CREATIVE LEARNING CENTERS

Fairfield ◆ Forest Park ◆ Hamilton ◆ Mount Healthy

Welcome to the Kid Works Family!

Dear Incoming Families,

Welcome to the Kid Works Family!

We appreciate the trust you've placed in us to care for and instruct your children and will endeavor to provide the safest, highest quality facilities, instructors, and materials possible.

At Kid Works we operate with a simple philosophy: we put children first. This means that every decision we make is based on what will ultimately benefit and help us best serve the children in our care. For you that means peace of mind.

As our name states, we are a Creative Learning Center. We have a strong partnership with the State of Ohio Department of Education and ODJFS and are committed active participants in the Step Up to Quality program utilizing the Creative Curriculum to work with your children. Creative Curriculum is most successful when there is a positive partnership between our families and us and we depend on everyone doing their part in order to provide the best care possible.

We trust that you will find our center meets or exceeds your expectations; if you ever have any questions or concerns please do not hesitate to contact your Administrator directly. Thanks for being a part of Kid Works!

Sincerely,

The Kid Works Team

Door Code_____
(press start, enter code, and press open)

CREATIVE LEARNING CENTERS

SCAN ME
Parent Handbook

What to Bring on your first day at Kid Works

Before admission to school, parents must review Kid Works policies and procedures outlined in the parent handbook and review, initial and sign the Admissions Agreement with the Administrator and turn in all completed Enrollment Forms listed on the admissions agreement and included in the enrollment packet.

Items that need to be brought daily/weekly:

Infants

- Bottles with lids - Minimum 4 (must go home and be washed daily)
- Formula
- Diapers - Minimum 6 a day or a pack a week and wipes for the week
- Two to three extra changes of clothes (seasonal)
- Pacifier (optional)
- Shoes & Socks

Toddlers

- Travel blanket and pillow
- Pull-ups – Minimum 6 a day or a pack of week and wipes for the week
- Two to three extra changes of clothes (seasonal)
- Sippy Cup (must go home and be washed daily) (optional)
- Closed toe shoes

Preschool /Prek

- Travel blanket and pillow
- One pair of extra changes of clothes (seasonal) - two if potty training
- Closed toe shoes and back
- A minimal of 6 pull ups a day or a pack a week and wipes for the week
- Water bottle permitted with water only

School Age

- Water bottles with water only and labeled
- Closed toe shoes with back
- No Electronics (unless approved by management)

IMPORTANT REMINDERS:

- **Taps must be done daily at drop-off and pick-up**
- **Snacks and Meals:** Breakfast served from 8am – 9am you must arrive by 9 to receive breakfast. All snacks and meals will be provided by the center – *no outside food is allowed*.
- **Cut off Time is 9:30 am** (please call in advance if running late to be permitted in the center, if ratio permits)

CREATIVE LEARNING CENTERS

ADMISSIONS AGREEMENT

I. Admissions Agreement & Enrollment Forms

Before admission to school, parents must provide a completed Admissions Agreement (this document) and all Enrollment Forms which includes the following forms (Admin will check off each confirming completion)

___ JFS 01234 Child Enrollment & Health Information (annual review)
___ JFS 01305 Child Medical Statement for Childcare (annual)
___ JFS-01511 Family Information for Step Up To Quality (annual)
___ CACFP Enrollment Form
___ CACFP Income Eligibility Form (annual) *** $25 will be charged weekly for meals if form is not completed.**
___ Parent Transportation Agreement/Policies **Parent Initial _____**

II. Preschool/Childcare Agreement

The undersigned parent or legal guardian hereby give consent to Kid Works Creative Learning Centers to provide childcare/preschool services to my child.

Parent Initial _____

III. Family Information

This contract is being made between the Parents/Guardians listed below:

_____ Relationship to Child _____
_____ Relationship to Child _____
_____ Relationship to Child _____
and Kid Works CLC for the care of the following child:

Name of Child being enrolled: _____Age:_____

Child will attend ____Full-time/____Part-time, for the school year _____to _____

Parent Initial _____

IV. Alternate Pick-up Authorization

In addition to those listed in section III, the following individuals are authorized to pick-up:

Name: _____ Address: _____Phone Number: _____
Name: _____ Address: _____Phone Number: _____
Name: _____ Address: _____Phone Number: _____

Parent Initial _____

V. Attendance/Schedule

We request that your child **arrive no later than 9:30 am** to avoid interrupting the start of classroom activities.
My child will attend the following hours:

Monday	Tuesday	Wednesday	Thursday	Friday
____to____	____to____	____to____	____to____	____to____

Parent Initial _____

Over →

CREATIVE LEARNING CENTERS

VI. Fees & Payments

The undersigned parent or legal guardian acknowledge responsibility for all fees associated with the care being provided and that fees must be paid ***prior*** to receiving care.

