



**FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY**

# **Out of School Time Enrollment Packet**



**Cross Lanes YMCA Child Development Center**  
5113 Rocky Fork Road  
Cross Lanes, WV 25313  
304-776-3323  
[www.ymcaofkv.org](http://www.ymcaofkv.org)

Dear Parent/Guardian/Custodian,

Welcome to Cross Lanes YMCA Child Development Center! Thank you for trusting us to care for child. We look forward to getting to know both you and your family during your time here.

To register your child for any programs at the Cross Lanes YMCA Child Development Center, you will need to do the following:

1. Complete, sign and return all forms in the enrollment packet.
2. Submit a current Child Health Assessment that has been completed and signed by a physician for children over the age of three (3) months. Health assessments must be updated every six (6) months for children under two (2) years and every two (2) years for children over two (2) years.
3. For children between the ages of six (6) weeks and three (3) months, a signed statement from the child's physician permitting the child to attend group care must be submitted at time of enrollment.
4. Submit a current copy of your child's immunization records. Immunization records must be updated every six (6) months for children under two (2) years and every two (2) years for children over two (2) years.
5. Submit a copy of your child's birth certificate for children under the age of six (6) years.
6. Complete and sign the Free and Reduced Meals Application. This form is required for all families, qualifying and non-qualifying, in order for the YMCA to receive reimbursement for meals served and help maintain compliance with the Child and Adult Care Food Program (CACFP). Only one form is required per family.
7. Submit a copy of your insurance information with carrier and policy number. You may enter this information into the attached Medical Information form or attach a copy of your insurance card to your enrollment packet.
8. Read the Family Handbook and sign the Agreement Page at the end after discussing with the Director any questions you may have regarding policies and procedures.
9. Read and sign the Financial Agreement.
10. Pay a \$45 non-refundable registration fee.

**Registration may not be completed until all of the above requirements have been met.**

If you have any questions, please do not hesitate to contact us at your convenience.

Sincerely,

Ashley N. Garnes – Youth Development Director  
agarnes@ymcaofkv.org

Karleigh M. Fellure – Executive Director of Youth Development  
kfellure@ymcaofkv.org

Shannon Cox – Administrative Office Assistant  
scox@ymcaofkv.org

Janet Reed – Billing Coordinator  
jreed@ymcaofkv.org

Ginny Johnson – Pre-K Coordinator  
ginny.johnson@mail.kana.k12.wv.us

Amanda Jones – School Age Coordinator  
ajones@ymcaofkv.org

**Cross Lanes YMCA Child Development Center**  
5113 Rocky Fork Rd. \* Cross Lanes, WV 25313  
(P) 304-776-3323 \* (F) 304-776-0800

**CHECK DAYS ATTENDING**

After School:

M  T  W  R  F

Full Day Out Only:

**Cross Lanes YMCA  
Child Development Center**  
5113 Rocky Fork Road  
Cross Lanes, WV 25313

**Out of School Time Programs  
2023 - 2024**

**Enrollment Date:**

\_\_\_\_\_

**Withdrawal Date:**

\_\_\_\_\_

**Child's Information Record**

*We accept all children without regard to race, ethnicity, creed, religion, gender, national origin, sexual orientation, gender identity, ability, or parent's marital status.*

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Current Age \_\_\_\_\_

Gender \_\_\_\_\_

Name of School Attending \_\_\_\_\_

School Phone Number \_\_\_\_\_

Grade (2022-2023) \_\_\_\_\_

Child's Primary Address \_\_\_\_\_

**Parent/Guardian/Custodian Information**

Parent/Guardian/Custodian Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Relationship to the Child \_\_\_\_\_

Primary Address \_\_\_\_\_

Email Address \_\_\_\_\_

Primary Phone Number \_\_\_\_\_

Work Phone Number \_\_\_\_\_

Cell Phone Carrier (Used for Family Communication) \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Parent/Guardian/Custodian Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Relationship to the Child \_\_\_\_\_

Primary Address \_\_\_\_\_

Email Address \_\_\_\_\_

Primary Phone Number \_\_\_\_\_

Work Phone Number \_\_\_\_\_

Cell Phone Carrier (Used for Family Communication) \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

If child does not reside with the above, please explain the arrangements below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who should be contacted first? \_\_\_\_\_

