BC_____
SS_____
IM_____

# Student Information Sheet

**2026-2027**

*(Please print all information)*

## *Student Information*

**Legal Name** *(L-F-M):* _____

**Physical Address**: _____

City _____Zip Code _____

**Mailing Address** *(if different)*: _____

City _____Zip Code _____

**Physical Home Phone**: _____

**Gender**:_____ **Grade Level**: _____

**Birth date**:_____ **Age**: _____

**Social Security #:**_____

**Race** *(Circle One)* | African American | American Indian | Asian | Caucasian | Hispanic | Pacific Islander |

**Legal Alerts**:_____

_____

**Student lives with**: *(circle one)*
| Mother & Father | Mother & Stepfather | Father & Stepmother |
| Mother Only | Father Only | Foster Home | Other: _____

## *Student Medical Information*

Doctor's Name: _____

Doctor's Phone:_____

Dentist's Name:_____

Dentist's Phone: _____

**Special Medical Conditions**
(ex. Hearing aid, glasses, medicines, etc):

_____

_____

**Allergies**: _____

_____

**Brothers**, names & ages:

_____

_____

**Sisters**, names & ages:

_____

_____

## *Male Legal Guardian Information*

**Name** *(Last-First)*: _____

Physical Address *(If different from student):* _____

_____

**Day Phone**: _____

Employer:_____

Home Phone:_____

Email Address:_____

## *Female Legal Guardian Information*

**Name** *(Last-First)*: _____

Physical Address: *(If different from student):*_____

_____

**Day Phone**: _____

Employer:_____

Home Phone:_____

Email Address:_____

## *Emergency Contact Information*

*(Other than Legal Guardians)*

**Contact 1**

Contact Name :_____Address:_____

Phone:_____Circle one: | Cell | Home | Work | Relationship_____

**Contact 2**

Contact Name :_____Address:_____

Phone:_____Circle one: | Cell | Home | Work | Relationship_____

**Contact 3**

Contact Name :_____Address:_____

Phone:_____Circle one: | Cell | Home | Work | Relationship_____

**Guardian's Signature:**_____**Student T-Shirt size:**_____ **Date:**_____

# 2026-2027 DENTAL Consent

Community Health Center of Southeast Kansas, Inc. (CHC/SEK) provides dental services at your student's school. Students are invited to participate in dental outreach services. No student will be denied services based on insurance status or ability to pay. If available, insurance will be billed.

**School Name** _____**Grade** _____

**Student's LEGAL Full Name** _____ **Preferred Name** _____

**Student's Date of Birth (DOB)** _____/ _____/_____ **AGE**_____ **SEX at Birth** □ Male □ Female

**Parent/Guardian Name** _____ **Parent/Guardian DOB** _____/ _____/_____

**Address** _____ **City** _____ **State** _____ **Zip** _____

**Parent/Guardian Primary Phone** _____ **Cell Phone** _____

| RACE | ETHNICITY | PREFERRED LANGUAGE |
|---|---|---|
| □ **White**<br>□ **Black/African American**<br>□ **American Indian/Alaska Native**<br><br>**Native Hawaiian/Pacific Islander**<br>□ Native Hawaiian □ Marshallese<br>□ Guamanian or Chamorro<br>□ Samoan □ Other Pacific Islander<br>□ Decline to Specify<br>**Asian**<br>□ Asian Indian □ Japanese<br>□ Chinese □ Korean<br>□ Filipino □ Vietnamese<br>□ Other Asian | □ Not Hispanic/Latino<br>□ Mexican<br>□ Chicano<br>□ Mexican American<br>□ Cuban<br>□ Puerto Rican<br>□ Other Hispanic Latino | □ English<br>□ Spanish<br>□ Other:<br>□ Interpreter Needed: |

**RESPONSIBLE PARTY**

_____ _____/ _____/ _____ _____

LEGAL NAME DOB PRIMARY PHONE

_____ _____

ADDRESS RELATIONSHIP TO STUDENT



**DATE (MM/DD/YEAR)** _____/ _____/_____

# 2026-2027 DENTAL CONSENT PAGE TWO

**Student's Legal Full Name _____ Date of Birth (DOB) _____/ _____/_____**

**DENTAL INSURANCE**

□ **Kansas, Missouri, or Oklahoma MEDICAID** (United Healthcare, Healthy Blue, Sunflower, Home State Health, Aetna, Humana Healthy Horizons, OK Complete Health**) Policy #_____**