Parent Initial _____

A. **Payment Schedule:** All fee payments are **due by Friday at noon for services the following week**. With payments received late receiving a $25 late fee.

Parent Initial _____

B. **NSF Fees:** I understand that a processing fee of $40 and a late payment fee of $25 will be billed to my account for non-sufficient funds. NSF fees must be paid by money order, credit or cash. If my account incurs an NSF fee two times, I will be required to pay all future tuition with money order, credit or cash.

Parent Initial _____

C. **Late pickup fee:** For all late pickups a late fee of $1 per minute, per child will be charged to compensate staff who will have stayed off the clock.

Parent Initial _____

D. **Full-time Fees:** The undersigned parents or guardians acknowledge that they are responsible to attend full-time for children registered for full-time attendance; that they are responsible for full-time fees whether the attendance met the full-time hours or not. For families receiving assistance this means that they are responsible for any difference for full-time children who did not TAP full-time hours.

Parent Initial _____

E. **Transportation Fees (For Parents of School Age Children):** I understand that from September through May I will be required to pay a $25 transportation fee prior to each month in order to be transported to and from school. This fee must be paid in advance – no exceptions. If the $25 fee is not paid prior to the first of the month, your child/ren will not be transported to school; they will remain at the center until you pick them up. Nor will we allow them to be put on our bus after school.

   I also understand that my account must be current each week in order for my child/ren to ride the Kid Works CLC bus to and from school.

Parent Initial _____

F. **Damages:** The undersigned parents or legal guardians acknowledge that they are responsible for all costs associated with repairs of damages at the center caused by their child.

Parent Initial _____

VII. Lost or Stolen Items

While great care is taken to keep personal items organized and cared for we cannot be held responsible for damaged, lost or stolen articles. We recommend labeling personal items such as names on jackets and other clothing items. No outside toys or money permitted. Please report any lost articles immediately and we will endeavor to provide reasonable assistance to search for and recover the item.

Parent Initial _____

CREATIVE LEARNING CENTERS

VIII. Time, Attendance and Payment System (TAPS) Agreement (for families receiving assistance only)

You may use the system at the center or your mobile phone - please see the office if you need help registering your mobile phone. Failure to TAP takes time and resources away from better serving your family.

The undersigned parent or legal guardian agrees to:

A. TAP my child in every morning **Parent Initial _____**

B. TAP my child out every evening **Parent Initial _____**

C. Being turned away or withdrawn for failing to TAP **Parent Initial _____**

D. Have my child attend the center as a full-time student (over 25 hours a week) as agreed with ODJFS and the childcare provider and will be responsible for the difference between full-time private pay rate and part-time voucher payment if I fall into part-time status.

Parent Initial _____

E. Fix any TAP error within 3 days of the error or a failure to swipe occurred.

Parent Initial _____

F. Not to exceed my allowed 10 days of absences from Jan – Jun & Jul – Dec. If I exceed my 10 absences I will be responsible for any fees not paid by ODJFS.

Parent Initial _____

G. Pay any charges that ODJFS refuses to pay due to my failure to follow this TAP system policy.

Please note that per your agreement with ODJFS you are responsible for paying your co-pay and any other associated charges. Failure to pay those charges will result in your child being withdrawn from care and a lien placed on your publicly funded vouchers until your balance is paid in full

Parent Initial _____

IX. Hours of Operation, Closures & Holidays

Hours of operation are Monday through Friday from 6:30 am – 6:00 pm, 12 months a year. Our Schools are licensed for specific hours of operation; early arrival and late pick-up cannot be allowed. Additional details are provided in the parent handbook for Closures and Holidays.

Parent Initial _____

X. Snacks and Meals (Breakfast served from 8 - 9 you must arrive by 9 to receive breakfast)

All snacks and meals will be provided by the center – ***no outside food is allowed***. The only exceptions are birthdays, holiday parties, and special events that have received the approval of the Director. **Any other situation *must* be directed by a doctor's note per state regulation on "Dietary Restriction".**

Parent Initial _____

XI. Photo & Social Media Release

As the internet and Social media have become great ways to communicate with parents and the public, the center and assignees may use photographs, reproductions, and/or sound recordings of my child. Such use may include advertising and publicity purposes such as Website, Facebook or Instagram or other publicity or advertising materials.

