



<input type="checkbox"/> CHOICES <input type="checkbox"/> YMCA Financial Assistance
Enrollment Date: _____
CCC Date: _____
Received at Site: _____
Discharge Date: _____

YMCA of Parkersburg AFTER-SCHOOL REGISTRATION FORM

SELECT: **Elementary Program** **Middle School Program**

To comply with State Licensing, all sections of this form must be completed before we can accept any child for care. Registration forms must be printed.

Questions? Contact our Youth Development Department at (304) 485-5585 ext. 219

Child's Last Name, First Name: _____

Child's Street Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone #: _____

Circle One: Male Female Age: _____ Date of Birth: _____

Grade (2023/24): _____ School Child Attends: _____

School Phone #: _____

I identify my child's ethnicity as (circle all that apply):

Asian Black/African Caucasian/White Hispanic
 Native American Pacific Islander Other: _____ Prefer Not To Answer

Please select the program your child will attend:

Middle School Program

Blennerhasset Middle School

Elementary School Program			
<input type="checkbox"/> Blennerhasset Elementary	<input type="checkbox"/> Criss bused to YMCA	<input type="checkbox"/> Emerson bused to YMCA	<input type="checkbox"/> Fairplains bused to Gihon
<input type="checkbox"/> Franklin bused to Gihon	<input type="checkbox"/> Gihon	<input type="checkbox"/> Greenmont	<input type="checkbox"/> Jefferson bused to YMCA
<input type="checkbox"/> Kanawha	<input type="checkbox"/> Lubeck bused to Blennerhasset	<input type="checkbox"/> Neale	<input type="checkbox"/> Madison bused to YMCA
<input type="checkbox"/> Martin bused to Gihon	<input type="checkbox"/> Mineral Wells	<input type="checkbox"/> Vienna bused to Greemont	<input type="checkbox"/> Williamstown

My child will attend Elementary Out-Of-School Days at the YMCA: **Yes** **No**



Please circle who is the custodian of this child: Both Parents Other: _____

GUARDIAN #1: _____ Last 4 SS#: xxx-xx-_____

Home Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone #: _____

Cell Phone #: _____ Email: _____

Employer: _____ Work Phone #: _____

Work Address: _____

City: _____ State: _____ Zip Code: _____

Relationship to child: _____

GUARDIAN #2: _____ Last 4 SS#: xxx-xx-_____

Home Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone #: _____

Cell Phone #: _____ Email: _____

Employer: _____ Work Phone #: _____

Work Address: _____

City: _____ State: _____ Zip Code: _____

Relationship to child: _____

If guardian(s) cannot be reached, person to call in emergency and authorized to pick up:

Contact #1: _____ Relationship to child: _____

Home #: _____ Cell #: _____ Work #: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Contact #2: _____ Relationship to child: _____

Home #: _____ Cell #: _____ Work #: _____

Address: _____ City: _____

State: _____ Zip Code: _____



MEDICAL INFORMATION

Child's Last Name, First Name: _____

Any medications to be taken? No Yes

If yes, you must fill out a medication release form.

Allergies, medical or behavior information we should know about:

EMERGENCY INFORMATION

In case of emergency, please contact the following first:

Guardian #1 Guardian #2 Other: _____

Preferred Physician: _____

Phone #: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Dentist: _____

Phone #: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Hospital: _____

Phone #: _____ Address: _____

City: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION:

Is the child covered by medical insurance? Yes No

If so, indicate carrier or plan name: _____

Group: # _____ ID # _____

Carrier Address: _____

City: _____ State: _____ Zip Code: _____

Name of Insured: _____ Relationship to child: _____



After-School Program Waiver & Emergency Contact

Child's Name: _____ Age: _____ Date of Birth: _____

Child's Name: _____ Age: _____ Date of Birth: _____

Guardian #1: _____ Cell Phone #: _____

Guardian #2: _____ Cell Phone #: _____

Emergency Contact Name if Guardian(s) can't be reached: _____

Emergency Contact Cell Phone #: _____

Special notes regarding your child:

I/We, the undersigned, are the guardian(s) of the above named child and we agree, in taking advantage of child care service provided by YMCA of Parkersburg, a nonprofit organization under the laws of the State of West Virginia, to release and hold harmless YMCA of Parkersburg, its officers, directors, agents, employees and volunteers, from any and all claims, demands, suits, costs and charges, in connection with or arising out of the child care service, including, but not limited to, bodily harm or injury to our children, except only for loss, harms or injury occasioned by gross negligence or intentional misconduct by the YMCA of Parkersburg and/or its officers, agents, employees and volunteers and further authorize YMCA of Parkersburg and/or its officers, agents, employees and volunteers to administer, or cause to be administered, at my/our sole cost and expense, medical treatment and/or medication to the above named child/children in the event of any emergency.

