FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

BUILDING BRIGHTER FUTURES

BEFORE AND AFTER SCHOOL ENRICHMENT

Firestone Park YMCA- License #102939 *Serves Betty Jane CLC, Firestone Park Elementary, Glover CLC, Rimer CLC, Sam Salem CLC*	Ritzman CLC- License #107186
Hatton CLC- License #100231	Voris CLC- License #106755
King CLC- License #100277	Windemere CLC- License #100088

**Location and transportation are subject to change due to low enrollment/low attendance.*
***Based on need, other CLCs may be served at our YMCA branch.*

PROGRAM	Y MEMBER RATE	NON-Y MEMBER RATE
Before Care	$57/week	$65/week
After Care	$60/week	$70/week
Before AND After Care	$85/week	$95/week
Fun Days/Snow Days	$30/day (BASE participants)	$40/day (non-BASE participants)

**Programming subject to change based on low enrollment.*

FIRESTONE PARK YMCA
350 E Wilbeth Rd
Akron, OH 44301
330-724-1255

akronymca.org

The Y strives to make programs and membership available to all. Financial assistance may be available to those who qualify.

FIRESTONE PARK YMCA BEFORE AND AFTER SCHOOL ENRICHMENT

Please select the weeks and/or service you need*

☐ Before Care ☐ AfterCare School _____

☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday Anticipated Start Date _____

*Location and transportation are subject to change due to low enrollment/low attendance.

Child's Name _____ ☐ male ☐ female

Child's Date of Birth _____ Age _____

Street Address _____

City _____ State _____ Zip_____

Parent/Guardian Name		**Parent/Guardian Name**	
Primary Number ( )	☐ C ☐ H ☐ W	Primary Number ( )	☐ C ☐ H ☐ W
Secondary Number ( )	☐ C ☐ H ☐ W	Secondary Number ( )	☐ C ☐ H ☐ W
Email		Email	
Date of Birth		Date of Birth	

Payment Information:

Please draft payment: ☐ Weekly on Fridays ☐ Other (contact YMCA director)

Account: ☐ Use account on file (ending in _____) ☐ Provide account info at registration

Do you have Publicly Funded Child Care? ☐ Yes ☐ No

Are you or another parent/guardian currently an employee of the YMCA? ☐ Yes ☐ No

If yes, what is his/her name? _____

Authorized Persons to Pick Up Child

Your child will only be released to a parent/guardian or persons listed in this section. Staff will require a government issued identification before releasing your child.

Name _____		**Relation** _____	
Primary Number ( )	☐ C ☐ H ☐ W	Second Number ( )	☐ C ☐ H ☐ W
Name _____		**Relation** _____	
Primary Number ( )	☐ C ☐ H ☐ W	Second Number ( )	☐ C ☐ H ☐ W
Name _____		**Relation** _____	
Primary Number ( )	☐ C ☐ H ☐ W	Second Number ( )	☐ C ☐ H ☐ W
Name _____		**Relation** _____	
Primary Number ( )	☐ C ☐ H ☐ W	Second Number ( )	☐ C ☐ H ☐ W

****If you receive publicly funded child care, all authorized persons to pick up will be required to use the mobile TAP System**

Please note: if there are any custody issues involved with your child, you must provide the center Director with full court papers including who has permission to pick up the child. The program may not deny a parent access to his/her child without proper documentation.

Child's name: _____ **Date of Birth:** _____

Photograph Consent

I give my permission for my child _____ to be in photographs, slides, DVDs, and/or videotapes for the promotion of the Akron Area YMCA.

Parent/Guardian Signature _____ Date _____

Permission for Routine Walks

As part of our curriculum, and weather permitting, we routinely include outdoor walks and/or playground time. At any time you may request that your child remains inside during these routine walks. I give permission for my child _____to accompany his/her class on routine walks to neighborhood of the program.

Parent/Guardian Signature _____ Date _____

Child Drop-Off/Pick-Up Policy

When you enroll your child in any YMCA Child Care Program, it is to be understood our policy is for you to bring your child into the center each day, sign in using the Kindersmart app or TAPS tablet (if receiving Title XX), and let one of the staff members know your child has arrived. We also require you to sign out your child using the Kindersmart app or TAPS tablet upon your child's departure. Please note, we are not legally responsible for your child when he/she is dropped off without completing the above procedure.
I understand state law requires me to sign my child in and out each day as well as notify staff that my child is arriving / departing for the day.

Parent/Guardian Signature _____ Date _____

(ONLY FOR CHILDREN TRANSPORTED)

Permission for Routine Trips

I give permission for my child _____ to be transported via YMCA mini bus on all dates Akron Public School District is in session to the YMCA BASE program destination listed below.
Routine Trip Destination:
BEFORE CARE
☐ Firestone Park Elementary ☐ David Hill CLC ☐ Glover CLC ☐ McEbright CLC ☐ Voris CLC
AFTER CARE
☐ Firestone Park YMCA

My child is
☐ not over 4 years and/or 40lbs ☐ over 4 years and 40lbs ☐ 8 years and/or over 4'9"

During this trip children will NOT have access to water that is 18 inches or more in depth and water activities are NOT planned in water that is 18 inches or more in depth.

I grant permission for my child to participate in the routine trips described above.

Parent/Guardian Signature _____ Date _____

Child's name _____

2021 Center Policies Agreement
Please read the policies carefully and **initial** all boxes.

☐ I understand there is a $40 non-refundable registration fee per child.

☐ Weekly tuition is due on Fridays prior to the week of service via auto draft.

☐ I understand that if my childcare payments fall one week behind I will be asked to withdraw my child until payment is made.

☐ Outstanding balances of $100 or more that are past 30 days in arrears will be turned over to Collections.