Over →

Parent Initial _____

XII. Step Up To Quality (SUTQ)

I give parent consent to screen my child using the Ages & Stages Developmental Screening in the first 30-60 days of enrollment and annually thereafter for the purpose of identifying any developmental delays or special needs and to keep this assessment in my child's records. I understand if any signs of early intervention are determined, I will follow through on any referrals necessary to get my child the support he/she needs.

Parent Initial _____

XIII. Concerns/Communication

As a parent, if you ever have a concern or question regarding your child, the program, or activities we are readily available to talk to you. Please feel free to stop by or call the office to set up an appointment to meet with the Director. We also have, for your convenience, a Parent Communication Form located in the lobby to be filled out and turned into the center director. Please do not hesitate to talk to us anytime! If after speaking with your director, you are unsatisfied with the current resolution you may request to speak with a Senior Director or our Executive Director as a final step to resolve your concerns. Please understand that setting an appointment vs an impromptu meeting will ensure attention undivided. Note: at no time is inappropriate language or tone to be used in addressing Kid Works staff or management and you will be asked to leave the premises until such time as a civil conversation can be scheduled to address your concern.

Parent Initial _____

XIV. Parent Handbook

SCAN ME

I understand that a copy of the parent handbook is available at all times in the center office/lobby, on the Kid Works website: http://www.kidworks.com or with this QR code. If requested one can be emailed or printed**. I have read/or will read to understand all the policies and procedures set forth in the Parent Handbook.**

Parent Initial _____

XV. Signatures:

The signatures below indicate agreement and understanding with this contract and with the written policies of Kid Works contained herein and within the Parent Handbook and will comply with them. The provider may change policies as needed.

_____ _____

Parent/Guardian's name Parent's signature/date

_____ _____

Parent/Guardian's name Parent's signature/date

_____ _____

Administrator's name Administrator's signature/date

KidoWorks
CREATIVE LEARNING CENTERS

Parent Transportation Agreement & Policies

I, _____ , give permission for my child care provider, or any approved
(Name of parent)

employee of the above program, to transport my child _____
(Name of child)

for the following reasons (check all that apply):

☐ School _____ Dropoff Time ☐ AM/PM, Pickup Time ☐ AM/PM
(Name of school) (Check One) (Check One)

☐ Field trips

☐ Emergency purposes

☐ Any reason deemed necessary by the program

It is agreed that:

1. A list of all drivers & all children being transported will be kept on file at all times.
2. Any motor vehicle used to transport children will have current registration and inspection report, insurance and must be operated by a person who is at least 18 years of age and possesses a valid driver's license.
3. The caregiver will never leave my child(ren) unattended in any motor vehicle or other form of transportation.
4. Each child will board or leave a vehicle from the curb side of the street.
5. Each child must wear shoes on the bus.

_____ _____
(Parent or Guardian) (Date)

Reset Form

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name	Date of Birth	First Day at Program/Home
Home Address		City
State	Zip Code	Home Telephone Number

Parent/Guardian Name #1	Relationship to Child
Home Address ☐ Same as Child's	Home Telephone Number ☐ Same as Child's
City	State / Zip
Email Address *(if applicable)*	Cell Phone *(if applicable)*
Parent's Work/School Name	Parent's Work/School Telephone Number
Parent's Work/School Address	City

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name #2	Relationship to Child
Home Address ☐ Same as Child's	Home Telephone Number ☐ Same as Child's
City	State / Zip
Email Address *(if applicable)*	Cell Phone
Parent's Work/School Name	Parent's Work/School Telephone Number
Parent's Work/School Address	City

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name	Name
City / State	City / State
Telephone Number / Relationship to Child	Telephone Number / Relationship to Child
Other numbers where emergency contact can be reached *(if applicable)*	Other numbers where emergency contact can be reached *(if applicable)*

Name of Physician or Clinic/Hospital		
Street Address		
City	State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Medical Foods

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - *check all that apply* ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on file.

☐ N/A - program does not provide meals or snacks to the child.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation**.**

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

☐ Not applicable

Child's Name

Diapering Statement

Is your child toilet trained? ☐ Yes *(If yes, skip to Emergency Transportation Authorization section)*

☐ No (If no, fill out the following:)

The program's policy is to check diapers every - 2 - hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport			**Do Not Give Permission to Transport**	
Program or Home Name Kid Works Creative Learning Centers		**OR** **Do not sign both**	Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No *(check one)*

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note:

This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15, 5101:2-13-15, and 5101:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth

Note: Sections A and B must be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):

Section A- EXAMINATION

√ The above named child has been examined.

