STUDENT FEE WAIVER APPLICATION

Date _____   School Year: _____

All Information provided in connection with this application will be kept confidential.

Name of student: _____ Grade/School _____

Name of student: _____ Grade/School _____

Name of student: _____ Grade/School _____

Name of parent, guardian,
or legal or actual custodian: _____

This includes all required student fees (registration, driver's ed and instrument rental.)
Please check type of waiver desired:

Full Waiver _____ Partial Waiver _____
Temporary Waiver _____

Please check if the student or the student's family meets the financial eligibility criteria or is involved in one of the following programs:

Full waiver

_____ Free meals offered under the Child Nutrition Program (CNP)

_____ The Family Investment Program (FIP)

_____ Transportation assistance under open enrollment

_____ Foster Care

Partial waiver

_____ Reduced priced meals offered under the Children Nutrition Program

Temporary waiver

If none of the above apply, but you wish to apply for a temporary waiver of school fees because of serious financial problems, please state the reason for the request:

_____

Signature of parent, guardian,
Or legal or actual custodian: _____

hawk-i/Medicaid Information Form

Read this information and sign if you decide you do not want your name released to hawk-i or Medicaid.

If your children do not have health insurance, you will be interested to know that many families getting free and reduced price meals can also get free or low-cost health insurance for their children.

The law now requires schools to share your free and reduced price meal eligibility information with Medicaid and hawk-i, the State's medical insurance program for children. Specifically, we will give them your child's name and 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 and then to contact you. They are not allowed to use the information from your free and reduced meal application for any other purpose.

You are not required to allow us to share information from your children's free and reduced price meal application with Medicaid or the hawk-i program. It will not affect your children's eligibility for free and 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 at the time you complete your free/reduced application. If you want further information, you may call hawk-i at 1-800-257-8563.

I DO NOT want school/home sponsor/child care or Head Start center officials to share information from my free and reduced price meal application with Medicaid or hawk-i. Also, if you are already receiving Medicaid or hawk-i, please sign below. This will avoid another contact.

Child's Name: _____   School/Child Care/Head Start Center: _____

Child's Name: _____   School/Child Care/Head Start Center: _____

Child's Name: _____   School/Child Care/Head Start Center: _____

Parent/Guardian Name (Printed)_____Signature_____Date_____

Reviewed 4/7/16, 12/2/21, 11/7/2024