□ NO INSURANCE

□ COMMERCIAL/PRIVATE DENTAL INSURANCE

Commercial/Private Dental Insurance Company Name_____

Commercial Insurance Policy Holder's Name _____DOB _____/ _____/_____

SSN#_____ Employer _____ Policy#_____ Group#_____

**STUDENT'S HEALTH HISTORY** *Student's Health Care Provider* _____

| **STUDENT'S HEALTH HISTORY** *(PLEASE MARK ALL THAT APPLY)* | |
|---|---|
| □ Hepatitis □ Diabetes □ Seizure Disorder □ Artificial Joint/Valve<br>□ Asthma □ Alpha Gal □ Heart Disorder □ Other_____ | |
| **Food, Drug, and/or Other Allergies:** □ Yes □ No | **Please List Allergies:** |
| **Required by a Provider to take pre-medications (antibiotics) prior to dental treatment: □ Yes □ No** | **Please State Condition:** |
| **Surgeries, Hospitalizations, or Other Health Conditions CHC/SEK should know: □ Yes □ No** | **Please Explain:** |
| **Any Current Medications: □ Yes □ No** | **Please List:** |

**CONSENT TO TREAT**

As parent or legal guardian of the student named above, I give CHC/SEK permission to provide dental services by CHC/SEK clinical professionals as necessary in their judgement. I understand that no promise, guarantee, or warranty has been made regarding the result of any care provided by CHC/SEK. This consent is valid for **one (1) year** from the parent/guardian signature date below. Dental services **MAY** include the following**: Cleaning, Sealant, Fluoride, Silver Diamine Fluoride, Temporary Filling, Injection of Local Anesthetic, Baby Tooth Removal, and Exam (*exam for Head Start locations only). You will receive a phone call before performing any local anesthetic or removing any baby teeth.***

Please list any services you do **NOT** want your student to receive: _____

_____ _____

***Signature of Parent, Legal Guardian or Responsible Party** **Relationship to Patient**

**DATE(MM/DD/YEAR)** _____/_____/_____

**OFFICE USE ONLY**

CARRIES RISK □ MOD □ HIGH FR_____ P / F / S #:_____ SCRN #:_____

EO: 3 _____ 14 _____ 19 _____ 30_____ SDF: _____ ITR: _____

REFERRAL: YES NO _____

EXT: _____ TEACHER/GR _____ HYG INITIALS _____

CHC SEK School Health

Office Use
USD: _____
Grade:

# PATIENT REGISTRATION FORM

| LEGAL FULL NAME | LAST NAME | FIRST NAME | MIDDLE NAME | PREFERRED NAME |
|---|---|---|---|---|
| | | | | |

| ADDITIONAL/FORMER NAMES (EX. MAIDEN NAME) | DATE OF BIRTH (MM/DD/YY) | SSN# | |
|---|---|---|---|
| ADDRESS | CITY | STATE | ZIP CODE |
| MAILING ADDRESS (IF DIFFERENT FROM ADDRESS) | MAILING CITY | MAILING STATE | MAILING ZIP CODE |
| HOME PHONE | CELL PHONE | WORK PHONE | |

**EMAIL ADDRESS** (REQUIRED FOR PATIENT PORTAL ACCESS)

**PRIMARY CARE PROVIDER**
NAME CITY & STATE

## SEX ASSIGNED AT BIRTH

□ Male □ Female

## RACE
*(Check all that apply)*

□ **White**

□ **Black/African American**

□ **American Indian/Alaska Native**

**Asian**

□ Asian Indian □ Japanese

□ Chinese □ Korean

□ Filipino □ Vietnamese

□ Other Asian

**Native Hawaiian/Pacific Islander**

□ Native Hawaiian □ Marshallese

□ Guamanian or Charmorro

□ Samoan □ Other Pacific Islander

□ Decline to Specify

## ETHNICITY

□ Not Hispanic/Latino

□ Mexican, Mexican American, Chicano

□ Puerto Rican

□ Cuban

□ Other Hispanic Latino

## PREFERRED LANGUAGE

□ English

□ Spanish

□ Other:

□ Interpreter Needed:

## EMERGENCY CONTACT

**Emergency Contact Name:**

Phone:

Relationship to Patient:
□ Spouse □ Parent □ Child □ Other

**Emergency Contact Name:**

Phone:

Relationship to Patient:
□ Spouse □ Parent □ Child □ Other

## PHARMACY

□ Apothecare Pharmacy *(CHC in-house pharmacy)*
Location:

□ Other Pharmacy

## INSURANCE – CHECK ALL THAT APPLY
*(PLEASE PROVIDE COPY OF CARD)*

□ Medicare □ Medicare Supplement □ Medicare Advantage Plan □ Commercial Insurance
□ No Health Insurance □ Dental Insurance □ State Medicaid Kan Care, SoonerCare, MO HealthNet □ CHIP □ Other Medicaid

| PRIMARY INSURANCE POLICY HOLDER | | SECONDARY INSURANCE POLICY HOLDER | |
|---|---|---|---|
| FULL NAME | DATE OF BIRTH (MM/DD/YY) | FULL NAME | DATE OF BIRTH (MM/DD/YY) |
| INSURANCE PLAN | SSN# | DATE OF BIRTH | SSN# |
| INSURANCE ID NUMBER | INSURANCE GROUP NUMBER | INSURANCE ID NUMBER | INSURANCE GROUP NUMBER |
| POLICY HOLDER'S RELATIONSHIP TO PATIENT<br>□ Self □ Spouse □ Parent □ Other | | POLICY HOLDER'S RELATIONSHIP TO PATIENT<br>□ Self □ Spouse □ Parent □ Other | |

## RESPONSIBLE PARTY

□ Check if same as patient

*(PERSON RESPONSIBLE FOR PAYING PATIENT ACCOUNT)*

| FULL NAME | DATE OF BIRTH (MM/DD/YY) | SSN# | PRIMARY PHONE | |
|---|---|---|---|---|
| EMAIL | ADDRESS | CITY | STATE | ZIP CODE |

CHC SEK School Health

| Office Use |
| --- |
| USD: _____ |
| Grade: |

**PATIENT LAST NAME:** **FIRST NAME:** **DATE OF BIRTH:**

## CONSENT TO TREAT- MEDICAL

I give consent for treatment by Community Health Center of Southeast Kansas, Inc. (CHC/SEK) for medical health services. If I am consenting for a minor child, I understand that no treatment will be given without my knowledge or consent unless the treatment relates to an emergency or the treatment is otherwise permitted under applicable federal or state law.

I understand that if I am consenting to treatment of my child, if a court order has been entered with respect to the conservatorship of said child, or impacting my rights to consent to the child's care and treatment, CHC/SEK will not render services to the child until CHC/SEK has received and reviewed the most recent court order.

I understand that the information in my health record (if a mature minor) or my child's health record is confidential and will not be released to any unauthorized person or agency without consent.

I assign to CHC/SEK any and all benefits payable from any insurance provider covering the patient or person responsible for the patient's care to be paid directly to CHC/SEK which will be applied to the charges for services rendered (example: vision and hearing screenings).

I understand that CHC/SEK may disclose all or any part of the patient's medical record to any insurance company, corporation or person which is or may be liable under a contract or part of CHC/SEK's charges, including, but not limited to, medical services companies, insurance companies or pharmaceutical manufacturers.

I authorize CHC/SEK to disclose all or any portion of my health record (if a mature minor) or my child's health record to my health care provider (if a mature minor) or my child's health care provider who is: _____

I authorize CHC/SEK to disclose all or any portion of my health record (if a mature minor) or my child's health record to school personnel as it relates to my child's academic success.

I authorize CHC/SEK to examine my school records (if a mature minor) or my child's school records to assist staff in providing the necessary care for my child and for the school and school personnel to communicate (including providing necessary record(s)) with CHC/SEK as necessary and appropriate.

With my signature, I certify that I understand the above and that I am authorized to sign for the patient listed above on this Patient Registration/Consent for Treatment Form

| _____ | _____ | _____ /____ /____ |
| --- | --- | --- |
| Signature of Patient, Agent, Representative, Parent, Legal Guardian or Responsible Party | Relationship to Patient | Month/Date/Year |

# Health Services

2026-2027 School Year  Baxter Springs USD #508

Students Name  DOB  Grade

| Yes | No | |
|---|---|---|
| | | **Attention Deficit Disorder** (if YES circle) ADHD ADD<br>Medication: |
| | | **Allergies** (if YES, circle below and explain)<br>Food Insect bites/Stings Pollen Animals Medication<br>Will your child have an Epi-pen at school? YES NO |
| | | **Asthma**<br>Will your child have an inhaler at school? YES NO |
| | | **Diabetes**<br>Medication: |
| | | **Emotional Problems**<br>Medication &/or Counseling: |
| | | **Seizure Disorder** Type of Seizure:<br>Medication: |
| | | **Other Health Concerns Including Hospitalizations, Operations, or Medications Not Previously Mentioned:** |

**Kansas State Law** requires that each student must present to the school:

- An **up to date immunization record** or a religious exemption or medical exemption
- A **physical exam** performed by a licensed healthcare provider
- A copy of an **official state issued birth certificate**

**All medications given at school must be provided by the parent** and come in a properly labeled original container and **an authorization for medication form** must be filled out and signed by the prescribing provider/doctor.

