Full Day Child Care 2020-2021
Bremerton School District | School Based Registration
YMCA OF PIERCE AND KITSAP COUNTIES

the YMCA
FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Return completed registration to:

- YMCA Child Care office: 3330 Kitsap Way Ste. A, Bremerton, WA 98312, Fax 360-627-9047 Email: kitsapchildcare@ymcapkc.org

GENERAL INFORMATION		
CHILD'S FIRST NAME	**CHILD'S LAST NAME**	**FIRST DAY OF CARE (DATE):**

BELOW, PLEASE SELECT THE SCHOOL YOUR CHILD WILL ATTEND IN 2020-2021.

BREMERTON SCHOOL DISTRICT	Site Hours 6 am- 6 pm
☐ **Crownhill Elementary** | 1500 Rocky Pt Rd NW, Bremerton, WA 98312 ☐ **Armin Jahr Elementary*** | 800 Dibb Street, Bremerton, WA 98312 *Armin Jahr opens January 4, 2021 and serves children who are registered for school at Armin Jahr & View Ridge.	**Which school is your child registered at for the school year?**

DISTANCE LEARNING

I would like the YMCA to assist my child with distance learning and I will:
☐ include the information below with my registration
☐ bring the information below on the first day of care

☐ Distance learning schedule
☐ Login information

RATES | Select your schedule

WEEKLY RATE | $200	DAILY RATE | $45 per day*	
☐ Monday – Friday | $200	☐ Mondays | $45 per day ☐ Tuesdays | $45 per day ☐ Wednesdays | $45 per day ☐ Thursdays | $45 per day ☐ Fridays | $45 per day **TOTAL WEEKLY FEES: $ _____**	***You will be enrolled in the **specific** days selected above for the year. If you have a rotating schedule, you will need to attach a copy of your schedule.

These rates apply to full day care while the school districts are operating virtually.

PAYMENTS

Each Wednesday, the fees for the next week are due. If fees are not received on Wednesday:
On Thursday, a $25 late payment fee will apply.
On Friday, care for the following week will be cancelled.
The late payment fee plus weekly fees will be due in order to return to care.

Refer to the payment page to choose your preferred method of payment.
Payments can be accepted over the phone at your child care business office.
Payments can be made online at ymcapkc.org (do not make payments after 8pm).
Cash or check can be dropped off at the child care business office.
Payments cannot be accepted at the child care site.

REGISTRATION FEES

$50 Registration Fee - Full registration fee applies per child	***Registration fees are per child. $100 max per family**
Registration fees are non-refundable and non-transferrable	

FOR OFFICE USE ONLY			
DATE ACCEPTED	**BY: STAFF NAME/SITE**		☐ **VERIFIED INFORMATION** ☐ **CHILD CARE MEMBERSHIP**
DATE ENTERED IN DAXKO	**BY: STAFF NAME**		☐ **CHECKED FOR DISCOUNTS/SUBSIDIES** ☐ **SCHEDULED PAYMENTS**
APPROVED BY PROGRAM DIRECTOR ☐ Yes ☐ No	**PROGRAM DIRECTOR NAME**	**DATE APPROVED**	☐ **WELCOME LETTER** ☐ **CHILD FILE COPIED**

CHILD NAME: ____BIRTHDATE: ______________________

All fields must be completed for registration packet to be considered complete.

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN FULL NAME		AUTHORIZED TO PICK UP CHILD? ☐ Yes ☐ No
PHYSICAL ADDRESS (no PO Box)	CITY	ZIP CODE
MAILING ADDRESS	CITY	ZIP CODE
HOME PHONE NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER
EMAIL	RELATIONSHIP TO CHILD	

PARENT/GUARDIAN FULL NAME		AUTHORIZED TO PICK UP CHILD? ☐ Yes ☐ No
PHYSICAL ADDRESS (no PO Box)	CITY	ZIP CODE
MAILING ADDRESS	CITY	ZIP CODE
HOME PHONE NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER
EMAIL	RELATIONSHIP TO CHILD	

WHO DOES CHILD LIVE WITH? (SELECT ALL THAT APPLY)

☐ **PARENT(S)** ☐ **STEPPARENT** ☐ **GRANDPARENT(S)** ☐ **GUARDIAN** ☐ **OTHER**

IF APPLICABLE, WHO IS CUSTODIAL PARENT/GUARDIAN?

