

Formulario de Matrícula Arickaree Elementary

Nombre:		Segundo Nombre:		Apellido:	
Apellido:		Grado:		Lugar de Nacimiento:	
Raza: Indio Americano o Nativo de Alaska		Asiático		Afroamericano	
Hispano/Latino? Si No (subrayar uno)		GAcnero:		Lenguaje del Hogar:	
Acceso a Internet?		Mobil #		Email:	
Residencia Primaria (En la cual el Estudiante Reside)					
Postal:			Calle:		
Ciudad:		Estado:	CA3digo Postal:	Ciudad:	
Estado:		CA3digo Postal:	Estado:		CA3digo Postal:
TelAcfono:					
Informaci3n de los adultos que residen en la direcci3n arriba indicada					
Nombre:		Relaci3n:		Trabaja Para:	
Trabajo #		Mobil #		Cuenta POL:	
Email:		Email de trabajo:		Recibir correspondencia impresa:	
Nombre:		Relaci3n:		Trabaja Para:	
Trabajo #		Mobil #		Cuenta POL:	
Email:		Email de trabajo:		Recibir correspondencia impresa:	
Residencia Adicional (No Custodia)					
Postal:			Calle:		
Ciudad:		Estado:	CA3digo	Ciudad:	
Estado:		CA3digo Postal:	Estado:		CA3digo Postal:
TelAcfono:					
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Nombre:		Relaci3n:		Trabaja Para:	
Trabajo #		Mobil #		Cuenta POL:	
Email:		Email de trabajo:		Recibir correspondencia impresa:	
Residencia Adicional (No Custodia)					
Postal:			Calle:		
Ciudad:		Estado:	CA3digo Postal:	Estado:	
Estado:		CA3digo	Estado:		CA3digo
Phone:					
Informaci3n de los adultos que residen en la Direcci3n arriba indicada					
Nombre:		Relaci3n:		Trabaja Para:	
Trabajo #		Mobil #		Cuenta POL:	
Email:		Email de trabajo:		Recibir correspondencia impresa:	
Nombre:		Relaci3n:		Trabaja Para:	
Trabajo #		Mobil #		Cuenta POL:	
Email:		Email de trabajo:		Recibir correspondencia impresa:	
Contactos de Emergencia: aAdir adicionales no listados en las encasillados superiores					
Nombre:		Relaci3n:		Email:	
Hogar #		Trabajo #		Mobil #	
Nombre:		Relaci3n:		Email:	
Hogar #		Trabajo #		Mobil #	
Nombre:		Relaci3n:		Email:	
Hogar #		Trabajo #		Mobil #	
Informaci3n de Emergencia Medica					
Medico:		TelAcfono:		Hospital:	
Notas Medicas:					
Informaci3n de la guarderA-a (si aplica)					
Proveedor:			TelAcfono:		
Hermanos (ostros estudiantes viviendo en la misma direcci3n					
Nombre	Segundo Nombre	Apellido	Grado	Fecha De Nacimiento	Escuela

Atte: _____ firma: _____ Fecha: _____

Enrollment Form for Arickaree Elementary

First Name:		Middle:		Last Name:	
Preferred Name:		Grade:		Birth Place: DOB:	
Race: Amer. Indian or Alaska Native Asian Black or African American Native Hawaiian/Pac Islander White (<i>underline</i>)					
Hispanic/Latino? Yes No (<i>underline one</i>)		Gender:		Home Lang.:	
Access Internet?		Cell #		Email:	

PRIMARY HOUSEHOLD (STUDENT RESIDES AT)

Mailing:			Street:		
City:	State:	Zip:	City:	State:	Zip:

Information for adults living at the above address.

Name:		Relationship:		Employer:	
Work #		Cell #		POL Account: Receive Printed Mailings:	
Email:		Wk Email:		Home #	
Name:		Relationship:		Employer:	
Work #		Cell #		POL Account: Receive Printed Mailings:	
Email:		Wk Email:		Home #	

ALTERNATE HOUSEHOLD (NON-CUSTODIAL)

Mailing:			Street:		
City:	State:	Zip:	City:	State:	Zip:

Information for adults living at the above address.