I hereby certify that I have read and understand the school requirements for my child. Furthermore, permission is hereby granted to the attending team physician, athletic trainer, coach, school nurse, sponsor, and/or teacher to render any necessary first aid treatment to the child listed below. I understand that in an emergency, effort will be made to contact the Parent/Guardian or other contact persons listed. If such contact is not possible, the transportation and treatment necessary for the best interest of the student may be given.

I also authorize USD #508 schools to release, exchange, and obtain immunization and/or health in their possession, relating to the named student, to the Health Department, physician(s), school personnel working with the student, and/or Kansas Immunization Registry. I understand that this authorization will expire when the student is no longer enrolled in the above named school district and that I may revoke this authorization in writing at any time.

_____

Parent/Guardian signature  Today's date

# BAXTER SPRINGS SCHOOLS, USD 508

1520 Cleveland Avenue ♦ Baxter Springs, KS 66713 ♦ 620-856-2375 ♦ Fax: 620-856-3943

***Lincoln Elementary***
801 Lincoln Ave
620-856-3322

***Central Elementary***
1501 Park Ave
620-856-3311

***Middle School***
104 North Military
620-856-3355

***High School***
100 North Military
620-856-3366


## STUDENT PERMISSION FORM

_____ _____ _____
Student's Name Grade DOB

The student listed above has permission to: **(Initial for consent)**

_____ take part in all school sponsored activities.

_____ allow USD 508 to use my child's name, picture, and/or classroom work on the district's web site, school publications, and to provide the same information to local newspapers and/or television stations.

_____ to participate in any reward programs (Weekly Homework Completion Drawings, AR Reading, etc.)

_____ I do give my permission for information contained on my student's permanent school immunization record to be released to the Kansas Immunization Program for the purpose of assessment and reporting. I also give my permission to share these immunization records with other schools, physicians, or health departments as deemed necessary for my child to be immunization compliant as per Kansas laws.

_____ _____
Parent/Guardian Signature Date

# BAXTER SPRINGS USD #508

## CUSTODY LAW NOTIFICATION

Custody disputes must be handled by the courts. By law, if parents are legally separated or divorced, each parent has equal rights to the custody of the children *UNLESS* one of them has a signed court order that indicates otherwise. The school has no legal right to refuse biological parent's access to their children and/or school records.

If a parent has a signed, ***current*** court order limiting the other parent, or any other person, the school *MUST HAVE A COPY* of the court order on file. If a copy is not on file, the school is required by law to release children to their parents with proper identification. Situations that put the welfare of students in question will be handled at the discretion of the Principal/designee. In situations that become a disruption to the school, the Baxter Police Department will be contacted, and an officer will be requested to intervene.

Parents are asked to make every attempt not to involve schools in custody matters. Please have current information on file for your children.

Student Name: _____

Parent/Guardian Signature: _____

Date: _____

**Baxter Springs, Kansas**
**Parent & Student Learning Compact**

Student _____ Date_____

School _____

This Learning Compact is a way for the school and the parents to become equal partners in student learning.

The school will do the following.

- Provide education activities that are appropriate for your child.
- Provide communication to parents concerning your child.
- Procide necessary assistance to parents so they can hep their child.
- Have high expectations for student achievement.
- Provide a safe and encouraging learning environment.
- Make learning as enjoyable and relevant as possible.
- Make use of all supposrt services and materials available.
- Assign relevant and useful homework.
- Show respect for each child.

Signature _____

As a student I will do the following. (optional)

- Attend school regularly.
- Work Hard to do the best I can in class.
- Respect and cooperate with other students and adults.
- Ask for help when I need it.
- Complete and return homework.
- Help keep my school safe.
- Follow school rules.

Signature _____

As a parent I will do the following.

- Attend parent-teacher conferences.
- Make sure my child has their physical and emotional needs met.
- Encourage my child to do their best in school.
- Talk to my child and show interest in what they are doing in school.
- Provide a quiet place for study in my home.
- Make sure my child does assigned homework and provide support when needed.