√ The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care).

√ The above named child does not have allergies OR is allergic to the following (*please list in space below)*:

Check below, if applicable:

☐ Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) accompanies this form.

Optional: Measurements and Recommended Assessments/Screenings

Height _____ Vision _____ ☐ Yes ☐ No Lead _____ ☐ Yes ☐ No

Weight _____ Hearing _____ ☐ Yes ☐ No Hemoglobin _____ ☐ Yes ☐ No

BMI _____ Dental _____ ☐ Yes ☐ No Other: _____

Notes:

Signature of Examining Health Care Practitioner	Date of Examination
Name of Examining Health Care Practitioner	Telephone Number
Street Address	City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.

IMMUNIZATION (*Complete ONLY ONE SECTION below)*

Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:

Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.

Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:	**Initials of Examining Health Care Practitioner**
☐ The above named child has been immunized against the diseases listed above. *If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):*	Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S): ☐ I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):	**Signature of Parent** Date

Ohio Department of Job and Family Services

FAMILY INFORMATION
FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

Child's Name *(Last)*	*(First)*	Nickname *(If any)*

By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.

Who is in the child's immediate family?

Who lives at home with your child?

What is the primary language spoken in your child's home?

Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?

Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) Additional Details?

Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)

Do you have any pets at home? If so, what are they and what are their names?

Has your child had a previous care arrangement? ☐ Yes or ☐ No Additional Details? (Center based, in home, with family, with parents, etc.)

My child drinks ☐ milk, ☐ formula, ☐ juice or ☐ water. *(Check all that apply)*
How much and how often?

Does your child have any favorite foods?

Does your child dislike any foods?

Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)

Please check all of the words that best describe your child's personality and behavior

☐ active ☐ adventurous ☐ affectionate ☐ anxious ☐ bossy ☐ bright ☐ busy ☐ calm ☐ cautious ☐ cheerful
☐ content ☐ creative ☐ curious ☐ easily-angered ☐ emotional ☐ energetic ☐ excitable ☐ friendly ☐ gives-in-easily
☐ happy ☐ hesitant ☐ insecure ☐ jealous ☐ likes structure/routines ☐ loud ☐ loving ☐ mellow ☐ outgoing
☐ prefers adult attention ☐ quiet ☐ sensitive ☐ serious ☐ shares-well ☐ social ☐ spontaneous ☐ stubborn ☐ tentative
☐ other:

child?

Are there additional personality and behavior characteristics that would be useful to know about your child?

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

What routines/actions or items do you use to comfort your child?

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

Does your child use any special comfort or support items that help him/her go to sleep? If so, what?

What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?

My child sits in a ☐ high chair, ☐ booster, ☐ child size chair or ☐ adult size chair. *(Check the one that applies.)*

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.

Does your child need assistance when using the toilet? If so, how?

What words, gestures or signs does your child use if he/she needs to use the bathroom?

What time does your child normally go to bed at night and wake up in the morning?

What time(s), and for how long, does your child usually nap?

Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain.
What might you and/or your child be anxious about as he/she starts in this program?
What are you and/or your child excited about as he/she starts in this program?
What are your expectations of this program?
What other information would be helpful for the staff caring for your child to know?

Parent/Guardian's Signature	Date

CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICE MEALS Fiscal Year 2024-2025

INSTRUCTIONS: To apply for free and reduced-price meals, read the household Letter and instructions on backside of this form. Complete application and return to the center. In accordance with the NSLA, information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure. *Part 1* is to be completed by all households. *Part 2* is to be used only for a child living in a household receiving food assistance (SNAP) or Ohio Works First (OWF) benefits. *Part 3* is only for children NOT receiving Food Assistance or OWF benefits. *Part 4 an a*dult household member must sign and date form; the last 4 digits of social security number must be listed if Part 3 is completed. *Part 5* is optional. * Asterisks indicate info that must be completed. Form must be completed annually and valid for only 12 months.

CENTER NAME

PART 1 – PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER

* NAME OF ENROLLED CHILD(REN)	AGE	BIRTH DATE	CHECK IF A FOSTER CHILD (The legal responsibility of a welfare agency or court. Attach documentation)
1.			☐
2.			☐
3.			☐
4.			☐

PART 2 – LIST EACH CHILD'S FOOD ASSISTANCE (SNAP) OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 7 DIGITS.