Name:		Relationship:		Employer:	
Work #		Cell #		POL Account: Receive Printed Mailings:	
Email:		Wk Email:		Home #	
Name:		Relationship:		Employer:	
Work #		Cell #		POL Account: Receive Printed Mailings:	
Email:		Wk Email:		Home #	

ALTERNATE HOUSEHOLD (NON-CUSTODIAL)

Mailing:			Street:		
City:	State:	Zip:	City:	State:	Zip:

Information for adults living at the above address.

Name:		Relationship:		Employer:	
Work #		Cell #		POL Account: Receive Printed Mailings:	
Email:		Wk Email:		Home #	
Name:		Relationship:		Employer:	
Work #		Cell #		POL Account: Receive Printed Mailings:	
Email:		Wk Email:		Home #	

EMERGENCY CONTACTS: Enter additional contacts not listed above.

Name:		Relationship:		Email:	
Home #		Work #		Cell #	
Name:		Relationship:		Email:	
Home #		Work #		Cell #	
Name:		Relationship:		Email:	
Home #		Work #		Cell #	

Emergency Medical Information

Physician:		Phone:		Hospital:	
Medical Notes:					

Daycare Information (if applicable)

Provider:			Phone:		
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SIBLINGS (other students living at same address)

First Name	Middle Name	Last Name	Grade	Birthdate	School Name

Completed By: _____ Signature: _____ Date: _____

Enrollment Form for Arickaree Jr/Sr High School

First Name:		Middle:		Last Name:	
Preferred Name:		Grade:		Birth Place:	
				DOB:	
Race:		Amer. Indian or Alaska Native		Asian	
		Black or African American		Native Hawaiian/Pac Islander	
		White		<i>(underline)</i>	
Hispanic/Latino? Yes No <i>(underline one)</i>		Gender:		Home Lang.:	
Access Internet?		Cell #		Email:	

PRIMARY HOUSEHOLD (STUDENT RESIDES AT)

Mailing:			Street:		
City:	State:	Zip:	City:	State:	Zip:

Information for adults living at the above address:

Name:		Relationship:		Employer:	
Work #		Cell #		POL Account: Receive Printed Mailings:	
Email:		Wk Email:		Home #	
Name:		Relationship:		Employer:	
Work #		Cell #		POL Account: Receive Printed Mailings:	
Email:		Wk Email:		Home #	

ALTERNATE HOUSEHOLD (NON CUSTODIAL)

Mailing:			Street:		
City:	State:	Zip:	City:	State:	Zip:

Information for adults living at the above address:

Name:		Relationship:		Employer:	
Work #		Cell #		POL Account: Receive Printed Mailings:	
Email:		Wk Email:		Home #	
Name:		Relationship:		Employer:	
Work #		Cell #		POL Account: Receive Printed Mailings:	
Email:		Wk Email:		Home #	

ALTERNATE HOUSEHOLD (NON CUSTODIAL)

Mailing:			Street:		
City:	State:	Zip:	City:	State:	Zip:

Information for adults living at the above address:

Name:		Relationship:		Employer:	
Work #		Cell #		POL Account: Receive Printed Mailings:	
Email:		Wk Email:		Home #	
Name:		Relationship:		Employer:	
Work #		Cell #		POL Account: Receive Printed Mailings:	
Email:		Wk Email:		Home #	

EMERGENCY CONTACTS: Enter additional contacts not listed above.

Name:		Relationship:		Email:	
Home #		Work #		Cell #	
Name:		Relationship:		Email:	
Home #		Work #		Cell #	
Name:		Relationship:		Email:	
Home #		Work #		Cell #	

Emergency Medical Information

Physician:		Phone:		Hospital:	
Medical Notes:					

Daycare Information (if applicable)

Provider:			Phone:		
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SIBLINGS (other students living at same address)

First Name	Middle Name	Last Name	Grade	Birthdate	School Name

Completed By: _____ Signature: _____ Date: _____

Formulario de Matrícula Arickaree Jr/Sr High School

Nombre:		Segundo Nombre:		Apellido:	
Apellido:		Grado:		Lugar de Nacimiento:	
Raza:		Indio Americano o Nativo de Alaska		Asiático	
		Afroamericano		Nativo Hawaiano o Isla de las Azores del Pacífico	
		Blanco		<i>(subrayar)</i>	
Hispano/Latino? Si No (subrayar uno)		Género:		Lenguaje del Hogar:	
Acceso a Internet?		Móvil #		Email:	

