Attachment D

06/18

SAMPLE NOTIFICATION FORM
Insert school name and address here

Date:_____

Dear_____

Your child(ren) _____
_____
_____

have been:

☐ **Approved for free meals starting _____because:**
- ☐ **one or more of your children were directly certified***
- ☐ your household income was within the eligibility limits
- ☐ the child(ren) listed above is/are a foster child(ren) indicated on an application
- ☐ your child(ren) is/are homeless or runaway
- ☐ your child is enrolled in Head Start
- ☐ your child(ren) live(s) in a household where a member's case number for Food Assistance (FA) or the Family Investment Program (FIP) was written on an application or you submitted a letter from DHS indicating your participation in one of these programs

☐ **Approved for reduced price meals starting _____because: ($____ for lunch, $____ for breakfast and $____ for snacks)**
- ☐ **one or more of your children were directly certified*.** Your household income as reported to DHS was within the reduced price eligibility limits. See the income guidelines which were in the Information Letter you received and if you feel you would qualify for free meal benefits, complete an application for free and reduced price meals.
- ☐ your household income was within the eligibility limits based on the application you submitted to the school.

*If your children were directly certified automatically for free or reduced price meal benefits, Federal law allows us to receive information about your family's participation in Food Assistance (FA), Family Investment Program (FIP) or a few specific Medicaid programs to determine meal eligibility. No other information about your household has been shared. **Your child(ren) listed will get meal benefits automatically. No further application is necessary.** If there are additional students in your household, you must notify the school, as meal benefits may extend to them. If you do **NOT** want your child(ren) to receive these automatic meal benefits, you must inform us. Fill in the information on the other side of this form and return this form to the school within ten calendar days of the date on this letter if you DO NOT want your children to get free or reduced price meals.

☐ **Denied benefits because:**
- ☐ your income is over the allowable amount
- ☐ your application was incomplete because _____

☐ **Identified as receiving an incorrect benefit type**

Starting **[insert date- if increasing benefits, must be within 3 operating days from the date this letter is sent. If decreasing benefits must be changed within 10 operating days following the appeal period date specified below]** your child(ren)'s eligibility status for meals will be changed from _____ to _____ because _____.

If you disagree with this decision, you may discuss it with **[Name]** at **[Phone].** You also have the right to a fair hearing. If you request a hearing by **[insert date that is 10 calendar days from the date this letter is sent],** your children will continue to receive free or reduced price meals until the decision of the hearing official is made. If you wish to review the decision further, you have a right to a fair hearing. This can be done by calling or writing the following official:

NAME _____ PHONE _____

ADDRESS _____

You may reapply for benefits at any time during the school year. If you are not eligible now but have a decrease in household income, become unemployed, or have an increase in family size, fill out an application at that time.

You may be eligible for Food Assistance. Food Assistance, also known as Food Stamps, is a program to help buy food for good health. If you want information or you want to apply, call 1-877-347-5678. Go to www.yesfood.iowa.gov to apply online.

If you have questions or if one or more of your children are not listed above, CONTACT YOUR CHILDREN'S SCHOOL.

Return this page to your school if you complete the section refusing meal benefits, decline having your information shared with hawk-i or Medicaid or sign the waiver statement.

REFUSAL OF MEAL BENEFITS BASED ON DIRECT CERTIFICATION

I DO NOT want my child(ren) to receive meal benefits.

Child's Name: _____ School: _____
Child's Name: _____ School: _____
Child's Name: _____ School: _____

Parent/Guardian Name (Print)_____
Signature_____ Date_____

DO NOT FILL IN THIS BOX IF YOU WANT YOUR CHILDREN TO RECEIVE FREE OR REDUCED PRICE MEALS.

hawk-i /Medicaid Information Form

Read this information. Sign below and return this page to the school **if you decide you do not want** your name released to ***hawk-i*** or Medicaid. If your children do not have health insurance, many families getting free or reduced price meals can also get free or low-cost health insurance for their children. The law requires public schools to share your free or reduced price meal eligibility information with Medicaid & ***hawk-i***, the State's medical insurance program for children. Private schools, RCCIs and childcare organizations may choose to share this information. Specifically, we will give them your child's name, your name and address. Medicaid and ***hawk-i*** can only use the information to identify children who may be eligible for free or low-cost health insurance & then to contact you. They are not allowed to use the information from your free and reduced meal application for any other purpose or to share it with any other entity or program. You are not required to allow us to share this information, it will not affect your child's eligibility for free or reduced price meals. If you do NOT want your information shared with Medicaid or ***hawk-i***, you must tell us by completing the information below. If you want further information, you may call ***hawk-i*** at 1-800-257-8563. Also, if you are already receiving Medicaid or ***hawk-i***, please sign below. This will avoid another contact.

I DO NOT want school officials to share information from my free and reduced price meal application with Medicaid or ***hawk-i***..

Parent/Guardian Name (Printed) _____ Signature _____ Date _____

Optional Waiver Information for Directly Certified Households

USDA Nondiscrimination Statement

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.

Iowa Nondiscrimination Statement:

"It is the policy of this CNP provider not to discriminate on the basis of race, creed, color, sex, sexual orientation, gender identity, national origin, disability, age, or religion in its programs, activities, or employment practices as required by the Iowa Code section 216.6, 216.7, and 216.9. If you have questions or grievances related to compliance with this policy by this CNP Provider, please contact the Iowa Civil Rights Commission, Grimes State Office building, 400 E. 14th St. Des Moines, IA 50319-1004; phone number 515-281-4121, 800-457-4416; website: https://icrc.iowa.gov/."