Signature _____

# USD 508 Housing Information Form

Your answers will help determine if the student meets eligibility requirements for services under the McKinney-Vento Act.

Student_____ Parent/Guardian _____

School_____Phone _____

Age _____ Grade _____ D.O.B. _____

Address_____City _____

Zip Code_____Is this address Temporary or Permanent? (circle one)

Please choose which of the following situations the student currently resides in (you can choose more than one):

_____House or apartment with parent or guardian
_____Motel, car, or campsite
_____Shelter or other temporary housing
_____With friends or family members (other than or in addition to parent/guardian)

If you are living in shared housing, please check all of the following reasons that apply:

_____Loss of housing
_____Economic situation
_____Temporarily waiting for house or apartment
_____Provide care for a family member
_____Living with boyfriend/girlfriend
_____Loss of employment
_____Parent/Guardian is deployed
_____Other (Please explain)

Are you a student living apart from your parents or guardians? Yes No

**Housing and Educational Rights**

Students without fixed, regular, and adequate nighttime residences have the following rights:

1) Immediate enrollment in the school they last attended or the local school where they are currently staying even if they do not have all of the documents normally required at the time of enrollment without fear of being separated or treated differently due to their housing situations;
2) Transportation to the school of origin for the regular school day;
3) Access to free meals, Title I and other educational programs, and transportation to extra-curricular activities to the same extent that it is offered to other students.

Any questions about these rights can be directed to the local McKinney-Vento liaison at [Insert phone number] or the State Coordinator at [Insert phone number].

By signing below, I acknowledge that I have received and understand the above rights.

_____

*Signature of Parent/Guardian/UHY Youth* *Date*

_____

*Signature of McKinney-Vento Liaison/* *Date*

# 2026-2027 APPLICATION PACKET FOR FREE AND REDUCED PRICE SCHOOL MEALS

**How to Apply for Free and Reduced Price School Meals.**
Please use these instructions to help you fill out the application for free or reduced price school meals. You only need to submit one application per household, even if your children attend more than one school in USD 508, Baxter Springs Schools. The application must be filled out completely to certify your children for free or reduced price school meals. Please follow these instructions in order! Each step of the instructions is the same as the steps on your application. If at any time you are not sure what to do next, please contact Misha Gavin, 620-856-2375 / himesm@usd508.org.

**PLEASE USE A PEN (NOT A PENCIL) WHEN FILLING OUT THE APPLICATION AND DO YOUR BEST TO PRINT CLEARLY.**

## STEP 1: LIST ALL HOUSEHOLD MEMBERS WHO ARE INFANTS, CHILDREN, AND STUDENTS UP TO AND INCLUDING GRADE 12

Tell us how many infants, children, and school students live in your household. They do NOT have to be related to you to be a part of your household.
**Who should I list here?** When filling out this section, please include ALL members in your household who are:

- Children age 18 or under AND are supported with the household's income;
- In your care under a foster arrangement, or qualify as homeless, migrant, or runaway youth;
- Students attending USD 508, regardless of age.

| A) List each child's name. | B) Is the child a student at USD 508? | C) Do you have any foster children? | D) Are any children homeless, migrant, or runaway? |
|---|---|---|---|
| Print each child's name. Use one line of the application for each child. If there are more children present than lines on the application, attach a second piece of paper with all required information for the additional children. | Mark 'Yes' or 'No' under the column titled "Student" to tell us which children attend USD 508. If you marked 'Yes,' write the name of the school and the grade level of the student in the 'School' and 'Grade' columns to the right. | If any children listed are foster children, mark the "Foster Child" box next to the child's name. If you are ONLY applying for foster children, after finishing **STEP 1**, go to **STEP 4**. Foster children who live with you may count as members of your household and should be listed on your application. If you are applying for both foster and non-foster children, go to step 3. | If you believe any child listed in this section meets this description, mark the "Homeless, Migrant, Runaway" box next to the child's name and complete all steps of the application. |

## STEP 2: DO ANY HOUSEHOLD MEMBERS CURRENTLY PARTICIPATE IN FOOD ASSISTANCE, TAF, OR FDPIR?

**If anyone in your household (including you) currently participates in one or more of the assistance programs listed below, your children are eligible for free school meals:**

- Food Assistance (FA).
- Temporary Assistance for Families (TAF).
- The Food Distribution Program on Indian Reservations (FDPIR).