Residencia Primaria (En la cual el Estudiante Reside)

Postal:			Calle:		
Ciudad:	Estado:	CA3digo Postal:	Ciudad:	Estado:	CA3digo Postal:

Teléfono:

Información de los adultos que residen en la dirección arriba indicada

Nombre:		Relación:		Trabaja Para:	
Trabajo #		Móvil #		Cuenta POL:	
Email:		Email de trabajo:		Recibir correspondencia impresa:	
Nombre:		Relación:		Trabaja Para:	
Trabajo #		Móvil #		Cuenta POL:	
Email:		Email de trabajo:		Recibir correspondencia impresa:	

Residencia Adicional (No Custodia)

Postal:			Calle:		
Ciudad:	Estado:	CA3digo	Ciudad:	Estado:	CA3digo Postal:

Teléfono:

Información de los adultos que residen en la Dirección arriba indicada

Nombre:		Relación:		Trabaja Para:	
Trabajo #		Móvil #		Cuenta POL:	
Email:		Email de trabajo:		Recibir correspondencia impresa:	
Nombre:		Relación:		Trabaja Para:	
Trabajo #		Móvil #		Cuenta POL:	
Email:		Email de trabajo:		Recibir correspondencia impresa:	

Residencia Adicional (No Custodia)

Postal:			Calle:		
Ciudad:	Estado:	CA3digo Postal:	Estado:	Estado:	CA3digo

Phone:

Información de los adultos que residen en la Dirección arriba indicada

Nombre:		Relación:		Trabaja Para:	
Trabajo #		Móvil #		Cuenta POL:	
Email:		Email de trabajo:		Recibir correspondencia impresa:	
Nombre:		Relación:		Trabaja Para:	
Trabajo #		Móvil #		Cuenta POL:	
Email:		Email de trabajo:		Recibir correspondencia impresa:	

Contactos de Emergencia: Añadir adicionales no listados en las encasillados superiores

Nombre:		Relación:		Email:	
Hogar #		Trabajo #		Móvil #	
Nombre:		Relación:		Email:	
Hogar #		Trabajo #		Móvil #	
Nombre:		Relación:		Email:	
Hogar #		Trabajo #		Móvil #	

Información de Emergencia Médica

Medico:		Teléfono:		Hospital:	
Notas Medicas:					

Información de la guardería (si aplica)

Proveedor:			Teléfono:		
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Hermanos (otros estudiantes viviendo en la misma dirección)

Nombre	Segundo Nombre	Apellido	Grado	Fecha De Nacimiento	Escuela

Atte: _____ firma: _____ Fecha: _____

Arickaree School District
12155 County Road NN
Anton, CO 80801
970-383-2202

Please complete this form so that we may better serve your family.

<i>Please list each student in your household</i>		<i>Please ✓ on which child(ren) will be riding the school bus</i>	<i>Please ✓ <u>one</u> box for each child on whether you choose for your child(ren) to receive In-Person Learning or if you prefer the Distance Learning option.</i>		
First Name	Last Name		In Person Learning	OR	Distance Learning
<i>Total Children</i>		<input style="width: 100px; height: 20px;" type="text"/>			

Please return all forms during registration the week of August 10th-13th.

Parent or Guardian

If the user is under 18 years of age, a parent or guardian must also sign this Agreement.

As the parent or guardian of this student, I have read the district's policy on Student Use of the Internet and Electronic Communications. I understand that access to the Internet and electronic communications is designed for educational purposes and that the school district has taken reasonable steps to block or filter material and information that is obscene, child pornography or otherwise harmful to minors, as defined by the Board. I also recognize, however, that it is impossible for the school district to prevent access to all materials or information I might find harmful or controversial and I agree not to hold the district responsible for any such materials and information accessed by my child. Further, I accept full responsibility for supervision if and when my child's Internet or electronic communications use is not in a school setting.

