Prescribed by State Board of Accounts School Form No. 521 / 2018

SCHOOL CORPORATION	CORP. NUMBER

APPLICATION FOR CURRICULAR MATERIAL ASSISTANCE AND OTHER ASSISTANCE
Effective July 1, 20_____- One Application per **Household**

Part 1. Names of **all** household members (First, Middle Initial, Last)	Living with parent or caretaker relative?	Only for students: Name of each child's school building	Student? Yes or No	Only for students: Grade	Only for students: Birthdate	Check if a Foster child	Check if Homeless, Migrant, Runaway	Check if no income
	Yes ☐ No ☐		Yes ☐ No ☐			☐	☐	☐
	Yes ☐ No ☐		Yes ☐ No ☐			☐	☐	☐
	Yes ☐ No ☐		Yes ☐ No ☐			☐	☐	☐
	Yes ☐ No ☐		Yes ☐ No ☐			☐	☐	☐
	Yes ☐ No ☐		Yes ☐ No ☐			☐	☐	☐
	Yes ☐ No ☐		Yes ☐ No ☐			☐	☐	☐
	Yes ☐ No ☐		Yes ☐ No ☐			☐	☐	☐
	Yes ☐ No ☐		Yes ☐ No ☐			☐	☐	☐
	Yes ☐ No ☐		Yes ☐ No ☐			☐	☐	☐
		If ALL children listed above are foster children, skip to Part 5 and sign.						

Part 2. If any member of your household (student, adult or non-student) has a valid Food Stamp (SNAP) or TANF case number, please provide the name of the person who receives benefits, check the box indicating the benefit program, and enter the case number, then skip to Part 5. If no one receives these benefits, skip to Part 3.
Name:_____ **Food Stamp** ☐ **TANF** ☐ **Case Number:**___/___/___/___/___/___/___/___/___/___

Part 3. If any child you are applying for is migrant, homeless, or runaway, check the appropriate box and call **at**

Part 4.	**Section 2** TOTAL HOUSEHOLD GROSS INCOME (BEFORE DEDUCTIONS). LIST ALL INCOME ON THE SAME LINE AS THE PERSON WHO RECEIVES IT. CHECK THE BOX FOR HOW OFTEN IT IS RECEIVED. RECORD EACH INCOME ONLY ONCE. **GROSS INCOME and HOW OFTEN IT WAS RECEIVED** *Examples: $100 / monthly or $100 / every 2 weeks or $100 / twice a month or $100 / weekly*																			
Section 1 Name of Household Member (First and Last)	Earnings from Work	Weekly	Every 2	Twice A	Monthly	Public Assistance/ Child Support/ Alimony	Weekly	Every 2	Twice A	Monthly	Pensions/ Retirement	Weekly	Every 2	Twice A	Monthly	All Other Income	Weekly	Every 2	Twice A	Monthly
Example: Jane Smith	*$ 200*	☐	☒	☐	☐	*$ 150*	☒	☐	☐	☐	*$ 100*	☐	☐	☐	☒	*$ 50*	☐	☐	☐	☒
1.	*$*	☐	☐	☐	☐	*$*	☐	☐	☐	☐	*$*	☐	☐	☐	☐	*$*	☐	☐	☐	☐
2.	*$*	☐	☐	☐	☐	*$*	☐	☐	☐	☐	*$*	☐	☐	☐	☐	*$*	☐	☐	☐	☐
3.	*$*	☐	☐	☐	☐	*$*	☐	☐	☐	☐	*$*	☐	☐	☐	☐	*$*	☐	☐	☐	☐
4.	*$*	☐	☐	☐	☐	*$*	☐	☐	☐	☐	*$*	☐	☐	☐	☐	*$*	☐	☐	☐	☐
5.	*$*	☐	☐	☐	☐	*$*	☐	☐	☐	☐	*$*	☐	☐	☐	☐	*$*	☐	☐	☐	☐
6.	*$*	☐	☐	☐	☐	*$*	☐	☐	☐	☐	*$*	☐	☐	☐	☐	*$*	☐	☐	☐	☐

7.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

Part 5. Do you want to receive Curricular Material assistance? Yes ☐ No ☐

Part 6. SIGNATURE: My signature below authorizes the release of information on this application for curricular material assistance. I give up my right of confidentiality for this purpose only. The application may be subject to audit by the State of Indiana to determine student eligibility for curricular materials. The application information may be shared with the Indiana Family and Social Services Administration pursuant to I.C. 20-33-5-2 and I.C. 12-14-28-2, solely for purposes of complying with 45 C.F.R. PARTS 260 AND 265 and for the purpose of identifying children who may qualify for free or low-cost health insurance under Medicaid or Hoosier Healthwise. I certify that I am the parent/guardian of the child(ren) for whom application is being made and authorize the release of information for the purposes outlined in the application.

School Use Only:
___ Approved
___ Denied
___ Not applicable

_____ xxx-xx- _____
(Printed name) **(last 4 digits of social security number)**

_____ _____
(Signature of adult completing the form) **(Today's date)**

Part 7. RACE AND ETHNICITY:
Optional - You are not required to answer this question. No child will be discriminated against because of race, color, sex, national origin, age, or disability.

Race (check one or more) :
- ☐ Asian
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Mark one ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Part 8. For information about Hoosier Healthwise health insurance, call 1-800-889-9949.

FOR SCHOOL USE ONLY – DO NOT WRITE BELOW THIS LINE

INCOME CONVERSION to YEARLY: WEEKLY INCOME X 52

EVERY 2 WEEKS X 26	TWICE A MONTH X 24	MONTHLY INCOME X 12

ELIGIBILITY DETERMINATION

Income Eligibility: Total Household Size:_____Total Income:$_____per: ϒ Weekly ϒ Every 2 Weeks ϒ Monthly
ϒ Twice a Month ϒ Yearly
OR Categorical Eligibility: ϒ Food Stamps ϒ TANF ϒ Migrant ϒ Homeless ϒ Runaway ϒ Foster
Eligibility Determination: ϒ Approved Free ϒ Approved Reduced Price • Denied
Reason for Denial: ϒ Income Too High ϒ Incomplete Application ϒ Other(Reason)_____
Signature of Determining Official:_____Date:_____
Date Withdrawn: _____

VERIFICATION

Confirmation Review Official: _____ Date Verification Notice Sent: _____ Date Response due from Households: _____ Date Second Notice Sent (or N/A): _____	**Approval Based on:** ___ Food Stamps//TANF Case Number ___ Household Size and Income ___ Other	**Verification results:** ___ NO change ___ Free to Reduced ___ Free to Paid ___ Reduced to Free ___ Reduced to Paid	**Reason for Change:** ___ Income: _____ ___ Household Size_____ ___ Change in Food Stamps/TANF _____ ___ Did not respond ___ Other_____	**Date Notice of Change Sent** _____ **Date Change Made:** _____

Request for appeal	**Verifying Official's Signature** _____
Date Hearing Requested: _____	Signature date: _____
Hearing Decision: _____	

Use of Information Statement: This explains how we will use the information you give us.
The information contained in the application will be used to determine eligibility for curricular materials assistance under Indiana Code 20-33. You do not have to provide the information, but if you do not, we cannot approve your child for curricular materials assistance. You must include the last four digits of the social security number of the adult household member who signs the application. The last four 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 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 the State of Indiana school curricular materials program. 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.