Check type of benefit: □ FOOD ASSISTANCE (SNAP) or □ OHIO WORKS FIRST (OWF)

CASE NO.	__ __ __ __ __ __ __
CASE NO.	__ __ __ __ __ __ __
CASE NO.	__ __ __ __ __ __ __
CASE NO.	__ __ __ __ __ __ __

PART 3 – TOTAL HOUSEHOLD SIZE, TOTAL HOUSEHOLD GROSS INCOME AND HOW OFTEN IT WAS RECEIVED: List names of all household members. List all gross income: list how much and how often. If Part 2 is completed, skip to Part 4.

a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	b. CHECK IF NO/ZERO INCOME	c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED: Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annually			
		1. Earnings from work before deductions	2. Welfare payments, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA	4. All Other Income
EXAMPLE: JANE SMITH	☐	$ amount / how often	$ amount / how often	$ amount / how often	$ amount / how often
1.	☐	$ /	$ /	$ /	$ /
2.	☐	$ /	$ /	$ /	$ /
3.	☐	$ /	$ /	$ /	$ /
4.	☐	$ /	$ /	$ /	$ /
5.	☐	$ /	$ /	$ /	$ /
6.	☐	$ /	$ /	$ /	$ /

PART 4 – SIGNATURE & LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: Adult household member must sign/date form. If Part 3 is completed, the adult signing the form must also list last 4 digits of his/her Social Security Number or check the "I do not have a Social Security Number" box.

I certify that all information on this form is true and correct and that all income is reported. I understand that the center will get Federal Funds based on the information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

* SIGNATURE OF ADULT HOUSEHOLD MEMBER	* DATE	* If Part 3 is completed, insert last 4 digits of Social Security Number ☐☐☐☐
		☐ (Check if applicable) I do not have a Social Security Number

Print Name:	Daytime Phone Number:	Work Phone Number:
Street / Apt:	City / State / Zip:	County:

PART 5: RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race and ethnicity of enrolled child(ren).

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

Please mark one ethnic identity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Privacy Act Statement: 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 the participant 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 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 for the participant or other (FDPIR) identifier 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 the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program. **State Distribution: July 2024**

THIS SECTION TO BE COMPLETED BY CENTER. Note: All information above this section is to be filled in by the parent or guardian.

Complete information below only if qualifying child(ren) by household income from Part 3. Per the total household size, compare total household income to the USDA Income Eligibility Guidelines to determine correct categorization. When income is listed in different frequencies of pay in Part 3, you must convert all income to annual income before determination. Use the following Annual Income Conversion:
Weekly x 52, Every 2 Weeks (biweekly) x 26, Twice per Month (semi-monthly) x 24, Monthly x 12

Application Certified/Categorized as:

☐ **FREE,** based on □ Food Assistance/OWF Case No.
□ Household size and income
□ Foster Child

☐ **REDUCED-PRICE**, based on Household size and income

Total Household Size: _____

Total Household Income: $_____
Per: □ week □ every two weeks □ twice per month □ month □ year

☐ **PAID,** based on □ Income too high
□ Incomplete
□ Invalid case number or information

Signature of Sponsor / Center Representative	Date Sponsor Certified/Categorized Form	Effective Date (From the first of month of date signed)	Expiration Date (Valid until last day of month in which form was signed one year earlier)

Note: Effective date is determined by parent or sponsor signature date as selected on CRRS application. If date of parent signature is not within month of certification or immediately preceding month, effective date must be date of sponsor certification.

HOUSEHOLD LETTER - Dear Parent or Guardian

Please help us comply with the requirements of the U.S. Department of Agriculture's Child and Adult Care Food Program (CACFP) by completing the attached income eligibility application for free and reduced-price meals. All information will be treated with strict confidentiality. The CACFP provides reimbursement to the child care center for healthy meals and snacks served to children enrolled in child care. **The completion of the income eligibility application is optional.** Complete the application on the reverse side using the instructions below for your type of household. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center. Households with incomes less than or equal to the reduced-price values listed on the chart at the bottom of this page are eligible for free meal benefits**.** An application must contain complete information to be considered for free or reduced-price meals. Households are no longer required to report changes regarding the increase or decrease of income or household size or when the household is no longer certified eligible for food assistance (SNAP) or Ohio Works First (OWF). Once approved for free or reduced- price benefits, a household will remain eligible for these benefits for a period not to exceed 12 months. During periods of unemployment, your child(ren) is eligible for meal reimbursement provided the loss of income during this time causes the family to be within eligibility standards for meals. In operation of the CACFP, no person will be discriminated against because of race, color, national origin, sex, age or disability §226.23(e)(2)(iv). If you have questions regarding the completion of this application, contact the child care center.