I hereby release the school district from all costs, claims, damages or losses resulting from my child's use of district computers and computer systems, including use of the Internet and electronic communications, including but not limited to any user fees or charges incurred through the purchase of goods or services.

I hereby give permission to issue an Internet and electronic communications account for my child and certify that the information contained on this form is true and correct.

Your signature on this Acceptable Use Agreement is binding and indicates you have read the district's policy on Student Use of the Internet and Electronic Communications carefully and understand its significance.

Parent/Guardian's Name (printed)

Parent/Guardian's Signature

Date

(Adopted 11/2012)

[Revised July 2002]

Student Use of the Internet and Electronic Communications
(Annual Acceptable Use Agreement)

Students

I have read, understand and will abide by the district's policy on Student Use of the Internet and Electronic Communications. Should I commit any violation or in any way misuse my access to the school district's computers or computer system, including use of the Internet and electronic communications, I understand and agree that my access privileges may be revoked and disciplinary and/or legal action may be taken.

If I am 18 years or older, I hereby release the school district from all costs, claims, damages or losses resulting from my use of district computers and computer systems, including use of the Internet and electronic communications, including but not limited to any user fees or charges incurred through the purchase of goods or services.

Your signature on this Acceptable Use Agreement is binding and indicates you have read the school district's policy on Student Use of the Internet and Electronic Communications and understand its significance.

Student's Name (printed) Date of Birth (day/mo/yr)

Student's Signature Date



Arickaree School District R-2
 12155 County Road NN
 Anton, CO 80801
 970-383-2202

Otra Lado, Español

STUDENT HEALTH INFORMATION

Student's Name: _____ Sex: _____ Date of Birth: _____ Grade: _____

Child's Physician: _____ Phone: _____

Child's Dentist: _____ Phone: _____

Please indicate if your child has had any of the following by checking below:

- | | | | |
|-------------------------------|------------------------|-----------------------|--------------------------|
| _____ Arthritis | _____ Asthma | _____ Blood Disorder | _____ Blood Transfusions |
| _____ Braces/Orthodontic work | _____ Capped Teeth | _____ Chicken Pox | _____ Concussion |
| _____ Diabetes | _____ Ear Infections | _____ Ear Tubes | _____ Head Injuries |
| _____ Hearing Problems | _____ Hepatitis | _____ Heart Disorder | _____ Kidney Problems |
| _____ Migraines | _____ Pneumonia | _____ Rheumatic Fever | _____ Scarlet Fever |
| _____ Scoliosis | _____ Seizure Disorder | _____ Skin Conditions | _____ Speech Problems |
| _____ Strep Throat | _____ Tonsillitis | _____ Tuberculosis | _____ Vision Problems |
| _____ Other: _____ | | | |

Please specify any of the above you have entered including date/dates:

Is your child under the care of a physician for a current health problem? Please explain:

Does your child have Allergies to any Foods, Medications, Insects or Bee Stings? _____ Yes _____ No

Please explain & include treatment: _____

Medications: (Please state name, dose, time, frequency, and route)

Surgery: (Please state date & procedure) _____

Other illnesses or serious injuries: _____

Physical Limitations: _____

Is there anything concerning the health of your child which the school should know in order to give special care:

If yes, please specify: _____

Parent/Guardian Signature: _____ Date: _____

By signing this form, I acknowledge the responsibility of providing the school with accurate and updated information, I acknowledge that the appropriately trained staff at Arickaree School will care for my child when he/she is ill or injured, and I give my permission to release medical information to appropriate school personnel.



