEHOLDS GETTING SNAP, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN PART 4.

(1) List a current SNAP, TANF or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. The case number is provided on your benefit letter.
(2) An adult household member must sign the application in PART 4. SKIP PART 3. Do not list names of household members or income if you list a SNAP case number, TANF or FDPIR number.

PART 3 ALL OTHER HOUSEHOLDS MUST COMPLETE THESE PARTS AND ALL OF PART 4.

(1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are applying for, all other children, your spouse, grandparents, and other related and unrelated people in your household. Use another piece of paper if you need more space.
(2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. Specify how often this income amount is received: weekly, every other week (bi-weekly), 2 x per month, monthly. If no income, check the box. The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should not be considered as income for this program.
(3) Enter the total number of household members in the box provided. This number should include all adults and children in the household and should reflect the members listed in PART 1 and PART 3.
(4) The application must include the last four digits only of the social security number of the adult who signs PART 4 if Part 3 is completed. If the adult does not have a social security number, check the box. If you listed a SNAP, TANF or FDPIR number, a social security number is not needed.
(5) An adult household member must sign the application in PART 4.

OTHER BENEFITS: Your child may be eligible for benefits such as Medicaid or Children's Health Insurance Program (CHIP). To determine if your child is eligible, program officials need information from your free and reduced price meal application. Your written consent is required before any information may be released. Please refer to the attached parent Disclosure Letter and Consent Statement for information about other benefits.

USE OF INFORMATION STATEMENT

Use of Information Statement: 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 primary wage earner or other adult household member who signs the application. 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.

DISCRIMINATION COMPLAINTS

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, 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.

This institution is an equal opportunity provider.