PART 1 – CHILD INFORMATION: ALL HOUSEHOLDS COMPLETE THIS PART (*denotes required info)

- Print the name of the child(ren) enrolled at the child care center. All children (including foster children) can be listed on thesame application.
- List the enrolled child's age and birth date.
- Check box indicating if the child is a foster child. Foster children that are under the legal responsibility of the foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Attach documentation to show foster child status.

PART 2 – HOUSEHOLDS RECEIVING FOOD ASSISTANCE OR OHIO WORKS FIRST: COMPLETE THIS PART AND PART 4 – If a child is a member of a food assistance (SNAP) or OWF household, they are automatically eligible to receive free CACFP meal benefits.

Circle the type of benefit received: Food Assistance (SNAP) or Ohio Works First (OWF).

- List a current food assistance or OWF case number for each child. This will be a 7-digit number. Do not list a swipe card number.

SKIP PART 3 – Do not list names of household members or income if you listed a valid Food Assistance (SNAP) or OWF case number for each child in Part 2.

PART 3 – TOTAL HOUSEHOLD SIZE, GROSS INCOME AND HOW OFTEN RECEIVED: ALL OTHER HOUSEHOLDS COMPLETE PARTS 3 & 4.

a) Write the names of all household members including yourself and the child(ren) that attends the child care center, noting any income received. A household is defined as a group of related or unrelated individuals who are living as one economic unit that share housing and/or significant income and expenses of its members. This might include grandparents, other relatives, or friends who live with you. Attach another piece of paper if you need more space to list all household members.

b) Check the box for any person listed as a household member (including children) that has noincome.

c) For each household member, list each type of income received during the last month and list how often the money wasreceived.

1. Earnings from work before deductions: Write the amount of total gross income each household member received the last month, before taxes/deductions or anything else is taken out (not the take-home pay) and how often it was received (weekly, every two weeks, twice per month, monthly, annually). Income is any money received on a recurring basis, including gross earned income. Households are not required to include payments received for a foster child as income. If any amount during the previous month was more or less than usual, write that person's usual monthly income. If you normally get overtime, include it, but not if you only get it sometimes. If you are in the military and your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.
2. List the amount each person got the last month from welfare, child support or alimony and list how often the money wasreceived.
3. List the amount each person got the last month from pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits or disability benefits and list how often the money was received.
4. List all other income sources. Examples include: Worker's Compensation, strike benefits, unemployment compensation, regular contributions from people who do not live in your household, cash withdrawn from savings, interest/dividends, income from estates/trusts/investments, net royalties/annuities or any other income. Self-employed applicants should report income after expenses (net income) in column 1 under earnings from work. Business, farm or rental property report income should be entered in column 4. Do not include food assistance payments.

PART 4 – SIGNATURE AND LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: ALL HOUSEHOLDS COMPLETE THIS PART (* denotes required info)

a) * All applications must have the signature of an adult household member.

b) * The adult signing the application must also date the form.

c) * Only an application that lists income in Part 3 must have the last four digits of the social security number of the adult who signs. If the adult does not have a social security number, check the box marked, "I do not have a Social Security Number." If you listed a food assistance or OWF number for each child or if you are applying for a foster child, the last four digits of the social security number are notrequired.

PART 5 – RACIAL/ETHNIC IDENTITY – OPTIONAL

You are not required to answer this part in order for the application to be considered complete. This information is collected to make sure that everyone is treated fairly and will be kept confidential. No child will be discriminated against because of race, color, national origin, gender, age or disability.

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 (including gender identity and sexual orientation), 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: How to File a Complaint, 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.

REDUCED-PRICE INCOME ELIGIBILITY GUIDELINES

Guidelines to be effective from July 1, 2024 through June 30, 2025. Households with incomes less than or equal to the reduced-price values below are eligible for free or reduced-price meal benefits.