Arickaree School District R-2
 12155 County Road NN
 Anton, CO 80801
 970-383-2202

English Other Side

INFORMACION SOBRE LA SALUD DEL ESTUDIANTE

Nombre del alumno _____ Genero: _____ Fecha de nacimiento: _____ Grado: _____

Médico del niño: _____ Teléfono: _____

Dentista del niño: _____ Teléfono: _____

POR FAVOR INDIQUE SI EL ALUMNO HA TENIDO ALGUNO DE LO SIGUIENTE:

- | | | | |
|-------------------------------|------------------------|-----------------------|--------------------------|
| _____ Arthritis | _____ Asthma | _____ Blood Disorder | _____ Blood Transfusions |
| _____ Braces/Orthodontic work | _____ Capped Teeth | _____ Chicken Pox | _____ Concussion |
| _____ Diabetes | _____ Ear Infections | _____ Ear Tubes | _____ Head Injuries |
| _____ Hearing Problems | _____ Hepatitis | _____ Heart Disorder | _____ Kidney Problems |
| _____ Migraines | _____ Pneumonia | _____ Rheumatic Fever | _____ Scarlet Fever |
| _____ Scoliosis | _____ Seizure Disorder | _____ Skin Conditions | _____ Speech Problems |
| _____ Strep Throat | _____ Tonsillitis | _____ Tuberculosis | _____ Vision Problems |
| _____ Other: _____ | | | |

Por favor, especifique cualquiera de las anteriores se ha introducido con la fecha/fechas: _____

Su hijo está bajo el cuidado de un médico por un problema de salud actual? Por favor explique: _____

Si su niño tiene alergia a los alimentos, medicamentos, picaduras de abejas o insectos? _____ Si _____ No

Por favor, explique & incluyen el atamiento: _____

Medicamentos: (Por favor, indicar el nombre, dosis, tiempo, frecuencia y ruta) _____

Cirugía: (indique fecha y procedimiento) _____

Otras enfermedades o lesiones graves: _____

Limitaciones físicas: _____

¿Hay algo sobre el estado de salud de su hijo que la escuela debe saber con el fin de dar atención especial:

Si la respuesta es sí, por favor especifique: _____

Padre/guardián Firma: _____ Fecha: _____

Al firmar este formulario, he de reconocer la responsabilidad de proporcionar a la escuela con información precisa y actualizada, he de reconocer que el personal debidamente capacitado un Arickaree escuela de mi hijo cuando él/ella está enfermo o herido, y yo doy mi permiso para revelar información médica a personal de la escuela.

ARICKAREE SCHOOL DISTRICT R-2

EMERGENCY MEDICAL AUTHORIZATION FORM

In the event of an emergency medical problem with your child or children that occurs during the time they are in the care of Arickaree School District R-2, please fill in the following information that we may be take care of the problem in the shortest possible time.

STUDENT NAME _____

If parents are not at home, please list a number where you may be reached at work, or the name and telephone number of 3 friends or relatives who would be willing to care for your child until you can be reached.

Parent Telephone Number

Work Telephone Number

Friend or Relative Name

Telephone Number

Friend or Relative Name

Telephone Number

Friend or Relative Name

Telephone Number

Name & Address of Family Physician
& Telephone

Name & Address of Family Dentist
& Telephone

I understand that in the event of a medical emergency involving my child or children, Arickaree School will provide first aid if necessary and will contact me immediately. In the event the school is unable to contact me or the friend or relative listed above, I hereby give the school permission to call our family physician or dentist and , if the situation warrants it, transport my child to the physician or dentist or emergency room if so prescribed by the physician or dentist.

Parent or Guardian Signature

Date

FORMA DE EMERGENCIAS PARA AUTORIZACIÓN MÉDICO

En el evento de un problema médico de emergencia con su hijo/a cuando este en el cuidado de la escuela de Arickaree Distrito R-2, favor de llenar este informatorio en los espacios que siguen, para resolver el problema lo mas pronto posible.

NOMBRE DEL ESTUDIANTE _____

Si los padres no estan en casa, por favor anoten un número en donde podemos comunicarnos, o el nombre y numero de telefono de 3 familiares o amigos que esten dispuestos a cuidarle su hijo/a hasta que nos podamos comunicar con un padre.

Numero de Telefono de un Padre

Numero del Trabajo

Nombre de Familiar o Amigo

Numero de Telefono

Nombre de Familiar o Amigo

Numero de Telefono

Nombre de Familiar o Amigo

Numero de Telefono

Nombre, Dirección, y Numero de Telefono de su Doctor Familiar.

Nombre, Dirección, Numero de Telefono de su Dentista Familiar.