☐ I understand that if I have any outstanding balance at any facility within the Akron Area YMCA Association I am unable to register for any programs or membership until balance is paid.

☐ I understand that there will be a $10 fee assessed for any and every returned payment.

☐ CANCELLATION POLICY: Notification must be given no later than one week in advance. Otherwise, I understand that I will be responsible to pay that week's tuition in-full, regardless of attendance.

☐ I understand that late pick-up fees in the amount of $15 for every 15 minute increment per family will be imposed if my child(ren) is picked up after the center's designated closing time (6:00 pm).

☐ I understand that staff will contact Summit/Medina County Children Services if my child remains at the center longer than one hour after closing and all attempts to reach me, the child's other parent, and authorized persons have been made, without success.

☐ I understand state licensing requires that all forms in this registration packet must be completely filled out and turned in prior to my child's (ren's) admission to the program.

☐ I understand that I am required to disclose all medical, physical, or behavioral issues that pertain to my child (ren) at the time of enrollment, and supplement that information on an ongoing basis.

☐ I have read the YMCA BASE/Day Camp Registration Packet and Parent Handbook and agree to all terms therein for child (ren) to receive childcare. I understand that I forfeit the privilege of childcare if all policies are not followed.

FOR PUBLICLY FUNDED CHILD CARE RECIPIENTS ONLY

☐ I understand that my Publicly Funded Child Care co-pay is due every Friday via auto draft prior to care.

☐ I understand that if my Publicly Funded Child Care authorization is not current and/or for the correct location, I will be responsible for private pay rates.

☐ I understand that I must tap using a mobile device daily. I understand there is a back date period if daily taps are missed. If I miss the back date period, I understand that I will be charged the difference between my co-pay and the weekly private-pay rates. I understand it is my responsibility to know for which dates and times I need to back date.

Parent/Guardian Signature _____ Date _____

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

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

If you answered yes, please indicate which number(s) 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			Relationship to Child
Home Address			Home Telephone Number
City			State / Zip
Email Address *(if applicable)*		Cell Phone	
Parent's Work/School Telephone Number		Parent's Work/School Name	
Parent's Work/School Address			City

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

If you answered yes, please indicate which number(s) 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 within one hour of the center/home, 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 Food Supplements

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 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or family child care 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, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a 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 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

☐ No

☐ Yes - please explain

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

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

☐ N/A - program does not administer any medications.

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 the JFS 01217 "Request for Administration of Medication."

☐ N/A - child does not attend a full time program.

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**.**
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

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 _____ 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 Firestone Park YMCA		**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 and 5101:2-13-15. 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/PHYSICAL CARE PLAN FOR CHILD CARE

Child's Name	Date of Birth

Special Health Conditions

Symptoms to watch for and emergency action to be taken if the following symptoms occur

Activities/foods/environmental conditions to avoid, if applicable

Medical procedures to be followed and expected benefit of treatment, if applicable

Are any medications required? ☐ Yes ☐ No *(If yes, complete JFS 01217 "Request for Administration of Medication")*
If yes, what medications?

In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate?
☐ Yes ☐ No

In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child?
☐ Yes ☐ No

Training Instructions *(Trainer must be a parent or certified professional)*

Signature of Trainer	Date

Signature of trained providers, substitutes or child care staff members who have been made aware of the condition.
(There must always be a trained caregiver present when the child is present)

Signature	Date	I have been ☐ Informed	I have been ☐ Trained

(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)

Additional services (educational/therapeutic) child is receiving

Who provides the above services?

Name	Phone Number	May we contact? ☐ Yes ☐ No

I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan.

Parent Signature	Date
Administrator/Provider Signature	Date

Note: A separate plan must be written for each condition that requires different actions to be taken

Child/Family Information Form

Child's Name: _____ Age: _____

School child will be attending in the fall: _____

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? _____

_____

Are there any changes or transitions that your child has recently experienced or is experiencing? (Divorce, new home, death of family member, friend, or pet) _____

_____

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

_____

Are there personality and behavior characteristics that would be useful to know about your child? (Shy, energetic, sensitive, etc.) _____

_____

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? _____

_____

Please list the three most important things you would like your child to work on while in our program:

_____

_____

What other information would be helpful for the staff caring for your child to know? _____

_____

What are your expectations of this program? _____

_____

Parent/Guardian Signature: _____ Date: _____

TOGETHERHOOD STARTS HERE

We will work together to reach my goals!

My name:_____ Parent name:_____

Date:_____ Parent Signature:_____

Goal for my Body:

Action Step 1:

Action Step 2:

Action Step 3:

Goal Accomplished ☐

Goal for my Mind:

Action Step 1:

Action Step 2:

Action Step 3:

Goal Accomplished ☐

Goal for Social Responsibility:

Action Step 1:

Action Step 2:

Action Step 3:

Goal Accomplished ☐

Goal for my Character:

Action Step 1:

Action Step 2:

Action Step 3:

Goal Accomplished ☐

These people will help me reach my goals:

This is how I will feel when I reach my goal (draw or write it):

My parent's goals for me:

Goal Accomplished ☐

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 adult 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		CHECK IF A FOSTER CHILD (The legal responsibility of a welfare agency or court)	PART 2 – LIST EACH CHILD'S FOOD ASSISTANCE (SNAP) OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 7 DIGITS.

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)	Check type of benefit: ☐ FOOD ASSISTANCE (SNAP) or ☐ OHIO WORKS FIRST (OWF)
1.			☐	CASE NO. _ _ _ _ _ _ _
2.			☐	CASE NO. _ _ _ _ _ _ _
3.			☐	CASE NO. _ _ _ _ _ _ _
4.			☐	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: 7/1/2020

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,** 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.

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**

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email:program.intake@usda.gov.

This institution is an equal opportunity provider.

Revised 10/2019