**A) If no one in your household participates in any of the above listed programs:**

- Leave **STEP 2** blank and go to **STEP 3.**

**B) If anyone in your household participates in any of the above listed programs:**

- Write a case number for FA, TAF, or FDPIR. You only need to provide one case number. If you participate in one of these programs and do not know your case number, contact Kansas Department for Children and Families.
- Go to **STEP 4**.

## STEP 3: REPORT INCOME FOR ALL HOUSEHOLD MEMBERS

**How do I report my income?**

- Use the charts titled **"Sources of Income for Adults"** and **"Sources of Income for Children",** printed on the back side of the application form to determine if your household has income to report.
- Report all amounts in GROSS INCOME ONLY. Report all income in whole dollars. Do not include cents.
  - Gross income is the total income received before taxes.
  - Many people think of income as the amount they "take home" and not the total, "gross" amount. Make sure that the income you report on this application has NOT been reduced to pay for taxes, insurance premiums, or any other amounts taken from your pay.
- Write a "0" in any fields where there is no income to report. Any income fields left empty or blank will also be counted as a zero. If you write '0' or leave any fields blank, you are certifying (promising) that there is no income to report. If local officials suspect that your household income was reported incorrectly, your application will be investigated.
- Mark how often each type of income is received using the check boxes to the right of each field.

**3.A. REPORT INCOME EARNED BY CHILDREN**

**A**) **Report all income earned or received by children.** Report the combined gross income for ALL children listed in STEP 1 in your household in the box marked "Child Income." Only count foster children's income if you are applying for them together with the rest of your household.

***What is Child Income?*** Child income is money received from outside your household that is paid DIRECTLY to your children. Many households do not have any child income.

**3.B REPORT INCOME EARNED BY ADULTS**

**Who should I list here?**

- When filling out this section, please include ALL adult members in your household who are living with you and share income and expenses, even if they are not related and even if they do not receive income of their own.
- ***Do NOT include:***
  - People who live with you but are not supported by your household's income AND do not contribute income to your household.
  - Infants, Children and students already listed in **STEP 1.**

| | | |
|---|---|---|
| **B) List adult household members' names.** Print the name of each household member in the boxes marked "Names of Adult Household Members (First and Last)." Do not list any household members you listed in **STEP 1**. If a child listed in **STEP 1** has income, follow the instructions in **STEP 3, part A.** | **C) Report earnings from work.** Report all income from work in the "Earnings from Work" field on the application. This is usually the money received from working at jobs. If you are a self-employed business or farm owner, you will report your net income. See detailed instructions on the back of the application.<br><br>***What if I am self-employed?*** Report income from that work as a net amount. This is calculated by subtracting the total operating expenses of your business from its gross receipts or revenue. | **D) Report income from public assistance/child support/alimony.** Report all income that applies in the "Public Assistance/Child Support/Alimony" field on the application. Do not report the cash value of any public assistance benefits NOT listed on the chart. If income is received from child support or alimony, only report court-ordered payments. Informal but regular payments should be reported as "other" income in the next part. |
| **E) Report income from pensions/retirement/all other income.** Report all income that applies in the "Pensions/Retirement/ All Other Income" field on the application. | **F) Report total household size.** Enter the total number of household members in the field "Total Household Members (Children and Adults)." This number MUST be equal to the number of household members listed in **STEP 1** and **STEP 3**. If there are any members of your household that you have not listed on the application, go back and add them. It is very important to list all household members, as the size of your household affects your eligibility for free and reduced price meals. | **G) Provide the last four digits of your Social Security Number.** An adult household member must enter the last four digits of their Social Security Number in the space provided. You are eligible to apply for benefits even if you do not have a Social Security Number. If no adult household members have a Social Security Number, leave this space blank and mark the box to the right labeled "Check if no SSN." |

## STEP 4: CONTACT INFORMATION AND ADULT SIGNATURE

***All applications must be signed by an adult member of the household. By signing the application, that household member is promising that all information has been truthfully and completely reported. Before completing this section, please also make sure you have read the privacy and civil rights statements on the back of the application.***

| | | | |
|---|---|---|---|
| **A) Provide your contact information.** Write your current address in the fields provided if this information is available. If you have no permanent address, this does not make your children ineligible for free or reduced price school meals. Sharing a phone number, email address, or both is optional, but helps us reach you quickly if we need to contact you. | **B) Print and sign your name and write today's date.** Print the name of the adult signing the application and that person signs in the box "Signature of adult." | **C) Mail Completed Form to:** 1108 Military Ave Baxter Springs, KS 66713 | **D) Share children's racial and ethnic identities (optional).** On the back of the application, we ask you to share information about your children's race and ethnicity. This field is optional and does not affect your children's eligibility for free or reduced price school meals. |

# 2026-2027 Household Application for Free and Reduced Price School Meals

Complete one application per household (use a pen not a pencil). Or apply online at https://schoolmealsapp.ksde.org/Home/welcome/D0508

## STEP 1 List ALL children, infants, and students up to and including grade 12. Attach another sheet of paper if you need space for more names.