Yo entiendo que en caso de una emergencia involucrando a mi hijo/a, la escuela de Arickaree va a procurar el primer auxilio si es necesario y me llaman los mas pronto posible. Por si a caso no se pueden comunicar con migo, o algunos de los que estan anotados arriba, yo doy permiso a la escuela para que llamen a nuestro doctor o dentista familiar, y por si el problema es mas grave doy permiso para que la escuela se encargue de lo necesario para que mi hijo/a tenga la atención que necesite.

Firma del Padre o Guardian

Fecha

Arickaree School District

Information about Applying for Free or Reduced-Price School Meals

Dear Parent/Guardian:

Children need healthy meals to learn. Arickaree School District offers healthy meals every school day. Elementary Breakfast costs \$1.25 and JH/HS Breakfast costs \$1.50. Elementary Lunch costs \$1.75 and JH/HS Lunch costs \$2.00. Your children may qualify for free or reduced-price school meals. Students in all grades that qualify for free or reduced-price meals will receive breakfast and lunch at no charge.

This packet includes an application for free or reduced-price meal benefits, and a set of detailed instructions. You can also find applications at Arickaree School.

Below are common questions and answers to help you with the application process.

1. WHO CAN RECEIVE FREE OR REDUCED-PRICE MEALS?
 - a. All children in households receiving benefits from the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR) or Temporary Assistance for Needy Family (TANF/Colorado Works – Basic Cash Assistance or State Diversion), are eligible for free meals.
 - b. Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Foster children may be added as a household member of the foster family if the foster family chooses to apply. Including foster children as household members may help other children qualify for benefits. If the foster family is not eligible, it does not prevent a foster child from receiving benefits.
 - c. Children who qualify for their districts Head Start program are eligible for free meals.
 - d. Children who meet the definition of homeless, runaway, or migrant are eligible for free meals.
 - e. Children may receive free or reduced-price meals if your household’s income is within the limits on the Federal Income Eligibility Guidelines. Your children may qualify for free or reduced-price meals if your household income falls at or below the limits on this chart.

FEDERAL ELIGIBILITY INCOME CHART For School Year 2020 – 2021			
Household size	Yearly	Monthly	Weekly
1	\$23,606	\$1,968	\$454
2	\$31,894	\$2,658	\$614
3	\$40,182	\$3,349	\$773
4	\$48,470	\$4,040	\$933
5	\$56,758	\$4,730	\$1,092
6	\$65,046	\$5,421	\$1,251
7	\$73,334	\$6,112	\$1,411
8	\$81,622	\$6,802	\$1,570
Each additional person:	\$8,288	\$691	\$160

2. HOW DO I KNOW IF MY CHILDREN QUALIFY AS HOMELESS, MIGRANT, OR RUNAWAY? Do the members of your household lack a permanent address? Are you staying together in a shelter, hotel, or other temporary housing arrangement? Does your family relocate on a seasonal basis? Are any children living with you who have chosen to leave their prior family or household? If you believe children in your household meet these descriptions and have not already been notified that your children will receive free meals, please call **Arickaree School 970-383-2202**
3. DO I NEED TO FILL OUT AN APPLICATION FOR EACH CHILD? No. Use one Free and Reduced-Price School Meals Application for all students in your household. We cannot approve an application that is not complete, so be sure to fill out all required information. Return the completed application to: **Arickaree School District 12155 County Road NN Anton, CO 80801**
4. SHOULD I FILL OUT AN APPLICATION IF I RECEIVED A LETTER THIS SCHOOL YEAR SAYING MY CHILDREN ARE ALREADY APPROVED FOR FREE MEALS? No, but please read the letter you received carefully and follow the instructions. If any children in your household are missing from your eligibility notification, contact **Marsha Jesse 970-383-2202 Ext 101** immediately.
5. CAN I APPLY ONLINE? No.
6. MY CHILD’S APPLICATION WAS APPROVED LAST YEAR. DO I NEED TO FILL OUT A NEW ONE? Yes. Your child’s application is only valid for that school year and for the first 30 days of this school year. You must send in a new application unless the school notified you that your child is eligible for the new school year.
7. I RECEIVE WIC. CAN MY CHILDREN RECEIVE FREE MEALS? Children in households participating in WIC may be eligible for free or reduced-price meals. Please send in a completed free and reduced-price school meal application.