IF APPLICABLE, WHO IS NOT AUTHORIZED TO PICK UP CHILD? (Must provide legal documentation with registration packet.)

EMERGENCY CONTACTS

(Local contacts only, must be different than parent/guardians listed above. Minimum of three emergency contacts required. Child will not be released unless they are listed below. Contacts must be at least 14 years old and must be able to provide photo identification.)

EMERGENCY CONTACT FULL NAME	RELATIONSHIP TO CHILD	
PHYSICAL ADDRESS (no PO Box)	CITY	ZIP CODE
CONTACT PHONE NUMBER	AUTHORIZED TO PICK UP CHILD? ☐ Yes ☐ No	

EMERGENCY CONTACT FULL NAME	RELATIONSHIP TO CHILD	
PHYSICAL ADDRESS (no PO Box)	CITY	ZIP CODE
CONTACT PHONE NUMBER	AUTHORIZED TO PICK UP CHILD? ☐ Yes ☐ No	

EMERGENCY CONTACT FULL NAME	RELATIONSHIP TO CHILD	
PHYSICAL ADDRESS (no PO Box)	CITY	ZIP CODE
CONTACT PHONE NUMBER	AUTHORIZED TO PICK UP CHILD? ☐ Yes ☐ No	

CHILD NAME: _____ BIRTHDATE: _____

All fields must be completed for registration packet to be considered complete.

CHILD'S INFORMATION (One form per child)

CHILD'S FIRST NAME		CHILD'S LAST NAME	
DATE OF BIRTH	**AGE**	**GRADE (FALL 2020)**	**GENDER** ☐ Male ☐ Female
HEIGHT	**WEIGHT**	**EYE COLOR**	**HAIR COLOR**

OPERATIONS/CHRONIC ILLNESSES

DATE OF LAST MEDICAL EXAM/PHYSICAL	DATE OF LAST DENTAL EXAM

ALLERGIES TO FOOD OR DRUGS

☐ No ☐ Yes: List allergies and fill out Individual Care Plan form at site with any other necessary medical information

DIETARY MODIFICATIONS

☐ No ☐ Yes: List dietary modifications and fill out Individual Care Plan form at site with any other necessary medical information

PHYSICAL, EMOTIONAL, PSYCHOLOGICAL, OR BEHAVIORAL NEEDS/CONSIDERATIONS

☐ No ☐ Yes: List needs/considerations and fill out Plan of Success form at site with any other necessary medical information

DOES YOUR CHILD TAKE ANY MEDICATIONS ON A REGULAR BASIS? ☐ No ☐ Yes: List medications and dosages below

Medication:	Dosage:	Reason/Diagnosis:	Administer daily by staff?
			☐ No ☐ Yes*
			☐ No ☐ Yes*
			☐ No ☐ Yes*

* Yes: Fill out medical authorization form at site and turn in with medication in original prescription container

MEDICAL CONTACT INFORMATION

(If child has no medical or dental provider, parent/guardian must provide a written plan for medical or dental injury or incident.)

FAMILY DENTIST		PRIMARY PHONE NUMBER
ADDRESS	**CITY**	**ZIP CODE**

FAMILY PHYSICIAN		PRIMARY PHONE NUMBER
ADDRESS	**CITY**	**ZIP CODE**

HOSPITAL OF CHOICE		PRIMARY PHONE NUMBER
ADDRESS	**CITY**	**ZIP CODE**

MUST BE SIGNED ON BOTH SIGNATURE LINES.

BIRTHDATE:

All fields must be completed for registration packet to be considered complete.

CHILD NAME:

Washington State Department of Health

Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

Office Use Only:
Reviewed by: Date:
Signed Cert. of Exemption on file? ❑ Yes ❑ No

Please print. See back for instructions on how to fill out this form or get it printed from the Washington Immunization Information System.

Child's Last Name:	**First Name:**	**Middle Initial:**	**Birthdate** (MM/DD/YY):	**Sex:**

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

Parent/Guardian Signature Required **Date**

I certify that the information provided on this form is correct and verifiable.