Who is responsible for payment of fees? \_\_\_\_\_

**Special Instructions:** Biological/custodial parents must be given access to their children unless there is a court order preventing contact. **A copy of the court order must be provided.**

Individuals with court orders against them preventing child pick up:

Name \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Name \_\_\_\_\_

Relationship to Child \_\_\_\_\_

## Emergency Contacts and Authorized Pick-Ups

### Emergency Contacts:

*These should be local persons who may be notified in case of emergency or illness when the parent/guardian/custodian is unavailable:*

Name \_\_\_\_\_ Relationship to the Child \_\_\_\_\_

Primary Address \_\_\_\_\_ Email Address \_\_\_\_\_

Primary Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_ Other Phone Number \_\_\_\_\_

Name \_\_\_\_\_ Relationship to the Child \_\_\_\_\_

Primary Address \_\_\_\_\_ Email Address \_\_\_\_\_

Primary Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_ Other Phone Number \_\_\_\_\_

### Authorized Pick-Ups:

*The following persons have permission to pick up my child from the center. Anyone not listed cannot pick up the child without written permission.*

1. Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ Other Phone Number: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ Other Phone Number: \_\_\_\_\_

3. Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ Other Phone Number: \_\_\_\_\_

4. Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ Other Phone Number: \_\_\_\_\_

5. Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ Other Phone Number: \_\_\_\_\_

*By signing below you certify that the information provided on this form is correct, current, and accurate to your best knowledge. You agree to review and update information whenever changes occur and at least every 12 months.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Authorizations and Permissions

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

### Authorization for Emergency Medical Treatment and Transportation

*Please complete section 1 or 2 below. DO NOT complete both.*

#### 1. Permission to Transport and Secure Medical Treatment:

In the event that I cannot be reached to make arrangements for emergency medical or dental care for my child, I hereby give the YMCA staff permission to transport my child, \_\_\_\_\_, to \_\_\_\_\_ (preferred hospital) for emergency medical care or to \_\_\_\_\_ (preferred dentist) for emergency dental care or to the nearest source available. I grant the YMCA staff permission to take whatever steps necessary to obtain emergency care, if warranted. I agree that the YMCA is released of liability in connection with medical treatment and unavoidable accidents.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

#### 2. Refusal to Grant Permission:

I **DO NOT** give the YMCA staff permission to transport my child, \_\_\_\_\_, to the nearest hospital or dental facility for emergency medical or dental care. **Instead**, I wish the following action to be taken:

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

### Child Care Permission Form

*Please read each statement below and initial in the provided space. If you do not agree with the statement or choose not to initial, please schedule a meeting with the Director.*

- \_\_\_\_\_ I hereby grant permission for the Cross Lanes YMCA Child Development Center staff to apply sunscreen and lip balms to my child when necessary. **(Please note that parent/guardians must supply sunscreen and lip balm)**
- \_\_\_\_\_ I hereby grant permission for the Cross Lanes YMCA Child Development Center staff to apply diaper ointments and/or creams, used for preventative purposes, to my diapered child when necessary. **(Please note that parent/guardians must supply diaper ointments and/or creams)**
- \_\_\_\_\_ I hereby grant permission for my child to leave the Cross Lanes YMCA premises as scheduled, under the supervision of YMCA staff members for daily activities and field trips in an authorized YMCA vehicle.
- \_\_\_\_\_ I hereby grant permission for my child to be included in evaluations, photos, and audio or video recordings connected with the program. Photographs and videos may be used for YMCA promotional purposes.
- \_\_\_\_\_ I hereby grant permission for my child to use all play equipment and participate in all activities associated with the child care program.
- \_\_\_\_\_ I hereby grant permission for my child to participate in water activities, on site, when weather permits.
- \_\_\_\_\_ I understand that children may not bring outside food or drink into the YMCA. This policy is a requirement to maintain compliance with the Child and Adult Care Food Program (CACFP). Please see the Director or Assistant Director if your child has special dietary needs.
- \_\_\_\_\_ I understand that the YMCA is released of liability in connection with medical treatment and unavoidable accidents.

**Approval:** As the parent or legal guardian the child named above, I approve the conditions stated in the section entitled "Child Care Permission Form."