8. WILL THE INFORMATION I GIVE BE CHECKED? You may be selected to provide written proof of the household income you report on the application.
9. IF I DON'T QUALIFY NOW, MAY I APPLY LATER? Yes, you may apply at any time during the school year. For example, children with a parent or guardian who becomes unemployed may become eligible for free and reduced-price meals if the household income drops below the income limit.
10. WHAT IF I DISAGREE WITH THE SCHOOL'S DECISION ABOUT MY APPLICATION? You should talk to school officials. You also may ask for a hearing by calling or writing to: **Mrs. Tonya Rodwell 970-383-2202 Ext. 103 or 12155 County Road NN Anton, CO 80801**
11. MAY I APPLY IF SOMEONE IN MY HOUSEHOLD IS NOT A U.S. CITIZEN? Yes. You, your children or other household members do not have to be U.S. citizens to apply for free or reduced-price meals. Immigration, migrant, citizenship or refugee status is not required to be provided during the application process, and families should continue to apply for free or reduced-price school meals. The application does require the last four numbers of a Social Security number or an indication that there is no Social Security number. Social Security number information is not reported to any organization outside of **Arickaree School District**.
12. WHAT IF MY INCOME IS NOT ALWAYS THE SAME? List the amount that you normally receive. For example, if you normally make \$1000 each month, but you missed some work last month and only made \$900, put down that you made \$1000 per month. If you normally get overtime, include it, but do not include it if you only work overtime sometimes. If you have lost a job or had your hours or wages reduced, use your current income. The last four digits of the Social Security Number of an adult household member (or an indication of "none") is required to process a complete income application.
13. WHAT IF SOME HOUSEHOLD MEMBERS HAVE NO INCOME TO REPORT? Household members may not receive some types of income we ask you to report on the application, or may not receive income at all. Whenever this happens, please write a 0 in the field. However, if any income fields are left empty or blank, those will also be counted as zeroes. Please be careful when leaving income fields blank, as we will assume you meant to do so. The last four digits of the Social Security Number of an adult household member (or an indication of "none") is required to process a complete income application.
14. WE ARE IN THE MILITARY. DO WE REPORT OUR INCOME DIFFERENTLY? Your basic pay and cash bonuses must be reported as income. If you get any cash value allowances for off-base housing, food, or clothing, or receive Family Subsistence Supplemental Allowance payments, it must also be included as income. However, if your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income. Any additional combat pay resulting from deployment is also excluded from income.
15. WHAT IF THERE ISN'T ENOUGH SPACE ON THE APPLICATION FOR MY FAMILY? List any additional household members on a separate piece of paper, and attach it to your application. Contact **Marsha Jesse 970-383-2202 Ext. 101** to receive a second application.
16. MY FAMILY NEEDS MORE HELP. ARE THERE OTHER PROGRAMS WE MIGHT APPLY FOR? To find out how to apply for other assistance benefits, contact your local assistance office. Colorado PEAK is an online service to screen and apply for medical, food and cash assistance programs. It can be accessed at <http://coloradopeak.force.com/>.

If you have other questions or need help, contact **Arickaree School District 970-383-2202**

Sincerely,

Marsha Jesse

Non-discrimination 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.

Complete one application per household. Please use a black or blue pen (not a pencil).

Student's First Name				MI	Student's Last Name				Birth Date			Grade
M	M	D	D	Y	Y							

Check all that apply. Read How to Apply for Free and Reduced Price School Meals for more information.

Foster Child	Head Start	Runaway	Homeless	Migrant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STEP 2 If any household members (including you) currently receive assistance from any of the following programs: SNAP, TANF or FDPIR list the case number below.

Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF/Colorado Works – Basic Cash Assistance or State Diversion), or Food Distribution Program on Indian Reservations (FDPIR). Provide case number and skip to Step 4.