Parent/Guardian Signature Required **Date**

♦ Required for School and Child Care/Preschool
● Required Only for Child Care/Preschool

Required Vaccines for School or Child Care Entry	**Date MM/DD/YY**	**Date MM/DD/YY**	**Date MM/DD/YY**	**Date MM/DD/YY**	**Date MM/DD/YY**	**Date MM/DD/YY**
♦ **DTaP / DT** (Diphtheria, Tetanus, Pertussis)						
♦ **Tdap** (Tetanus, Diphtheria, Pertussis)						
♦ **Td** (Tetanus, Diphtheria)						
♦ **Hepatitis B** ❑ 2-dose schedule used between ages 11-15						
● **Hib** (*Haemophilus influenzae* type b)						
♦ **IPV / OPV** (Polio)						
♦ **MMR** (Measles, Mumps, Rubella)						
● **PCV / PPSV** (Pneumococcal)						
♦ **Varicella** (Chickenpox) ❑ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV / MPSV (Meningococcal)						
MenB (Meningococcal)						
Rotavirus						

Documentation of Disease Immunity

Healthcare provider use only

If the child named in this CIS has a history of Varicella (Chickenpox) or can show immunity by blood test (titer) it MUST be verified by a healthcare provider

I certify that the child named on this CIS has:

❑ a verified history of Varicella (Chickenpox).

❑ laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers MUST also be attached.**

❑ Diphtheria	❑ Mumps	❑ Other:
❑ Hepatitis A	❑ Polio	_____
❑ Hepatitis B	❑ Rubella	_____
❑ Hib	❑ Tetanus	
❑ Measles	❑ Varicella	

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) Date

Printed Name

To print with immunization information filled in: Ask if your healthcare provider's office enters immunizations into the WA Immunization Information System (Washington's statewide database). If they do, ask them to print the CIS from the IIS and your child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at https://wa.myir.net. If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waiisrecords@doh.wa.gov or 1-866-**397-0337.**

CHILD NAME: _____ BIRTHDATE: _____

All fields must be completed for registration packet to be considered complete.

PARENT/GUARDIAN GUIDE ACKNOWLEDGEMENT

READ AND INITIAL EACH STATEMENT

INITIAL	I understand that I can find the Parent/Guardian Guide online at ymcapkc.org/childcare and I am responsible for reading it.
INITIAL	I recognize participants are expected to follow all safety instructions, remain in areas designated by staff, and refrain from behavior harmful to oneself or others. I understand that failure to adhere to program and behavior policies could be cause for participant's dismissal without refund of program fees. Please refer to Parent/Guardian Guide for clarification.

STATEMENT OF UNDERSTANDING, PERMISSION, AND COMPLIANCE

INITIAL	I am aware and I approve of my child having an opportunity to participate in program activities, which may involve a degree of risk, and I hereby release the YMCA of Pierce and Kitsap Counties from any and all responsibility and liability of any nature resulting from my child's participation in YMCA activities and transportation as required.
INITIAL	In the event my child is injured, I give YMCA first-aid and CPR-certified staff the authority to provide basic first-aid and CPR as the situation requires including splinter removal, if necessary, and/or if they become seriously ill or injured and I cannot be reached.
INITIAL	I authorize any emergency transportation, hospitalization, x-ray, medical, dental, and/or emergency surgical treatment advisable by the circumstances by any member of the medical staff of the medical facility.
INITIAL	I understand it is my responsibility to provide my own accident and health insurance while participating in all YMCA activities, and that the YMCA does not provide any health or accident coverage for its participants.
INITIAL	I understand I can request a health care plan that includes the child care disaster plan, from the business office and am responsible for reading it.
INITIAL	I grant permission for photographs/videos, which include my child in YMCA records, program projects, marketing, and public relations to be used in media releases and benefit the center to be taken.
INITIAL	Staff have permission to administer hand sanitizer to participants.
INITIAL	**Acknowledgement of 2020-2021 Attendance policy:** The YMCA Child Care branch is committed to the safety of students and staff. There will be registration limits and expected waitlists at our sites. Due to the implementation of capacity limits for safety, spaces are extremely limited and we know the need is still high within our community. **For these reasons, the YMCA Child Care branch will disenroll any participants that have not attended and no refunds will be provided for lack of attendance. All participants who are registered for care are expected to attend weekly.** Attendance will be monitored closely and students who do not attend will have future weeks removed from their accounts. By initialing, I acknowledge my understanding of the YMCA Child Care branch 2020-2021 attendance policy.