HOUSEHOLD SIZE	ANNUAL	MONTH	TWICE PER MONTH	EVERY TWO WEEKS	WEEK
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
For each additional family member, add	+9.953	+830	+415	+383	+192

Child and Adult Care Food Program (CACFP) Enrollment Form

Requirements:

a. CACFP child care centers and Head Start centers must have a completed CACFP Enrollment Form on file for each enrolled child. Siblings must have a separate form as attendance may be different.

b. The CACFP Enrollment Form is valid for 12 months following the month of parent/guardian dated the form. For example: Parent dated the form on 7/13/2024; form would expire on 7/31/2025). CACFP Enrollment forms must be completed annually by parent/guardian.

c. The following CACFP program types DO NOT need CACFP Enrollment forms:
   - Outside-School Hours Centers
   - Youth Development Programs
   - After School at Risk Programs
   - Emergency Shelters

Enrollment Form Reminders

- List one child per form
- All parts of form to be completed by parent/guardian including normal days, hours and meals
- If parent/guardian work schedule varies frequently thus the child's attendance pattern also will change frequently then parent should check the box at the bottom of the chart. Parent/guardian is not required to complete another form but may elect do so.
- For ease of collection, it is highly recommended that agencies/centers distribute enrollment forms to parents/guardians at the same time as the income eligibility application so that it is more likely that the forms would expire on the same date.
- If sponsor decides to develop own CACFP enrollment form, form contain all required information and be approved by state agency prior to use.

ATTACHMENTS

- State Agency Prototype CACFP Enrollment Form
- Example of completed CACFP Enrollment form

Ohio Department of Education and Workforce - Office of Nutrition

CHILD AND ADULT CARE FOOD PROGRAM

ENROLLMENT FORM

Required Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside School Hours, Youth Development & After School at Risk

Instructions to Complete

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

CENTER NAME		
CHILD'S NAME (please print)	**AGE**	**BIRTHDATE** / / month / day / year

CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE AND THE MEALS RECEIVED WHILE IN CARE

Check (✓) Days Child Normally in Care		List hours child normally in care				Check (✓) meals child normally receives while in care					
		Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday											
Tuesday											
Wednesday											
Thursday											
Friday											
Saturday											
Sunday											

☐ **Yes, the schedule listed above may frequently vary due to changes in parents/guardians schedule.**

SIGNATURE OF PARENT/GUARDIAN	**DATE**	**DAY PHONE NUMBER**
MAILING ADDRESS STREET /APT.	**CITY**	**ZIP CODE**
PARENT BIRTHDATE / / month / day / year	**PARENT EMAIL**	

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/USDAOASCR%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; (2) fax: (833) 256-1665 or (202)690-7448; or (3) email:program.intake@usda.gov.

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Revised 8/2024

USDA
United States Department of Agriculture

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC Program)



WIC Since 1974
The Foundation of Healthy Families

What is WIC? WIC was established as a permanent program in 1974 to safeguard the health of low-income women, infants, and children up to age 5 who are at nutritional risk. This mission is carried out by providing nutritious foods to supplement diets, nutrition education (including breastfeeding promotion and support), and referrals to health and other social services. Find out more: **http://www.fns.usda.gov/wic/about-wic-wic-glance**

Where is WIC available?

The program is available in all 50 States, 34 Indian Tribal Organizations, American Samoa, District of Columbia, Guam, Commonwealth of the Northern Mariana Islands, Puerto Rico, and the Virgin Islands. While funded through grants from the Federal Government, WIC is administered by 90 State agencies, with services provided at a variety of clinic locations including, but not limited to, county health departments, hospitals, schools, and Indian Health Service facilities. To find the WIC offices serving your area go to: **http://www.fns.usda.gov/wic/contacts**

What food benefits do WIC participants receive?

The foods provided through the WIC Program are designed to supplement participants' diets with specific nutrients. WIC authorized foods include infant cereal, baby foods, iron-fortified adult cereal, fruits and vegetables, vitamin C-rich fruit or vegetable juice, eggs, milk, cheese, yogurt, soy-based beverages, tofu, peanut butter, dried and canned beans/peas, canned fish, whole wheat bread and other whole-grain options. For infants of women who do not fully breastfeed, WIC provides iron-fortified infant formula. Special infant formulas and medical foods may also be provided if medically indicated. Learn more about food benefits here: **http://www.fns.usda.gov/wic/wic-food-packages**

Program benefits include more than food.

WIC benefits are not limited only to food. Participants have access to a number of resources, including health screening, nutrition and breastfeeding counseling, immunization screening and referral, substance abuse referral, and more. Find out more:
http://www.fns.usda.gov/wic/wic-benefits-and-services

Am I eligible?