Approval Signature: \_\_\_\_\_

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

## Medical Information Form

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy # \_\_\_\_\_

Name of Physician \_\_\_\_\_ Physician's Phone \_\_\_\_\_

Physician's Address \_\_\_\_\_

Has your child had any of the following illnesses or conditions?

	<u>Yes</u>	<u>No</u>	<u>When</u>		<u>Yes</u>	<u>No</u>	<u>When</u>
Poliomyelitis	( )	( )		Rheumatic Fever	( )	( )	
Tuberculosis	( )	( )		Meningitis	( )	( )	
Scarlet Fever	( )	( )		Mumps	( )	( )	
Pneumonia	( )	( )		Measles (type)	( )	( )	
Frequent Headaches	( )	( )		Heart Troubles	( )	( )	
Seizures	( )	( )		Hives	( )	( )	
Asthma/Hay Fever	( )	( )		Fainting	( )	( )	
Chronic Cough	( )	( )		Ear Infections	( )	( )	
Whooping Cough	( )	( )		Bronchitis	( )	( )	
Eczema	( )	( )		Chicken Pox	( )	( )	
Frequent Colds	( )	( )		Croup	( )	( )	
Influenza	( )	( )		Tonsillitis	( )	( )	

Other \_\_\_\_\_

Comments on checked items \_\_\_\_\_

Serious Injuries \_\_\_\_\_

Hospitalizations \_\_\_\_\_

Any Operations \_\_\_\_\_

Allergies \_\_\_\_\_

Unusually sensitive to: ( ) Poison Oak or Ivy ( ) Any Medications  
( ) Insect Stings ( ) Other: \_\_\_\_\_

Is your child currently taking any medications? (Specify) \_\_\_\_\_

Are any activities to be restricted? ( ) Yes ( ) No If yes, please specify: \_\_\_\_\_

Special Needs/Disabilities: \_\_\_\_\_

Any additional information that will help us better care for your child: \_\_\_\_\_

**IMPORTANT:** Please notify the Director if your child is exposed to any communicable disease during program attendance.

**PARENT/GUARDIAN AUTHORIZATION:** By signing below you certify that the above given information is current, correct, and accurate to your best knowledge.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



FOR YOUTH DEVELOPMENT®  
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## YMCA of Kanawha Valley Youth Development Financial Agreement

### REGISTRATION

- A valid credit card or banking information must be provided at the time of enrollment. This information will be securely stored on the account and used for tuition purposes only. Credit cards and banking information will not be shared with any other parties.
- A \$45 registration fee, per child, is due at time of registration or when registering for a new program. The registration fee does not apply to weekly tuition.
- Summer Day Camp and Funshine Camp – A \$25 deposit on every week of camp selected is due at the time of registration, \$5 per week for families on the YMCA Scholarship program. Families receiving subsidy are exempt from this policy. Your child's registration will be discontinued from future weeks if your child does not attend for two (2) or more consecutive weeks, without notification.
- All registration fees and deposits are non-refundable and non-transferable.
- A service fee of \$30 will be charged on all returned checks and returned bank drafts.

### PRIVATE PAY TUITION

- Weekly tuition will not be waived for any reason. Extenuating circumstances may be discussed with the Director.
- Weekly tuition is due in full regardless of the number of days your child attends. This reserves your child's place in our program.
- Refunds or adjustments will not be given for missed days.
- Credits will only be given for closures if the center is closed for three (3) or more days in a one (1) week period. Closures include, but are not limited to, major holidays, communicable disease outbreaks, severe weather, power outages, water outages, etc.
- Early Learning Programs (Nursery-Preschool)
  - Weekly tuition is due in full each Tuesday for the following week of care.
  - A fee of \$10 per week will be charged if tuition is not paid by Tuesday at 6:00 p.m.
  - Families registered in an Early Learning Program receive two (2) weeks' vacation per calendar year. Please see Billing Coordinator to request vacation time.
- Out of School Time and Pre-K Extended Care Programs
  - Weekly tuition is due in full each Tuesday for the following week of care.
  - A fee of \$10 per week will be charged if tuition is not paid by Tuesday at 6:00 p.m.
- Your child's registration may be discontinued if your account becomes past due.

