STUDENT FEE WAIVER FORM 2019-2020

Bettendorf Community School District

***PLEASE COMPLETE ALL INFORMATION ON THIS FORM TO HAVE FEES ADJUSTED*. RETURN COMPLETED AND SIGNED FEE WAIVER FORM TO THE BCSD DISTRICT ADMINISTRATION CENTER TO BE PROCESSED. PLEASE COMPLETE ONLY ONE FEE WAIVER PER FAMILY.**

If your child qualifies for free or reduced price meals, you may also be eligible for other benefits. One of these benefits is school fees. If you sign this waiver, your child will be **considered** for a full, partial or temporary waiver of textbook rental, transportation and/or musical instrument fees. **This waiver does not carry over from year to year and must be completed annually.**

Please print clearly. **Date Completed:**______________________

____

Name of parent, guardian, or legal/actual custodian

____

Street Address

____

City, State, Zip

Student Name	School	Grade
____	_________________	_____
____	_________________	_____
____	_________________	_____
____	_________________	_____
____	_________________	_____

Allow my child(ren)'s name and meal eligibility **to be shared with staff to adjust Textbook Rental Fee.**
Yes ☐ No ☐
Allow my child(ren)'s name and meal eligibility **to be shared with staff to adjust Transportation Fee**
Yes ☐ No ☐
Allow my child(ren)'s name and meal eligibility **to be shared with staff to adjust Musical Instrument Rental.**
Yes ☐ No ☐
Allow my child(ren)'s name and meal eligibility **to be shared with Outreach Services.**
Yes ☐ No ☐

Your signature below is **REQUIRED** for the release of information regarding the student or the student's family financial eligibility. Without your signature, this application cannot be processed.

I understand that I will be releasing information that will show that I applied for free and reduced price school meals for my child. I give up my rights to confidentiality for waiver of school fees **ONLY**.

➡ ____

Signature of parent, guardian or legal/actual custodian **Date**

For Office Use Only:
Date Approved: ________________
Full _________
Partial _________
Temporary Approval _______ **Expires:** _____ **Mo.** _____ **Day**

2019-08-27

If you have questions or if one or more of your children are not listed above, CONTACT YOUR CHILDREN'S SCHOOL.

Return this page to your school if you complete the section refusing meal benefits, decline having your information shared with hawk-i or Medicaid or sign the waiver statement.

REFUSAL OF MEAL BENEFITS BASED ON DIRECT CERTIFICATION

I DO NOT want my child(ren) to receive meal benefits.

Child's Name: ____ School: ______________________________

Child's Name: ____ School: ______________________________

Child's Name: ____ School:

hawk-i */Medicaid Information Form*

Read this information. Sign below and return this page to the school **if you decide you do not want** your name released to ***hawk-i*** or Medicaid. If your children do not have health insurance, many families getting free or reduced price meals can also get free or low-cost health insurance for their children. The law requires public schools to share your free or reduced price meal eligibility information with Medicaid & ***hawk-i***, the State's medical insurance program for children. Private schools, RCCIs and childcare organizations may choose to share this information. Specifically, we will give them your child's name, 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 & then to contact you. They are not allowed to use the information from your free and reduced meal application for any other purpose or to share it with any other entity or program. You are not required to allow us to share this information, it will not affect your child's eligibility for free or 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. If you want further information, you may call ***hawk-i*** at 1-800-257-8563. Also, if you are already receiving Medicaid or ***hawk-i***, please sign below. This will avoid another contact.

I DO NOT want school officials to share information from my free and reduced price meal application with Medicaid or ***hawk-i***..

Parent/Guardian Name (Printed) ___________________________________ Signature _________________________________ Date ___________

Optional Waiver Information for Directly Certified Households

USDA Nondiscrimination 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.

Iowa Nondiscrimination Statement:

"It is the policy of this CNP provider not to discriminate on the basis of race, creed, color, sex, sexual orientation, gender identity, national origin, disability, age, or religion in its programs, activities, or employment practices as required by the Iowa Code section 216.6, 216.7, and 216.9. If you have questions or grievances related to compliance with this policy by this CNP Provider, please contact the Iowa Civil Rights Commission, Grimes State Office building, 400 E. 14th St. Des Moines, IA 50319-1004; phone number 515-281-4121, 800-457-4416; website: https://icrc.iowa.gov/."