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the person in charge to take my child to the closest available medical treatment facility and I give my consent for any and all treatment for my child when the child is in this individual's care.

Signature of Guardian

Date

Signature of Guardian

Date



2023-2024 FEE & PAYMENT GUIDE

We are required by licensing to have an original signature on all forms. Please make a copy of this page and sign the bottom of this form.

YMCA After-School Care		
<i>\$25 mission investment fee per child</i>		
RATES	MEMBERS	NON-MEMBERS
After-School Daily Rate	\$14	\$20
Out-Of-School Daily Rate	\$24	\$32

Updated: 7/25/23

FEES & PAYMENT POLICIES

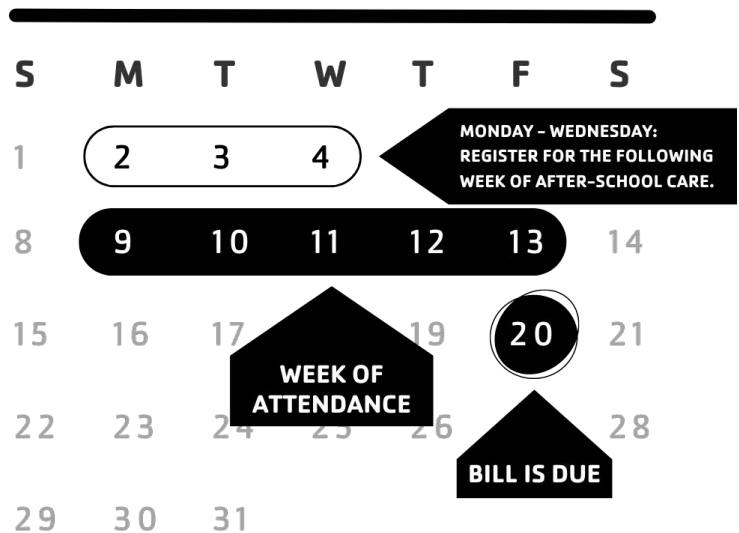
Mission Investment Fee (non-refundable) is due at the time of enrollment, and must accompany the registration packet. You may pay with check, cash, money order, debit/credit card. Those qualified for CHOICES are NOT required to pay the registration fee.

I _____ understand there will be \$1 late fee for every 1 minute past the closing time per child and repeated late pick-ups will result in dismissal from the program.

PAYMENT DUE DATES & NON-PAYMENT POLICY

- Bills can be viewed & paid on your Daxko online account.
- Payments are due 1 week from the Friday following the week of attendance. (view example for clarification)
- If you have a past due amount, you will be unable to register.
- We accept WV CHOICES.
- Out-Of-School Day care is on a first come, first-serve basis.
- If you are unable to pay your fees, please call our **BILLING OFFICE (304) 485-5585 ext. 213.**

EXAMPLE OF A MONTH



I HAVE READ & WILL AGREE TO THE ABOVE STATEMENTS & TERMS.

Signature of Guardian

Date



PARENT & PARTICIPATION STATEMENT OF AGREEMENT

1. I agree to abide by the policies and procedures of the YMCA Child Development Programs and WV DHHR Licensing.
2. I agree to permit my child to participate in age appropriate walking trips, field trips and other activities sponsored by the YMCA.
3. I understand that I must sign my child in and out each day (staff will sign children in for the After-school Program only).
4. In the event of an emergency in which the parent cannot be contacted, Emergency medical Staff and the YMCA may take appropriate action in the best interest of the child.
5. I understand that in case of a school closure that the YMCA will be the only school age site open for the day and parents will be responsible for transportation of the child on these days.
6. I understand that the YMCA is mandated by law to report any suspected cases of child abuse or neglect.
7. My child may swim as part of the school age program and will be swim tested (SELECT ONE):

AGREE

DISAGREE

9. I understand my child may be removed from the program for failure to pay program fees by designated deadlines.
10. I understand that my child may be suspended or terminated from the program for inappropriate behavior of the child/parent and failure to observe licensing or program policies. A refund, credit, or reimbursement will not be given.
11. I understand that due to the group format of child care that the YMCA is unable to provide one on one care for a child.
12. Information/orientation regarding the program is available to parents and guardians.
13. The YMCA does not issue refunds for programs under ordinary circumstances.