### SUBSIDIZED TUITION (Connect, Link, etc.)

- Parent/Guardians receiving subsidy are billed the second week of the month for the prior month of childcare services.
- Tuition is due one (1) week from the date billed. Failure to pay may result in dismissal from the subsidy program.
- If a child attends child care outside of the contracted subsidized hours, parent/guardians will be billed for the difference at the private pay tuition rate.
- Parent/Guardians of subsidized children are responsible for the payment of tuition in the event they become ineligible to receive child care subsidy.
- Children receiving subsidy must attend 13 or more full days per month. If child attends less than the necessary number of full days, there is a risk of the child's registration being discontinued. Full days are defined as four (4) or more hours per day.
- Your child's registration will be discontinued if your child does not attend for two (2) or more consecutive weeks, without notification.

### WITHDRAWALS

- Two (2) prior weeks' notice, or two (2) weeks tuition is payable upon a child's withdrawal from the program.
- The two (2) weeks' prior notice is to be in written form and must be received by the Director or Billing Coordinator.
- Parents are responsible for removal of all personal items within ten (10) days of withdrawal. After ten (10) days, items will be donated to a local charity.

### PAST DUE BALANCES

- **Past due balances will be automatically deducted on a bi-weekly basis, using the credit card on the account.**

### LATE PICK-UPS

- A fee of \$1 per minute past closure will be applied to your weekly tuition and will be due by the next billing period.
- Your child's registration may be discontinued for consistent late pickups.

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By signing this agreement, I acknowledge I have read and agree to the financial above policy.

Child's Name \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_ Parent/Guardian's Signature \_\_\_\_\_

Dear Parent or Guardian:

This center participates in the U.S. Department of Agriculture's Child and Adult Care Food Program (CACFP). Please help us comply with the requirements of the CACFP by completing, signing and returning the attached statement as soon as possible. The statement will be filed as confidential information. The names of the participants for which free or reduced price meals may be claimed shall not be published, posted or announced in any manner; this information is necessary to determine the amount of federal funding received by our center for the meal served to children. Higher reimbursement will contribute to the overall quality of care your provider maintains.

If you received Food Stamps or benefits under the West Virginia Temporary Assistance to Needy Families (TANF) on behalf of your child, then please list either your 10 digit Food Stamp case number or your TANF case number in Section 2 and sign and date the statement in Section 5. This means that your child is "categorically eligible" and will automatically qualify for reimbursement.

If a Food Stamp or TANF case number is not reported, Section 4 must be completed. You must include your total current household income by source and the names of all household members. CACFP defines a household as a group of related or unrelated individuals who are living as one economic unit (i.e. sharing living expenses). The reported income should be what each member received last month. If last month's income does not accurately reflect your circumstances, provide a projection of your income using last year's income as a basis. Please remember to put the name and social security number of the primary wage earner underneath the chart. You must also sign and date Section 5.

If this application is for a foster child, please read carefully the directions found on the "Instructions For Applying" sheet. If you have a foster child and have further questions, please contact our office for additional information before completing the application.

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, audiotope, 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](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.

Thank you for your cooperation:

  
Institution Representative



Program Year 2023-2024  
West Virginia Department of Education  
**FREE AND REDUCED PRICE SCHOOL MEALS FAMILY APPLICATION**  
**INSTRUCTIONS FOR APPLYING**

**If your household gets FOOD STAMPS OR TANF, follow these instructions:**

- Part 1:** List child(ren)'s name, date of birth, grade, and school, center, or camp.  
**Part 2:** Check the appropriate box and list the 10-digit Food Stamp or TANF case number.  
**Part 3:** Skip this part.  
**Part 4:** Skip this part.  
**Part 5:** Sign the form. A Social Security Number is not necessary.  
**Part 6:** Answer this question if you choose.  
**Part 7:** Answer this question if you choose.  
**Part 8:** (Found on back of application.) Call number listed to request WVCHIP or Medicaid information.

**If you are applying for a child who is HOMELESS, MIGRANT, or a RUNAWAY, follow these instructions: check the appropriate box and call your county contact at the phone number listed in Part 3 of the application. Fill out the rest of the application by following instructions for ALL OTHER HOUSEHOLDS.**

**If you are applying for a FOSTER CHILD, follow these instructions:**

**If all children in the household are foster children:**

- Part 1:** List all foster children, date of birth, grade and school, center, or camp.  
**Part 2:** Skip this part.  
**Part 3:** Skip this part.  
**Part 4:** Skip this part.  
**Part 5:** Sign the form. The last four digits of a Social Security Number are **not** necessary.  
**Part 6:** Answer this question if you choose.

