



Summer EBT Application

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

1. Names of ALL Children in School

| Last Name | First Name | MI | Date of Birth MM/DD/YY | Mark if Foster | Grade | School |
|-----------|------------|----|---------------------------|--------------------------|-------|--------|
| | | | / / | <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/WV WORKS/TANF, indicate which program and provide the **10-digit case #**
(If any, **SKIP TO PART 5**)

SNAP

☐

TANF

☐

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|

Homeless Migrant Runaway

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 _____ ☐ ☐ ☐

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 Public Assistance, 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 four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.

I certify (promise) that all information on this application is true, and that all income is reported. I understand that the West Virginia Department of Education and/or West Virginia Department of Health, Office of Inspector General may verify (check) the information. I understand that if I give incorrect or false information, I may be required to repay any benefits I receive and/or be prosecuted for fraud. I understand that these benefits are for buying eligible food items for my child(ren) and may not be traded, sold, or used for anything other than what this program allows, or I could be convicted for trafficking, be disqualified from the program, and/or forced to repay the benefits.

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 Summer EBT.)

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

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7 : Free and Low-Cost Health Care

If your children receive free or reduced-price school meals, they may also be eligible for free or low-cost insurance through WV 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 WV Medicaid, please call toll-free anytime at 1-877-982-2447, or visit www.chip.wv.gov. You may also apply online at www.wvpath.wv.org.

Your children may qualify for Summer EBT if your household income does not exceed the limits on this chart.

| FEDERAL INCOME CHART For School Year July 1, 2025 - June 30, 2026 | | | | | |
|--|---------------|----------------|------------------------|------------------------|---------------|
| Household size | Yearly | Monthly | Twice Per Month | Every Two Weeks | Weekly |
| 1 | \$28,953 | 2,413 | 1,207 | 1,114 | 557 |
| 2 | 39,128 | 3,261 | 1,631 | 1,505 | 753 |
| 3 | 49,303 | 4,109 | 2,055 | 1,897 | 949 |
| 4 | 59,478 | 4,957 | 2,479 | 2,288 | 1,144 |
| 5 | 69,653 | 5,805 | 2,903 | 2,679 | 1,340 |
| 6 | 79,828 | 6,653 | 3,327 | 3,071 | 1,536 |
| 7 | 90,003 | 7,501 | 3,751 | 3,462 | 1,731 |
| 8 | 100,178 | 8,349 | 4,175 | 3,853 | 1,927 |
| Each additional person: | 10,175 | 848 | 424 | 392 | 196 |

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 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

This institution is an equal opportunity provider.