



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

Early Learning Enrollment Packet



**Cross Lanes YMCA Child Development Center
5113 Rocky Fork Road
Cross Lanes, WV 25313
304-776-3323
www.ymcaofkv.org**

Dear Parent/Guardian/Custodian,

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

In order 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 two years for children under the age of six (6) 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 two years for children under the age of six (6) years.
5. Submit a copy of your child's birth certificate.
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).
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 Parent Handbook and sign the Agreement Page at the end after discussing with the Director or Assistant Director any questions you may have regarding policies and procedures.
9. Pay the first two weeks of tuition in full at time of enrollment.
10. Pay a \$25 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 me at your convenience.

Sincerely,



Karleigh M. Fellure – Branch Director (kfellure@ymcaofkv.org)

CC:

Lacie M. Stover - Assistant Branch Director (lstover@ymcaofkv.org)
Ashley Garnes – Program Director (agarnes@ymcaofkv.org)
Janet Reed – Childcare Services Coordinator (jreed@ymcaofkv.org)
Shannon Cox – Administrative Office Coordinator (scox@ymcaofkv.org)
Ginny Johnson – Pre-K Coordinator (ginny.johnson@mail.kana.k12.wv.us)
Nikki Braden – School Age Coordinator (nbraden@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

Days:	Time:
<input type="checkbox"/> Monday	_____ to _____
<input type="checkbox"/> Tuesday	_____ to _____
<input type="checkbox"/> Wednesday	_____ to _____
<input type="checkbox"/> Thursday	_____ to _____
<input type="checkbox"/> Friday	_____ to _____

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

Enrollment Date:

Withdrawal Date:

Early Learning

Child's Information Record

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

Child's Name _____ Date of Birth _____ Current Age _____ Gender _____

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 _____ Other Phone Number _____

Employer _____ Employer Address _____

Parent/Guardian/Custodian Name _____ Date of Birth _____ Relationship to the Child _____

Primary Address _____ Email Address _____

Primary Phone Number _____ Work Phone Number _____ Other Phone Number _____

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: _____

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 Program 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 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 a statement or chose not to initial, please schedule a meeting with the Program Director or Assistant 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: _____

Early Learning Social Resume'

Please complete the following form to your best ability. The information provided will help us better understand and care for your child.

Child's Basic Information

Child's Full Name: _____
(First Name) (Middle Name) (Last Name)
Date of Birth: _____ Nickname: _____

Family Information

Names of others living in the home	Relationship to Child	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your child have any pets? If yes, please explain _____

Liquid Feeding Information

Is your child breastfed? Yes No
Do you plan to continue breastfeeding? Yes No If yes, how do you plan to carry this out? _____
What is your child's nursing schedule? _____
Do you supplement? Yes No If yes, please explain. _____

Is your child bottle fed? Yes No
What formula/milk, bottle/nipples is your child currently using? _____
How do you give bottles? Room Temperature Warm Cold

What is your child's feeding schedule?

	Amount	How Often?	Comments
Breast Milk	_____	_____	_____
Formula	_____	_____	_____
Milk	_____	_____	_____
Water	_____	_____	_____

Any additional feeding information that will help us better care for your child? _____

Solid Feeding Information

If your child is not eating solids, please explain your plan for introducing solids _____

Is your child eating cereal? Yes No If yes, what type and how often? _____

Is your child eating baby foods? Yes No If yes, what type and often? _____

Is your child eating table foods? Yes No

Please list any foods that you would prefer your child not to eat _____

What foods does your child like? _____

What foods does your child dislike? _____

Does your child feed him/herself? Yes No

Diapering and Potty Training

Is your child in diapers? Yes No If yes, what type? _____

Is your child prone to diaper rash? Yes No If yes, what treatment do you use? _____

Has toilet training begun? Yes No

Is your child fully potty trained? Yes No

Sleeping and Napping

What is your procedure for putting our child to sleep? _____

Does your child prefer or require something special to fall asleep? Yes No If yes, explain _____

Is your child able to self-soothe and/or put themselves to sleep? Yes No

Please describe your child's sleep/nap schedule. Include when your child naps and how long naps last. _____

Social/Emotional Development

Describe your child's temperament: (Example; colic, likes to cuddle, etc.) _____

What signs does your child give of being... (Examples; pulls at ears, rubs eyes, etc.)