**If some children in the household are foster children:**

- Part 1:** List all children in the household (including foster children), date of birth, mark box if foster child, grade, and school, center, or camp.  
**Part 2:** If the household does not have a case number, skip this part.  
**Part 3:** If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call the contact number listed.  
**Part 4:** Follow these instructions to report total household income from last month.  
**Column 1–Name:** List all household members.  
**Column 2–Last month's income:** List the types of income your household received last month. *Employment Income:* List the **gross income** each person earned last month. It is not the same as take home pay. **Gross income is the amount earned before taxes and deductions.** It should be listed on your pay stub, or your boss can tell you. *Other Income:* List the total amount each person received last month from **all other sources.** Include welfare, child support, alimony, pensions, retirement, Social Security, Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household, withdrawals from savings, and ANY OTHER INCOME. Report net income for self-owned business, farm, or rental income.  
**Last Column–Check if no income:** If the person does not have any income, check the box.  
**Part 5:** An adult household member must sign the form and list the last 4 digits of his or her Social Security Number, or mark the box if he or she doesn't have one.  
**Part 6:** Answer this question if you choose.  
**Part 7:** Answer this question if you choose.  
**Part 8:** (Found on back of application.) Call number listed to request WVCHIP or Medicaid information.

**ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:**

- Part 1:** List each child's name, date of birth, grade and school, center, or camp.  
**Part 2:** Skip this part.  
**Part 3:** Check a box only if it applies.  
**Part 4:** Follow these instructions to report total household income from last month.  
**Column 1–Name:** List the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends). **You must include yourself and all children.** Attach another sheet of paper with household members if required.  
**Column 2–Last month's income:** List the types of income your household received last month. *Employment Income:* List the **gross income** each person earned last month. It is not the same as take home pay. **Gross income is the amount earned before taxes and deductions.** It should be listed on your pay stub, or your boss can tell you. *Other Income:* List the total amount each person received last month from **all other sources.** Include welfare, child support, alimony, pensions, retirement, Social Security, Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household, withdrawals from savings, and ANY OTHER INCOME. Report net income for self-owned business, farm, or rental income.  
**Last Column–Check if no income:** If the person does not have any income, check the box.  
**Part 5:** An adult household member must sign the form and list the last 4 digits of his or her Social Security Number, or mark the box if he or she doesn't have one.  
**Part 6:** Answer this question if you choose.  
**Part 7:** Answer this question if you choose.  
**Part 8:** (Found on back of application.) Call number listed to request WVCHIP or Medicaid information.

**Free and Reduced-Price Household Application for 2023-2024 – West Virginia Dept. of Education**

USE BLACK OR DARK BLUE INK, PRINT NEATLY, COMPLETE ONE APPLICATION PER HOUSEHOLD

**1. Names of ALL Children in School, Center, or Camp**

Last Name	First Name	MI	Date of Birth MM/DD/YY	Mark if Foster	Grade	School, Center, or Camp
			/ /	<input type="checkbox"/>		
			/ /	<input type="checkbox"/>		
			/ /	<input type="checkbox"/>		
			/ /	<input type="checkbox"/>		
			/ /	<input type="checkbox"/>		

**2. SNAP/TANF NUMBER**

If any member of your household receives SNAP or TANF, indicate which program and provide the 10-digit case # (If any, SKIP TO PART 5)

SNAP  TANF

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**3. HOMELESS, MIGRANT, RUNAWAY**

If the child you are applying for is homeless, migrant, or runaway, check the appropriate box and call your county contact at \_\_\_\_\_ Homeless  Migrant  Runaway

**4. HOUSEHOLD MEMBERS AND GROSS INCOME FROM LAST MONTH**

List each person in the household. For each person who receives income, write the amount received and fill in how often it is received.