INITIAL **Acknowledgement of COVID-19 risks:**

I understand that an outbreak of the COVID-19 virus has occurred in the State of Washington and that the virus is novel and may cause known, unknown, foreseen, and unforeseeable risks. I understand that the virus poses health risks to those who contract it and to those who come into contact with individuals who have contracted it. I understand that the virus may pose a higher risk to certain individuals such as those who are immunocompromised, have chronic medical conditions, are pregnant, and in older adults. I understand that the virus may cause illness and symptoms including fever, cough, shortness of breath, mild to severe respiratory illness, and death. I understand that childcare facilities are currently allowed to continue to operate during the COVID-19 outbreak, but that the virus is highly contagious and cannot be eliminated from the childcare environment. I certify that I am the parent and/or legal guardian of the above-named child, that I accept and agree to be bound by the requirements for continued childcare above, and give permission for my child to continue to participate in childcare with the childcare provider and at the facility stated above. I release all and hold the YMCA/District harmless of all claims that may arise out of or in connection with this Consent and Agreement to Continue Childcare and/or related in any way to COVID-19.

INITIAL	With my signature below, I agree to the policies outlined in this form and the Parent Handbook Guide information, including cancellations (due to unpaid tuition and behavior) and refund policies.

PARENT/GUARDIAN SIGNATURE	**DATE**

Completion of registration packet, immunization form, USDA eligibility form, and the registration fee/full payment for the month officially enrolls your child in the YMCA Child Care program. Your child will begin child care two business days following completed registration and payment processing. It is your responsibility to update all information in this form as needed. The Y is open to all, regardless of gender, race, age, background, income, or physical or mental ability. Financial Assistance is available.

CHILD NAME: _____ BIRTHDATE: _____

All fields must be completed for registration packet to be considered complete.

CHILD NAME: _____ BIRTHDATE: _____

All fields must be completed for registration packet to be considered complete.

PAYMENT POLICIES AND PROCEDURES

ANNUAL HOUSEHOLD INCOME (Please select from the choices below)

☐ Less than $15,000 ☐ Less than $30,000 ☐ Less than $45,000 ☐ Less than $60,000 ☐ More than $60,000

CHILD'S ETHNICITY/RACE

☐ Asian/Pacific Islander ☐ Native American ☐ African-American ☐ Hispanic ☐ Caucasian ☐ Other _____

MILITARY INFORMATION

Is your child a military dependent? ☐ Yes ☐ No

Branch of Military: ☐ N/A ☐ Army ☐ Air Force ☐ Navy ☐ Marines ☐ Coast Guard ☐ National Guard ☐ DOD Civilian

Would you like information on a NACCRRA application? ☐ Yes ☐ No

HOW DID YOU HEAR ABOUT OUR PROGRAM? (Check all that apply)

☐ Website ☐ Facebook ☐ I'm a YMCA Child Care participant ☐ Friend ☐ YMCA Branch ☐ Mailer ☐ Other

☐ Private Pay

☐ State Pay

DCYF/DSHS Authorization must be received directly from State in order to register.

Contact the Child Care office to get provider # for school

PAYMENT METHOD AND BILLING

FEES –Fees are due weekly each Wednesday prior to week

PRIMARY PERSON RESPONSIBLE FOR PAYMENTS

Name (First) _____ (Last) _____

Child's Name (First) _____ (Last) _____

SECONDARY PERSON RESPONSIBLE FOR PAYMENTS (Additional form required with account information)

Name (First) _____ (Last) _____

PAYMENT OPTIONS: (Select One)

☐ **Auto Draft using Debit or Credit Card | Auto draft applies weekly, Wednesday prior to the start of each week of care.**

☐ **Use card on file**

☐ **Use new card:** ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Name on Card _____ Expiration Date _____

Card Number _____ Verification Code _____

☐ **I choose <u>NOT</u> to auto draft.** I understand my payment is expected by the Wednesday prior to the start of each week or I am responsible for a late fee of $25 and a suspension of care will apply if my payment is late.

