



Application for Reduced Fee

P.O. Box 1652, Cottage Grove, Oregon 97424 541-942-9707

1 HOUSEHOLD INFORMATION Print name of person completing this application (Last name, First name)

Name Print _____

Mailing Address – Apt # _____

City State Zip _____

Home Phone or Cell Phone (Circle One)
 (____) _____
 Work Phone
 (____) _____

➔ Number living in household _____
 (Write names of **all** household members **except** foster children on parts 2 and/or 4 of this form)

Does this household receive FDPIR (Food Distribution on Indian Reservations) Yes (Complete parts 2 and 5)

2 STUDENT INFORMATION (do not include foster children, they need a separate application)

Child's Name (Last name, First name)	School	Grade	Birth Date
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

3 FOSTER CHILD INFORMATION (COMPLETE A SEPARATE FORM FOR EACH FOSTER CHILD) Child's Monthly Personal Use Income

Child's Name (Last name, First name)	School	Grade	Birth date	Personal Use Income
_____	_____	_____	_____	\$ _____

4 HOUSEHOLD MEMBERS & GROSS MONTHLY INCOME – if not monthly, see back for conversions

Column 1 List all household members including children not in school, and income. Do not include students shown in section 2 unless they receive income. (Last name, first name)	Column 2 MONTHLY INCOME (Total earnings & wages before deductions)	Column 3 MONTHLY CHILD SUPPORT, WELFARE, ALIMONY RECEIVED	Column 4 MONTHLY PENSIONS, SOCIAL SECURITY, RETIREMENT	Column 5 OTHER MONTHLY INCOME -including unemployment and workers comp.
1. _____	\$ _____	\$ _____	\$ _____	\$ _____
2. _____	\$ _____	\$ _____	\$ _____	\$ _____
3. _____	\$ _____	\$ _____	\$ _____	\$ _____
4. _____	\$ _____	\$ _____	\$ _____	\$ _____

5 SIGNATURE, DATE & SOCIAL SECURITY NUMBER

I certify (promise) that all of the information on this application is true (correct) and that all income is reported. I understand that this information is being given in connection with the receipt of federal funds; that state officials may verify (check) information; and that deliberate misrepresentation may subject me to prosecution under applicable state and federal statutes.

Signature of Adult Household Member _____ Date Signed _____ Social Security Number * (required) _____

X _____ Month/day/year _____ (See privacy statement on back) _____

I do not have a Social Security Number.

6 RACIAL OR ETHNIC GROUP (OPTIONAL)

Mark one or more racial identities:

Asian White, not of Hispanic origin
 American Indian & Alaskan Native Native Hawaiian or Other Pacific Islander
 Black or African American Other _____

Mark one ethnic identity:
 Hispanic or Latino
 Not Hispanic or Latino

I prefer all written correspondence in Spanish English Other _____

7 I do not want my information shared with State Children's Health Insurance Program Sign here:

SCHOOL USE ONLY - DO NOT WRITE BELOW THIS LINE

Total Income: _____ Number in household: _____ Date Withdrawn: _____

Free based on:
 food stamp/TANF
 FDPIR/homeless
 household income
 foster child's income

Reduced based on:
 household income
 foster child's income

Denied – Reason:
 income too high
 incomplete application

Temporary:
 Free
 Reduced
 Until: _____ Until: _____
 (maximum 45 days each)

Determining Official's Signature: _____ Date _____