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| --- | --- |
| Date: |  |

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| Dear Parent/Guardian of: |  |
|  | *Name of children and schools* |
| Effective on this date,**[insert date]***,* your application for free or reduced-price meals or free milk for your child has been:  |
| 🞎 | **APPROVED** for free (meals/milk). |
| 🞎 | **APPROVED** for reduced-price meals at $ **[insert price of reduced-price lunch]** for lunch and $ **[insert price of reduced-price breakfast]** for breakfast. |
|  | **Note:** If approved for free or reduced-price meals, maintain this copy for your records. This may be used as proof of this eligibility for other programs. |
| 🞎 | **DENIED** for the following reasons: |  |
|  | 1. Your income is higher than the qualifying income guidelines. The price of a paid lunch is $ **[insert price of paid lunch]**.
 |
|  | 1. We need more information. ***Please supply:***
 |
|  | * Proof from DSS of a Temporary Family Assistance (TFA) or Supplemental Nutrition Assistance Program (SNAP) Client ID Case Number. *(Not a copy of the CONNECT card.)*
* Income
* Clarification on the frequency of income
* The last four digits of your social security number or check the “No Social Security Number” box.
* Total number in family/household
* Names of **all** household members
* Original signature
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|  | * Other:
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Please note that your eligibility determination for free or reduced-price meals is valid for the entire school year unless you are selected during the school year for verification and the verification determination does not support your current benefit level.

If you have been denied benefits and your income or household size changes, you may reapply for free or reduced-price meals or free milk at any time during the school year.

If you do not agree with the decision, you may discuss it with the school. You may appeal the decision by calling or writing **[insert name and title of hearing official], [insert address city, state, and zip code], [insert telephone number], [insert e-mail address].** An appeal must be filed within the 10 calendar days advance notice period to ensure continued benefits while awaiting a hearing and decision.

|  |  |
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| Signature of Determining Official: |  |
| Date: |  |

**Nondiscrimination Statement:** This explains what to do if you believe you have been treated unfairly.

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/ad-3027.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:

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
2. fax: (833) 256-1665 or (202) 690-7442; or
3. email:program.intake@usda.gov

This institution is an equal opportunity provider.