Dear Parent/Guardian: Date:

Each child listed below is automatically approved to receive free or reduced price school meals for the current school year based on your eligibility for **FoodShare, Wisconsin Works (W-2) cash benefits, certain Medicaid programs, the Food Distribution Program on Indian Reservations (FDPIR), or Foster Child status**.

| **Name of Child** | **Name of School** | **Free** | **Reduced** |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

If your child(ren) are approved for free meals, do not fill out a *Household Application for Free and Reduced Price School Meals* for the student(s) listed above. If your child(ren) are approved for reduced price meals, you may complete a *Household Application for Free and Reduced Price Schools Meals* to see if your child(ren) are eligible to receive free meals.

**Extension of Benefits:** If there are additional students in your household who are not listed above, they are also eligible to receive free or reduced price meals. Note that if the child listed above is a foster child, the benefit may not be extended to other children in the household. The child(ren) you list below will be eligible for free or reduced price meals on the date you return the information to the address listed below. Please return the entire letter. If you have more children to list than the space allows, please attach a list on a separate sheet of paper.

| **Name of Child** | **Name of School** |
| --- | --- |
|  |  |
|  |  |

**Summer EBT:** Because your child(ren) qualify for free or reduced price meals this school year, they are also eligible to receive Summer EBT benefits for this upcoming summer. Summer EBT provides funds for each eligible child to help with costs of food during the summer months. To learn more about this program, to update your contact information, or to opt out of receiving these benefits visit [Summer EBT Benefit Management](https://schoolpebt.wi.gov/s/SummerBenefitInfo). *https://schoolpebt.wi.gov/s/SummerBenefitInfo*

**Reminder**: Meal benefits apply only to the reimbursable meal. The reimbursable meal includes milk as one of the required components and must be priced as a unit. If the student decides to only take milk, this is not a reimbursable meal, and the milk will be charged as an a la carte item.

**Decline the Benefit**: If you do not want your child(ren) to receive free or reduced price meal benefits, please complete the form on the back of this page and return it to the address listed below

If any of the information listed above is incorrect, or if you have any questions, please contact:

**[name]**

**[mailing address]**

**[phone number]**

**[e-mail address]**

Sincerely,

**[signature]**

**Decline the Benefit:** If you do not want your child(ren) to receive these school meal benefits, complete the section below and return the entire letter to the address listed on the reverse.

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I do not want my child(ren)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

to receive free or reduced price meals. (Child(ren)’s Name, please print clearly)

Signature of Parent or Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA’s TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant’s name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
2. **fax:**  
   (833) 256-1665 or (202) 690-7442; or
3. **email:**  
   [Program.Intake@usda.gov](mailto:program.intake@usda.gov)

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