Pregnant, postpartum, and breastfeeding women, infants, and children up to age 5 who meet certain requirements are eligible. These requirements include income eligibility and State residency. Additionally, the applicant must be individually determined to be at "nutrition risk" by a health professional or a trained health official. To find out if you might be income eligible for WIC benefits go to:
http://wic.fns.usda.gov/wps/pages/start.jsf

How WIC Helps

WIC supplemental foods have shown to provide wide ranging benefits. They include longer, safer pregnancies, with fewer premature births and infant deaths; improved dietary outcomes for infants and children; improved maternal health; and improved performance at school, among others. In addition to health benefits, WIC participants showed significant savings in healthcare costs when compared to non-participants. Learn more about how WIC helps:
http://www.fns.usda.gov/wic/about-wic-how-wic-helps

What is "nutrition risk" and why is it important?

Two major types of nutrition risk are recognized for WIC eligibility: medically-based risks such as anemia, underweight, history of pregnancy complications, or poor pregnancy outcomes; and dietary risks, such as inappropriate nutrition/feeding practices or failure to meet the current Dietary Guidelines for Americans. Women, infants, and children at nutrition risk have much greater risk of experiencing health problems. Learn more about nutrition risk:
http://www.fns.usda.gov/wic/wic-eligibility-requirements

I'm eligible, what do I do next?

Those who are interested in applying for benefits should contact their State agency to request information on where to schedule an appointment. Applicants will be advised on what to bring to the appointment in order to verify eligibility. Contact your State agency here:
http://www.fns.usda.gov/wic/contacts/

EBT makes it easier to use food benefits.

In most WIC State agencies, participants receive paper checks or vouchers to purchase food, while a few distribute food through centralized warehouses or deliver the foods to participants' homes. However, all WIC State agencies have been mandated to implement WIC electronic benefit transfer (EBT) statewide by October 1, 2020. EBT uses a magnetic stripe or smart card, similar to a credit card, that participants use in the check-out lane to redeem their food benefits. EBT provides a safer, easier, and more efficient grocery experience and provides greater flexibility in the way WIC participants can shop. Find out more and check if your State supports EBT:
http://www.fns.usda.gov/wic/wic-electronic-benefits-transfer-ebt

Focus on breastfeeding.

Even though breast milk is the most nutritious and complete source of food for infants, nationally less than 30% of infants are breastfed at 1 year of age. A major goal of the WIC Program is to improve the nutritional status of infants; therefore, WIC mothers are encouraged to breastfeed their infants, unless medically contraindicated. Pregnant women and new WIC mothers are provided breastfeeding educational materials and support through counseling and guidance. Explore the benefits of breastfeeding and find helpful resources here:
http://www.fns.usda.gov/wic/breastfeeding-promotion-and-support-wic

WIC Facts

- If you participate in another assistance program you may be automatically income-eligible for WIC.
- Breastfeeding mothers are eligible to participate in WIC longer than non-breastfeeding mothers.
- More than half of the infants in the U.S. participate in WIC.
- WIC participants support the local economy through their purchases.
- WIC works with farmers markets to help increase participant access to provide fresh, locally grown fruits and vegetables. Find out more here:
  http://www.fns.usda.gov/fmnp/wic-farmers-market-nutrition-program-fmnp

Where can I learn more?

Information on FNS programs is available at
www.fns.usda.gov/fns/

Building For the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.

Each day millions of children participate in CACFP at child care homes and centers across the country. Providers are reimbursed for serving nutritious meals which meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the five groups)
Milk Fruit or Vegetable Grain Meat/meat alternate (may be substituted for the grain up to 3 times per week)	Milk Meat/meat alternate Grain Vegetable (two different vegetables can be substituted for a fruit) Fruit	Milk Meat/meat alternate Grain Vegetable Fruit

Participating Facilities Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers**: Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- **Family Child Care Homes**: Licensed private homes.
- **After School Care Programs**: Centers in low-income areas provide free snack and/or meal to school-age children and youth.
- **Emergency Shelters**: Programs providing meals to homeless children.

Eligibility State agencies reimburse facilities that offer non-residential day care to the following children:

- Children age 12 and under,
- Migrant children age 15 and younger, and
- Youths through 18 in emergency shelters and after school care programs in needy areas.

Contact Information If you have questions about CACFP, please contact one of the following:

Sponsoring Organization/Center

Kid Works
10920 Hamilton Ave
Cincinnati OH 45231
(513) 686-8048

Ohio Department of Education

CACFP Program Specialist
25 S. Front Street, MS 303
Columbus, OH 43215-4183
Phone: 614-466-2945
Toll Free: 1-800-808-6235

Nondiscrimination

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.

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