STATEMENT OF UNDERSTANDING (Please read and initial each statement below)

INITIAL	I understand payment expectations and have chosen my payment method. I agree to abide by all policies in place, including that any changes must be in writing direct to YMCA Child Care. I understand failure to uphold my payment arrangements will result in cancelation of registration from the program
INITIAL	I have included all information as requested above, and if there is a secondary responsible party, it is my responsibility to have this form duplicated and submitted to that party for their acceptance of payment policies and procedures.
INITIAL	**I understand fees are due <u>weekly</u> each Wednesday.** If fees are not received, On Thursday, a $25 late payment fee will apply. On Friday, care for the following week will be cancelled. The late payment fee plus weekly fees will be due in order to return to care.
INITIAL	I understand that if the payment is not able to be collected at the weekly draft, a $30 NSF/processing fee will automatically be added to the account.
INITIAL	I understand that if I am receiving assistance from a Third Party Provider, it is my responsibility to begin the process with a caseworker or call center. I understand I may not be able to register or have my child attend child care until authorization is received in writing from the state. I understand that Third Party Provider reviews must be made on time to continue child care and full payment is expected without authorization until matter is resolved.
INITIAL	I understand to cancel a week of care; you must do so in writing before close of business on Monday, one week prior to the start of the week you wish to cancel. **There will be a $25 cancellation fee for any cancellation that is not made by this deadline.**

Signature _____ Date _____

CHILD NAME: _____ BIRTHDATE: _____

All fields must be completed for registration packet to be considered complete.

CHILD NAME: ______________________________BIRTHDATE: ______________

All fields must be completed for registration packet to be considered complete.

Child and Adult Care Food Program
ENROLLMENT/INCOME-ELIGIBILITY APPLICATION

PART 1 – CHILDREN'S INFORMATION—Required for all children in care.				
Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

☐ A family member in our household receives benefits from Basic Food, TANF, or FDPIR. (Please complete Part 2 and 5.)

☐ One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)

☐ My child(ren) may qualify for Free/Reduced-Price meals based on household income. (Please complete Part 4 and 5.)

☐ My child(ren) will not qualify for Free/Reduced-Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD/TANF/FDPIR— Any household member receiving benefits can establish eligibility for all children in the household.	Case Number or Identification Number

PART 3 – FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children.	

PART 4 – TOTAL HOUSEHOLD GROSS INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.

Tell us how much and how often. If no income, write "0". Use net income if self-employed.

List names (First and Last) of everyone in your household, including foster children	Earnings from Work Before Deductions	Weekly	Every 2 Weeks	2X Month	Monthly	Welfare, Alimony, Child Support	Weekly	Every 2 Weeks	2X Month	Monthly	Retirement, Pensions, Social Security, Other	Weekly	Every 2 Weeks	2X Month	Monthly
1.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
2.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
3.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
4.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
5.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
6.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number (SSN) or check the box if no SSN. *See Privacy Act Statement on the back of this page.*

If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced-Price meals, the last four digits of the SSN is not needed.

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Signature of Adult	Today's Date	Print Name of Adult Signing
X______________________________	______________	Social Security Number (SSN) (last four digits) XXX-XX- ☐ Check if no SSN
Address	City/State/Zip Code	Daytime Phone

CHILD NAME: _____ BIRTHDATE: _____

All fields must be completed for registration packet to be considered complete.

PART 6 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Multi-Racial
☐ Native Hawaiian or Pacific Islander ☐ White

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, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Basic Food, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

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:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue SW
Washington, D.C. 20250-9410

FAX: 202-690-7442
EMAIL: program.intake@usda.gov

***Only use this address if you are filing a complaint of discrimination.**

This institution is an equal opportunity provider.

DO NOT FILL OUT - CENTER USE ONLY

☐ Child(ren) are categorically free based on Basic Food/TANF/FDPIR.

☐ Foster child(ren) have been identified on this form and qualify for the free category.

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

☐ Child(ren) on this form who are not categorically eligible qualify as follows:
Check one: ☐ Free ☐ Reduced-Price ☐ Above-Scale

Total Income: $_____
☐ Annual ☐ Monthly ☐ Twice Per Month
☐ Every Two Weeks ☐ Weekly

X _____ _____
Signature of Institution's Representative **Today's Date**

NOT VALID WITHOUT SIGNATURE AND DATE.

EIEA Effective Date: If the institution is using the parent/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the parent signed the form or the immediately following month. If the institution representative does not evaluate and sign the EIEA within these guidelines, the institution representative's signature date must be used as the effective date.