**CONFIRMATION OF YOUR ELIGIBILITY FOR FREE/REDUCED-PRICE MEALS**

**[Date]**

Dear **[Parent/Guardian Name]**,

We checked the information you sent us to prove that **[Name(s) of child(ren)]** are eligible for free or reduced-price meals and have decided that:

* Your child(ren)’s eligibility has not changed.
* Starting **[Date]**, your child(ren)’s eligibility for meals will be changed from reduced-price to free because your income is within the free meal eligibility limits. Your child(ren) will receive meals at no cost.
* Starting **[Date]**, your child(ren)’s eligibility for meals will be changed from free to reduced-price because **[your income is over the limit]** or **[your income is over the limit, but your child(ren) receive Medicaid]** or **[you did not respond to our request, but your child(ren) receive Medicaid]**. During 2024-2025 School Year, households will not be required to pay the reduced price $0.30 for breakfast and the $0.40 for lunch due to the State of Georgia budget covering these costs.
* Starting **[Date]**, your child(ren) is/are no longer eligible for free or reduced-price mealsfor the following reason(s):

\_\_\_ Records show that no one in your household received **SNAP** or **TANF** benefits.

\_\_\_ Records show that the child(ren) is/are not homeless, runaway, or migrant.

\_\_\_ Your income is over the limit for free or reduced-price meals.

\_\_\_ You did not provide: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **[List missing information]**

\_\_\_ You did not respond to our request.

Meals cost **[$]** for lunch and **[$]** for breakfast. If your household income goes down or your household size goes up, you may apply again. If you were previously denied benefits because no one in the household received **SNAP or TANF** benefits, you may reapply based on income eligibility. If you did not provide proof of current eligibility, you will be asked to do so if you reapply.

If you disagree with this decision, you may discuss it with **[Name]** at **[Phone]**. You also have the right to a fair hearing. If you request a hearing by **[Date]**, your child(ren) will continue to receive free or reduced- price meals until the decision of the hearing official is made. You may request a hearing by calling or writing to: **[Name], [Address], [Phone number], or [Email]**.

Sincerely,

**[Signature]**

**[Verification Official]**

**[School District Name]**

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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/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.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

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