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in **Foster care** and children who meet the definition of **Homeless**, **Migrant** or **Runaway** are eligible for free meals. Read **How to Apply for Free and Reduced Price School Meals** for more information.

| Child's First Name | MI | Child's Last Name | School | Grade | Student? Yes | Student? No | Foster Child | Homeless, Migrant, Runaway |
|---|---|---|---|---|---|---|---|---|
| | | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ | ☐ |

Check all that apply

## STEP 2 Do any Household Members (including you) currently participate in one or more of the following assistance programs: Food Assistance, TAF, or FDPIR?

**If NO** > Go to STEP 3. **If YES >** Write a case number here then go to STEP 4 (Do not complete STEP 3)

**Case Number (Not EBT or Medicaid Number):**

Write only one case number in this space.

## STEP 3 List ALL Household Members and income for each member (before taxes and deductions) (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here?

Flip the page and review the charts titled "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income section.

The "Sources of Income for Adults" chart will help you with the All Adult Household Members section.

Flip the page to learn how to report Income from Self Employment.

### A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income (before taxes and deductions) received by all children listed in STEP 1 here.

Child Income ☐☐☐☐

How Often? Weekly | Every 2 Weeks | 2x Month | Monthly | Annual

### B. All Adult Household Members (Anyone who is living with you and shares income and expenses, even if not related, including you)

List all 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 deductions) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

| Name of Adult Household Members (First and Last) | Earnings from Work | How often? Weekly | Every 2 Weeks | 2x Month | Monthly | Annual | Public Assistance/ Child Support/Alimony | How often? Weekly | Every 2 Weeks | 2x Month | Monthly | Pensions/Retirement/ All Other Income | How often? Weekly | Every 2 Weeks | 2x Month | Monthly |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | ○ | ○ | ○ | ○ | ○ | $ | ○ | ○ | ○ | ○ | $ | ○ | ○ | ○ | ○ |
| | $ | ○ | ○ | ○ | ○ | ○ | $ | ○ | ○ | ○ | ○ | $ | ○ | ○ | ○ | ○ |
| | $ | ○ | ○ | ○ | ○ | ○ | $ | ○ | ○ | ○ | ○ | $ | ○ | ○ | ○ | ○ |
| | $ | ○ | ○ | ○ | ○ | ○ | $ | ○ | ○ | ○ | ○ | $ | ○ | ○ | ○ | ○ |
| | $ | ○ | ○ | ○ | ○ | ○ | $ | ○ | ○ | ○ | ○ | $ | ○ | ○ | ○ | ○ |

**Total Household Members (Children and Adults)** ☐☐

**Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member** X X X X X ☐☐☐☐

**Check if no SSN** ☐

## STEP 4 Contact information and adult signature. Return completed form to: 1108 Military Ave, Baxter Springs, KS 66713

"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."

Printed name of adult signing the form

Signature of adult

Today's date

Street Address (if available)

Apt #

City

State

Zip

Daytime Phone and Email (optional)

**Return completed form to your child's school. *Do not mail, fax, or email completed applications to the U.S. Department of Agriculture Office of the Assistance Secretary for Civil Rights.**

## INSTRUCTIONS — Sources of Income

### Sources of Income for Children

| Sources of Child Income | Example(s) |
|---|---|
| • Earnings from work | • A child has a regular full or part-time job where they earn a salary or wages |
| • Social Security<br>- Disability Payments<br>- Survivor's Benefits | • A child is blind or disabled and receives Social Security benefits<br>• A Parent is disabled, retired, or deceased, and their child receives Social Security benefits |
| • Income from person outside the household | • A friend or extended family member regularly gives a child spending money |
| • Income from any other source | • A child receives regular income from a private pension fund, annuity, or trust |

### Sources of Income for Adults

- Salary, wages, cash bonuses
- Net income from self-employment (farm or business

If you are in the U.S. Military:

- Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances)
- Allowances for off-base housing, food, and clothing
- Unemployment benefits
- Worker's compensation
- Supplemental Security Income (SSI)
- Cash assistance from State or local government
- Alimony payments
- Child support payments
- Veteran's benefits
- Strike benefits
- Social Security (including railroad retirement and black lung benefits)
- Private pensions or disability benefits
- Regular income from trusts or estates
- Annuities
- Investment income
- Earned interest
- Rental income
- Regular cash payments from outside household

**Income from Self Employment:** Self-employed persons may use income tax records for the preceding calendar year as a base to project the current year's net income, unless the current monthly income provides a more accurate measure. Report income derived from the business venture less operating costs incurred in the generation of that income. Deductions for personal expenses such as interest on home payments, medical expenses, and other similar non-business deductions are not allowed in reducing gross business income. Additional income from other kinds of employment must be treated as separate and apart from the income generated or lost from your business venture. For example, if you operated a business at a net loss, but held additional employment for which a salary was received, the income for purposes of applying for reduced price or free meals would be the income from the salary only. The loss from the business cannot be deducted from a positive income earned in other employment.

For purposes of this application, it is not possible to report a negative income from any business venture. The least income possible is zero (no income). The necessary information for arriving at allowable income from private business operation may be taken from your most recent U.S. Individual Income Tax Return - Form 1040, Schedule 1. Add together the amounts reported on the following lines:

| | | |
|---|---|---|
| Schedule 1, Line 3 | $_____ | Business Income or (Loss) |
| 1040, Line 7 | $_____ | Capital Gain or (Loss) |
| Schedule 1, Line 4 | $_____ | Other Gains or (Losses) |
| Schedule 1, Line 5 | $_____ | Rental real estate, royalties, partnerships, S corporations, trusts, etc. |
| Schedule 1, Line 6 | $_____ | Farm Income or (Loss) |
| TOTAL | $_____ | Gross Annual Income Before Any Deductions. |
| Computed Monthly Income | $_____ | Gross Annual Income ÷ 12 = Computed Monthly Income. Report in Step 3. |

## OPTIONAL — Children's ethnic and racial Identities. This information is kept confidential and may be protected by the Privacy Act of 1974.

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 (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin, regardless of race) ☐ 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

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, 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 Food Assistance (FA) Temporary Assistance for Families (TAF) 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.

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.

## Do not fill out — For School Use Only – Annual Income Conversion: Weekly x 52, Bi-Weekly x 26, Twice a Month x 24, Monthly x 12

☐ Total Income: $_____ How Often (Circle One): W E2W 2M A M Multiple=Yearly Household Size: _____

☐ Categorical Eligibility (FA, TAF, FDPIR, Foster)

Eligibility: ☐ Free ***OR*** ☐ Reduced Price ***OR*** ☐ Denied

Notes:_____

Determining Official's Signature: Approval/Denial Date: Notification Date:

**Processor's Initials:** **Confirming Official's Signature (ONLY for applications to be verified):** **Review Date:**

**Return completed form to your child's school. *Do not mail, fax, or email completed applications to the U.S. Department of Agriculture Office of the Assistance Secretary for Civil Rights.**

USD 508 Baxter Springs Schools

# Consent for Disclosure

**Sharing Information with Other Programs**

Dear Parent/Guardian:

**You do not have to sign or send in this form to get reduced price or free Child Nutrition Program benefits for your children. If you do not sign the Consent for Disclosure, it will not affect eligibility for or participation in the Child Nutrition Programs.**

To save you time and effort, information about your children's eligibility for reduced price or free Child Nutrition Program benefits may be shared with other programs for which your children may qualify. For the programs listed below, we must have your permission to share your information.

☒ **Yes**, I DO want school officials to share information about my children's eligibility for Child Nutrition Program benefits only with the programs I have checked below.

- ☒ Book Fee
- ☒ Technology Fee
- ☐ _____
- ☐ _____

If you checked yes to any or all of the boxes above, fill out the form below. Your information will be shared only with the programs you checked.

Child's Name: _____ School: _____

Child's Name: _____ School: _____

Child's Name: _____ School: _____

Child's Name: _____ School: _____

Child's Name: _____ School: _____

Child's Name: _____ School: _____

Signature of Parent/Guardian: _____ Date: _____

Printed Name: _____

Address: _____

For more information, you may call or e-mail:

School Official's Name: Misha Himes Phone: 620-856-2375 E-Mail: himesm@usd508.org

Return this form to the address below by _____.

Address: 1108 Military Ave. Baxter Springs, KS 66713

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