<input type="text"/>	<input type="text"/>	<input type="text"/>
SNAP Case Number	TANF Case Number	FDPIR Case Number

STEP 3 Report income for ALL household members (skip this step if you provided a case number in STEP 2)

A. Student Income
Please include the TOTAL income, if any, received by all students' listed above.

Student Income	How Often?				
	Weekly	Bi-Weekly	2x Month	Monthly	Annually
\$ <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

B. All Other Household Members (including yourself)
In the spaces below list all other 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 GROSS INCOME (BEFORE TAXES AND OTHER DEDUCTIONS) for each source in whole dollars only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying that there is no income to report.

Names of All Other Household Members (First and Last)	Earnings from Work	How Often?					Public Assistance/Child Support/Alimony	How Often?					Pensions/Retirement/All Other Income	How Often?				
		Weekly	Bi-Weekly	2x Month	Monthly	Annually		Weekly	Bi-Weekly	2x Month	Monthly	Annually		Weekly	Bi-Weekly	2x Month	Monthly	Annually
<input type="text"/>	\$ <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>	\$ <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>	\$ <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>	\$ <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Total Household Members Last four digits of Social Security Number (SSN) or mark "no SSN" of adult signing this form only if Step 3B has been completed. XXX-XX-

Check box if no SSN

STEP 4 Contact information and adult signature. Mail signed and completed application to: Arickaree School District 12155 County Road NN Anton, CO 80801

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

<input type="text"/>	<input type="text"/>	<input type="text"/>	CO	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mailing Address or PO Box	Apt. # or Lot #	City	State	Zip Code	Email Address	
<input type="text"/>	SIGNATURE of Adult Household Member (Required)			Printed First and Last Name of Signer		Today's Date

STEP 5 Release of Information

The information provided on this application will be used in conjunction with state educational programs and may be shared with Medicaid or State Children's Health Insurance Program (SCHIP) offices. If your students are eligible to receive free or reduced price meals this information may be shared with the school/district for purposes of waiving school/district program fees that your child(ren) might otherwise be required to pay. The school/district is not permitted to share your information with anyone else. You are not required to consent to the release of your information: this will not affect your student(s) eligibility for school meals. Your information WILL be shared unless you check one of the boxes below.

Do NOT share my information with any programs

Do NOT share my information with the programs I have checked:

Medicaid/SCHIP List Specific Program List Specific Program List Specific Program List Specific Program

OPTIONAL Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.

Ethnicity (check one): 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 Islander White

You may also qualify for the Supplemental Nutrition Assistance Program! See more information below.

NEED HELP BUYING GROCERIES?

- Receive one-on-one assistance with applying for food stamps
- Referrals to food pantries and free meals
- Get information on child and senior nutrition programs

Food Resource Hotline

CALL US TODAY! STATEWIDE, TOLL-FREE **855-855-4626**
METRO DENVER 720-382-2920

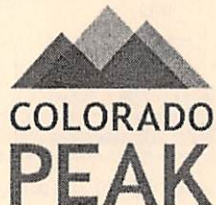
¿NO LE ALCANZA EL DINERO PARA COMPRAR COMIDA?

- Reciba ayuda personalizada para solicitar las estampillas de comida
- Derivaciones a bancos de comida y comidas gratis
- Obtenga información sobre programas de nutrición para niños y ancianos

Línea Directa de Recursos de Comidas

¡LLÁMENOS HOY! LÍNEA ESTATAL **855-855-4626**
METRO DENVER 720-382-2920

HUNGER FREE COLORADO HungerFreeColorado.org



Colorado PEAK is an online service for Coloradans to screen and apply for medical, food and cash assistance programs.

Visit coloradopeak.force.com to learn more.

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.

DISTRICT USE ONLY. DO NOT WRITE BELOW THIS LINE.

Annual Income Conversion: Weekly x 52; Bi-Weekly x 26; 2 Times per Month x 24; Monthly x 12

Application Type:
 Total Household Income: \$ _____ Household Size: _____
 Household Income Frequency - Weekly Bi-Weekly 2x/Month Monthly Annually
 Categorical Eligibility - SNAP FDPIR TANF Foster
 Homeless/Migrant/Runaway/Head Start

Application Status:
 Approved - Free Reduced
 Denied - Over Income Guidelines Incomplete/Missing: _____
 Notes: _____

Determining Official Signature:

Approval/Denial Date:

Notification Sent: