Use your "Mouse" or "Tab" key to move through the fields and check boxes. After completing last field, save document to hard drive to make future updates or click Print button.

Illinois State Board of Education

100 North First Street
Springfield, Illinois 62777-0001

SAMPLE NOTIFICATION LETTER - DIRECT CERTIFICATION MEDICAID REDUCED PRICE ELIGIBLE

NUTRITION DEPARTMENT

Date: _____

Dear Parent/Guardian:

Each student identified below is automatically approved for REDUCED-PRICE school meals for the current school year based on your eligibility for Income Eligible Medicaid.

Name of Student	Grade	Assistance Source	School Name

No further action is needed to receive reduced-price eligible meals at school for the enrolled students. If however, your household may qualify for free meals based on household size and income, please complete the Household Eligibility Application for free or reduced price meals enclosed. Once submitted, you will receive additional notification if the student(s) qualifies for greater benefits. **If you do not want your child to receive reduced-price meal benefits** please completely fill out the information in the box below and return to the school office no later than _____. (Insert Date)

If you have student(s) in your household who are not listed above, please contact this office at the telephone number provided below at your earliest convenience. A Household Eligibility Application is NOT needed; reduced-price meal benefits will be extended to all children residing in the same household.

☐ I DO NOT want my child(ren), as listed above, to receive reduced-price meal benefits.

_____ _____
Date Signature of Parent or Guardian

If any of the information listed above is incorrect, or you have any questions, please contact this office at (_____) _____.

_____ _____
Name Title

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/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

This institution is an equal opportunity provider.

Print Reset Form