Name (Last, First) List everyone in the Household. Attach a separate sheet if needed.	Monthly Earnings from Work (Before Deductions)	Monthly Welfare, Child Support, Alimony	Monthly Payments from Pensions, Retirement, Social Security	Other Monthly Income	Check if no Income
	\$	\$	\$	\$	<input type="checkbox"/>
	\$	\$	\$	\$	<input type="checkbox"/>
	\$	\$	\$	\$	<input type="checkbox"/>
	\$	\$	\$	\$	<input type="checkbox"/>
	\$	\$	\$	\$	<input type="checkbox"/>
	\$	\$	\$	\$	<input type="checkbox"/>

Total Number of Persons in Household \_\_\_\_\_ Total Monthly Income Before Deductions \$ \_\_\_\_\_

**5. Signature and Social Security Number (Adult must sign.)**

An adult household member must sign the application. If Part 4 is completed, the adult signing the form must also list the last 4 digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page)  
I certify (promise) that all information on this application is true and that all income is reported. I understand that the school system may get federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my child(ren) may lose meal benefits, and I may be prosecuted.

Today's Date

--	--	--	--	--	--

Last 4 Digits of Social Security Number

*	*	*	*	*				
---	---	---	---	---	--	--	--	--

I do not have a Social Security Number

Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Work Phone Number \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_

State 

--	--

ZIP Code \_\_\_\_\_

**6. Children's Race and Ethnicity - (You do not have to complete this part to receive free and reduced price meals.)**

Mark one or more racial identities from this group:

- Asian  American Indian or Alaska Native  White  
 Black or African American  Native Hawaiian or Other Pacific Islander

And mark one ethnic identity from this group:

- Hispanic or Latino  Not Hispanic or Latino

**7. Other Benefits - (You do not have to complete this part to receive free and reduced price meals.)**

Yes, school officials may use the information provided on this application to determine my child(ren)'s eligibility for free textbooks, workbooks, and other school supplies.

**Do not fill out this part. This is for sponsor's use only.** Annual Income Conversion: Weekly X 52, Every 2 Weeks X 26, Twice A Month X 24, Monthly X 12

Categorically Eligibility:  -OR- Income Eligibility:   Free Meals  
 Reduced Meals  
 Denied: Reason: \_\_\_\_\_

Signature/Stamp of Approving Official \_\_\_\_\_ Date Approved \_\_\_\_\_ Date Withdrawn \_\_\_\_\_

Verification: Confirming Official's Signature \_\_\_\_\_ Date \_\_\_\_\_

Follow-up Official's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Free and Reduced-Price Household Application for 2023-2024 – West Virginia Dept. of Education**

USE BLACK OR DARK BLUE **INK**, PRINT NEATLY, COMPLETE ONE APPLICATION PER HOUSEHOLD

**8: Free and Low-Cost Health Care**

If your children get free or reduced price school meals, they may also be able to get free or low-cost insurance through Medicaid or the West Virginia Children’s Health Insurance Program (WVCHIP). Children with health insurance are more likely to get regular health care and are less likely to miss school because of sickness.

If you would like information about WVCHIP or Medicaid, please call toll-free anytime at 1-877-982-2447 or visit [www.chip.wv.gov](http://www.chip.wv.gov) You may also apply online at [www.wvinroads.org](http://www.wvinroads.org).

**Your children may qualify for free or reduced price meals if your household income does not exceed the limits on this chart.**

<b>FEDERAL INCOME CHART</b>					
<b>For School Year July 1, 2023 – June 30, 2024</b>					
<b>Household size</b>	<b>Yearly</b>	<b>Monthly</b>	<b>Twice Per Month</b>	<b>Every Two Weeks</b>	<b>Weekly</b>
1	\$26,973	\$2,248	1,124	1,038	519
2	36,482	3,041	1,521	1,404	702
3	45,991	3,833	1,917	1,769	885
4	55,500	4,625	2,313	2,135	1,068
5	65,009	5,418	2,709	2,501	1,251
6	74,518	6,210	3,105	2,867	1,434
7	84,027	7,003	3,502	3,232	1,616
8	93,536	7,795	3,898	3,598	1,799
Each additional person:	9,509	793	397	366	183

**Privacy Act Statement:** This explains how we will use the information you give us.

**The Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

**Non-discrimination Statement:**

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, audiotope, 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  
fax:  
(833) 256-1665 or (202) 690-7442; or
2. email:  
[program.intake@usda.gov](mailto:program.intake@usda.gov)

**This institution is an equal opportunity provider.**