1900 Kanawha Boulevard, East, Building 6 • Charleston, WV 25305
wvde.us

May 15, 2024

Child and Adult Care Food Program (CACFP) Sponsors

2024 – 2025 Adult Day Care Only Free and Reduced Price Meals Family Application

Enclosed you will find a copy of the 2024 – 2025 Adult Day Care only Free and Reduced Price Meals Family Application. Also included in this mailling are the following:

- 2024 – 2025 Adult Day Care Free and Reduced Application
- Guidelines to determine participant eligibility for Free and Reduced-Price Meals

Application forms may be duplicated from the attached document or obtained from the OCN download site at **https://wvde.us/child-nutrition/child-and-adult-care-food-program/forms-and-reference-tools/**. Free and Reduced eligibility status may be effective for the entire year regardless of changes in the household's income status. Participants are always at liberty to apply for benefits throughout the year. Please be reminded that it is essential the confidentiality of participant's eligibility be protected, and that information be released only for the purposes permitted by federal rules or granted by parent or guardian signatures.

The 2024 – 2025 Adult Day Care Only Free and Reduced-Price Meals Family Application is effective July 1, 2024. If you have questions or need further assistance, please call Tracy Sayre, CACFP Coordinator at (304) 558-3396 or email her at **trcsayre@k12.wv.us**.

Sincerely,

Amanda Harrison, Director
Office of Child Nutrition

AH/TS/ja

Enclosures

05152024jaTS_FY2024-2025ADC_FREApps

ADULT DAY CARE only

FREE AND REDUCED PRICE MEALS FAMILY APPLICATION

Program Year 2024-2025

West Virginia Department of Education

Sponsor _____

Address _____

1. COMPLETE THIS PART IF THE INDIVIDUAL ENROLLED IN THE CENTER IS CURRENTLY INCLUDED IN A FOOD STAMP HOUSEHOLD OR RECEIVES ASSISTANCE UNDER THE SUPPLEMENTAL SECURITY INCOME (SSI) PROGRAM OR MEDICAID. IF YOU COMPLETE THIS PART, SKIP PART 2 AND GO TO ON TO PART 3.

Participants' Full Name(s)	Medicaid Case #	SSI Case #	Food Stamp Case #

2. COMPLETE THIS PART IF PART 1 DOES NOT APPLY. List all household members and current monthly income. Use line 1 to identify the individual enrolled in the adult day care center.

Names of Household Members (If you need more spaces, attach a separate sheet)	Age	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
1.		$	$	$	$	☐
2.		$	$	$	$	☐
3.		$	$	$	$	☐
4.		$	$	$	$	☐
5.		$	$	$	$	☐

Total Number of Persons in Household_____ Total Monthly Income Before Deductions $ _____

Go to Part 3.

3. Racial & Ethnic Identities (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

4. Signature and Social Security Number (Adult must sign.)

An adult household member must sign the application. If Part 2 is completed, the adult signing the form must also list the last four digits 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 sponsor may get federal funds based on the information I give. I understand that agency officials may verify (check) the information. I understand that if I purposely give false information, I may lose meal benefits and I may be prosecuted.

Sign Here: X_____Date:_____Print Name: _____ _____ ___
Last First MI

Address: _____ _____ _____ _____ _____ Phone: (____) _____
Street Name City State Zip

Social Security Number: * * *- * * - _ _ _ _ ☐ I do not have a Social Security Number

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

_____Free Meals
_____Reduced Meals
_____Denied: Reason: _____

Signature/Stamp of Approving Official _____ Date Approved_____Date Withdrawn _____

"Continue on Back"

Program Year 2024-2025

FREE AND REDUCED PRICE MEAL APPLICATION

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, 2024 – June 30, 2025					
Household size	Yearly	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	$27,861	$2,322	$1,161	$1,072	$536
2	37,814	3,152	1,576	1,455	728
3	47,767	3,981	1,991	1,838	919
4	57,720	4,810	2,405	2,220	1,110
5	67,673	5,640	2,820	2,603	1,302
6	77,626	6,469	3,235	2,986	1,493
7	87,579	7,299	3,650	3,369	1,685
8	97,532	8,128	4,064	3,752	1,876
Each additional person:	9,953	830	415	383	192

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, 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.

Attachment A

GUIDELINES TO DETERMINE PARTICIPANT ELIGIBILITY FOR FREE AND REDUCED PRICE MEALS

Effective from July 1, 2024 to June 30, 2025

ANNUAL FAMILY INCOME BEFORE DEDUCTIONS

ELIGIBLE FOR **FREE** MEALS OR **FREE** MILK						ELIGIBLE FOR **REDUCED** PRICE MEALS				
HOUSEHOLD SIZE	YEARLY	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY	YEARLY	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
ONE	19,578	1,632	816	753	377	27,861	2,322	1,161	1,072	536
TWO	26,572	2,215	1,108	1,022	511	37,814	3,152	1,576	1,455	728
THREE	33,566	2,798	1,399	1,291	646	47,767	3,981	1,991	1,838	919
FOUR	40,560	3,380	1,690	1,560	780	57,720	4,810	2,405	2,220	1,110
FIVE	47,554	3,963	1,982	1,829	915	67,673	5,640	2,820	2,603	1,302
SIX	54,548	4,546	2,273	2,098	1,049	77,626	6,469	3,235	2,986	1,493
SEVEN	61,542	5,129	2,565	2,367	1,184	87,579	7,299	3,650	3,369	1,685
EIGHT	68,536	5,712	2,856	2,636	1,318	97,532	8,128	4,064	3,752	1,876
FOR EACH ADDITIONAL FAMILY MEMBER, ADD										
	6,994	583	292	269	135	9,953	830	415	383	192

CONVERSION FACTOR

Annual Income Conversion: Weekly X 52, Every 2 Weeks X 26, Twice A Month X 24, Monthly X 12