- Hungry _____
- Tired _____
- Over stimulated _____
- Sick _____

Does your child separate easily from you? Yes No Please comment: _____

Is your child afraid of anything? Yes No Please comment: _____

Does your child take a pacifier? Yes No If yes, how often? _____

Does your child have a favorite toy, blanket or soother? Yes No Please comment: _____

Does your child spend time with other children? Yes No Please comment: _____

What activities does your child enjoy? _____

What activities does your child dislike? _____

Other Information

Please provide any other information relating to your child that would be helpful in understanding and caring for your child. _____

Name of parent/guardian filling out this form: _____ Relationship to child: _____

Signature: _____ Date: _____



FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Cross Lanes YMCA Child Development Center Childcare Financial Agreement

REGISTRATION

- The first two (2) weeks of tuition are due at time of registration.
- A \$25 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.
- All registration fees and deposits are non-refundable and non-transferable.
- **Summer Day Camp and Funshine Camp** – The first week of camp must be paid in full and a \$25 deposit on every other week of camp selected at the time of registration. This deposit is non-refundable and non-transferable. Families receiving subsidy must pay a \$25 deposit per child at time of registration and families receiving YMCA Scholarship funds must pay the first week in full and a \$5 deposit on all other weeks.

PRIVATE PAY TUITION

- Weekly tuition will not be waived for any reason.
- Weekly tuition is due in full regardless of the number of days your child attends. This reserves your child's place in our program.
- 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.
- 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.
- A service fee of \$25 will be charged on all returned checks and returned bank drafts.
- Your child's registration may be discontinued if your account becomes two (2) weeks past due.
- Credits will not be given for emergency closure days such as, but not limited to, severe weather, power outages, water outages, etc.
- Families registered in an Early Learning Program (Nursery-Preschool) receive two (2) weeks' vacation per calendar year.

SUBSIDIZED TUITION (Connect, Link, etc.)

- Parent/Guardians receiving subsidy are billed the first week of the month for the prior month of childcare services.
- Tuition is due two (2) weeks from the date billed. Failure to pay will 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.
- Your child's registration will be discontinued if your child does not attend for two (2) or more consecutive weeks.

WITHDRAWALS

- Two (2) prior weeks' notice or two weeks tuition is payable upon a child's withdrawal from the program or change of status.
- The two (2) weeks prior notice is to be in written form and must be received by the Director, Assistant Director, or Childcare Service Coordinator.
- Parents are responsible for removal of all personal items within thirty (30) days of withdrawal. After thirty (30) days, items will be donated to a local charity.

LATE PICK-UPS

- A fee of \$10 will be applied for pickups between 6:01pm – 6:10pm.
- A fee of \$20 will be applied for pickups after 6:10pm.
- Late pick-up fees will be added to your weekly tuition and are due by the next billing week.
- Consistently arriving after 6:00 p.m. may result in disenrollment.

By signing this agreement, I acknowledge I have read the financial policy, and am in agreement.

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 right 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, audiotope, 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.

Thank you for your cooperation:


Institution Representative

Program Year 2019-2020
West Virginia Department of Education
FREE AND REDUCED PRICE SCHOOL MEAL 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 2019-2020 – 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 3)

SNAP TANF

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.

Signature _____ Today's Date Last 4 Digits of Social Security Number * * * * I do not have a Social Security Number

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 2019-2020 – 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 You may also apply online at 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.

FEDERAL INCOME CHART For School Year July 1, 2019 – June 30, 2020					
Household size	Yearly	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	\$23,107	\$1,926	963	889	445
2	31,284	2,607	1,304	1,204	602
3	39,461	3,289	1,645	1,518	759
4	47,638	3,970	1,985	1,833	917
5	55,815	4,652	2,326	2,147	1,074
6	63,992	5,333	2,667	2,462	1,231
7	72,169	6,015	3,008	2,776	1,388
8	80,346	6,696	3,348	3,091	1,546
Each additional person:	8,177	682	341	315	158

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, 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.