

FEE WAIVER REQUEST

School _____ School Year _____

Parent/Guardian Name _____ Telephone _____

Street Address _____

City, State, Zip _____

Fee(s) requested to be waived: _____

I request a fee waiver for the following children:

Child's Birthdate	Child's Last Name	Child's First Name

I certify that I/we are unable to pay the fees because:

If temporary financial disability, state date of expected payment: _____

AFDC No. _____ Food Stamp No. _____

I understand school officials will notify me regarding a decision about this request.

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT THE AFDC AND/OR FOOD STAMP NUMBER IS CORRECT. I UNDERSTAND THAT THIS INFORMATION IS BEING GIVEN FOR THE PURPOSE OF DETERMINING ELIGIBILITY FOR WAIVER OF SCHOOL FEES, THAT SCHOOL OFFICIALS MAY VERIFY THE INFORMATION ON THE APPLICATION AND THAT DELIBERATE MISREPRESENTATION OF THE INFORMATION MAY SUBJECT ME TO PROSECUTION UNDER APPLICABLE STATE AND FEDERAL LAW.

Applicant's Signature _____ Date _____

Last Four Digits of Applicant's Social Security Number _____

Approved _____ Denied _____ Reason for denial: _____

School Principal's Signature _____ Date _____

If denied, a parent/guardian has the right to appeal this decision by submitting a written request to the superintendent within fourteen (14) days of the denial date listed above. You also have the right to meet with the person/board who will decide the appeal in order to explain why this fee waiver should be granted. A parent/ guardian may reapply for a fee waiver at any time during the school year if your circumstances change.