I HAVE READ & WILL AGREE TO THE ABOVE STATEMENTS & TERMS.

Signature of Guardian

Date



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

YMCA PHOTO/AUDIO VISUAL/NARRATIVE RELEASE

I am 18 years of age or older and, if not, my parent or legal guardian has also provided their consent by signing below.

Consent & License. For my participation in activities to be conducted by the National Council of Young Men’s Christian Associations of the United States of America (“YMCA of the USA”) or any of its chartered member associations in the United States (collectively “the Y”), and collaborating third parties, I consent, now and for all time, to the making, reproduction, editing, broadcasting or rebroadcasting of:

- video film or footage of me,
- sound track recordings of me
- photo reproductions of me
- any narrative account of my experience

My consent includes a perpetual license to the Y and collaborating third-parties for the use of the above materials for publication, display, sale or exhibition in promotions, advertising, education and commercial uses. Use includes reproductions in any form and media currently existing or later conceived adaptations and/or revisions, throughout the world in perpetuity.

I understand and agree there may be no additional compensation for this license, and I will not make any claim for payment of any kind from the Y or collaborating third-parties. I may, or may not be, identified in such licensed uses; however, my name will not be used to endorse any particular products or services.

Ownership, Confidentiality, and Shared Use. With respect to any of the above uses, I further agree:

- All works shall belong to YMCA of the USA;
- The Y has no duty of confidentiality regarding any licensed uses;
- YMCA of the USA shall exclusively own all known or later existing rights to the uses throughout the world;
- The Y and collaborating third-parties may use any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account for any purpose without additional compensation to me.

Release from Liability. I agree that my consent is irrevocable. I hereby release and discharge The Y and collaborating third-parties, from any and all claims, actions, lawsuits or demands of any kind arising out of my consent, license grants, uses, or the shared uses of any works or materials referenced herein.

Signature: _____ Date: _____

Printed Name: _____ Age: _____

Address: _____

I am the parent or legal guardian of (child’s name). I hereby consent and grant the licenses detailed in the foregoing on behalf of my minor child.

Signature of parent or legal guardian: _____

Printed name: _____

Please check box if you decline consent

YMCA OF PARKERSBURG

1800 30TH STREET PARKERSBURG, WV 26101
P 304-485-5585 ext. 224 • F 304-485-5590
WWW.PARKERSBURGYMCA.ORG

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

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 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, 2023 – June 30, 2024					
Household size	Yearly	Monthly	Twice Per Month	Every Two Weeks	Weekly
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, 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
- fax:
 (833) 256-1665 or (202) 690-7442; or
3. email:
program.intake@usda.gov

This institution is an equal opportunity provider.

GUIDELINES TO DETERMINE PARTICIPANT ELIGIBILITY FOR FREE AND REDUCED PRICE MEALS

Effective from July 1, 2023 to June 30, 2024
ANNUAL FAMILY INCOME BEFORE DEDUCTIONS

HOUSEHOLD SIZE	ELIGIBLE FOR FREE MEALS OR FREE MILK				
	YEARLY	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
ONE	18,954	1,580	790	729	365
TWO	25,636	2,137	1,069	986	493
THREE	32,318	2,694	1,347	1,243	622
FOUR	39,000	3,250	1,625	1,500	750
FIVE	45,682	3,807	1,904	1,757	879
SIX	52,364	4,364	2,182	2,014	1,007
SEVEN	59,046	4,921	2,461	2,271	1,136
EIGHT	65,728	5,478	2,739	2,528	1,264

YEARLY	MEALS				WEEKLY
	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY	
26,973	2,248	1,124	1,038	519	
36,482	3,041	1,521	1,404	702	
45,991	3,833	1,917	1,769	885	
55,500	4,625	2,313	2,135	1,068	
65,009	5,418	2,709	2,501	1,251	
74,518	6,210	3,105	2,867	1,434	
84,027	7,003	3,502	3,232	1,616	
93,536	7,795	3,898	3,598	1,799	

FOR EACH ADDITIONAL FAMILY MEMBER,
ADD

6,682	557	279	257	129
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9,509	793	397	366	183
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CONVERSION FACTOR

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