Ohio Department of Children and Youth

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 DCY 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 DCY 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 DCY 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 DCY 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a DCY 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 _____ 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			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.		**OR** **Do not sign both**	**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 5180:2-12-15, 5180:2-13-15, and 5180:2-14-04.

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.

Reset Form

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 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.

This institution is an equal opportunity provider

Revised 8/2024

CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICE MEALS Fiscal Year 2025-2026

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* 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. The 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: July2025**

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.

Authorized List for Pick up

1.
2.
3.
4.

Child's first and last name:_____

Date:_____

CHILD AND ADULT CARE FOOD PROGRAM
INFANT MEALS – PARENT PREFERENCE LETTER

TO: **Parents and Guardians of Infants under one year of age**

FROM:	**NAME OF CENTER/PROVIDER**	

TOPIC: **Who will provide food for your infant's meals?**

Due to participation on the Child and Adult Care Food Program (CACFP), all children enrolled at this child care center or family child care (FCC) home receive meals free of charge. The CACFP is a U.S. Department of Agriculture (USDA) child nutrition program. Child care centers and family child care homes are reimbursed a meal rate to help with the cost of serving nutritious meals to enrolled children. These centers and FCC homes can be reimbursed daily for up to two meals and one snack served to each enrolled child, including infants. Emergency Shelters can be reimbursed for up to three meals. The meals must meet CACFP meal pattern requirements for children and infants.

To meet CACFP requirements, the center or FCC home is required to **offer** formula and other required infant food to all enrolled infants. The iron fortified infant formula we will provide for infants until they turn one year of age is:

NAME OF FORMULA	

A parent or guardian may decline the formula offered by the center or home and supply the infant's formula themselves. However, when an infant turns one year of age, the center or FCC home will begin to provide milk and the other required food items to meet the meal pattern requirements for toddler age children.

To assist us in your infant formula and food preferences, please complete preferences below by checking one item each in the formula and solid food section. **When a child is developmentally ready, parents can provide only one component (food or formula) as part of a reimbursable meal or snack**.

PARENT OR GUARDIAN: PLEASE CHECK YOUR PREFERENCES FOR FORMULA AND FOOD

Formula or Breast Milk: (check one)

☐ I want the center or FCC home provider to provide formula for my infant

☐ I will bring iron fortified infant formula for my infant

Parent/Guardian: List Name of Formula You Will Provide

☐ I will bring expressed breast milk for my infant

☐ I will come to the center or FCC home to breast feed my infant

Solid Food: (check one)

☐ I want the center or FCC home to provide all solid foods for my infant when he/she is developmentally ready

☐ I will bring one solid food item for my infant when he/she is developmentally ready for it and the center will provide all other required components including formula.

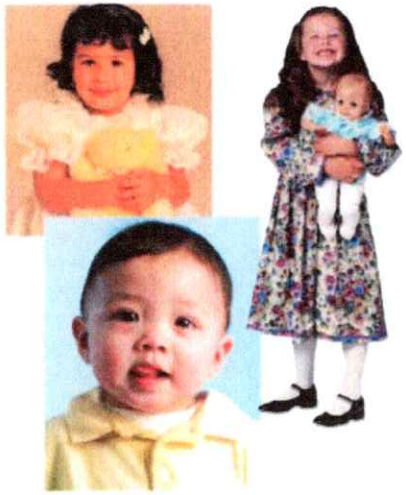
***Note: If your feeding preferences change, you will be asked to complete a new form.**

INFANT NAME:	**INFANT BIRTHDATE:**
PARENT/GUARDIAN SIGNATURE:	**DATE:**

 Rev. 8/2022

What Do I Bring to My First Visit?

- Proof of income (current pay stubs, approval letter for Healthy Start, Ohio Works First, Food Stamps or current Medicaid card)
- Proof of address (utility or credit bill, or Ohio driver's license)
- Proof of identity for you and any other applicants (birth certificate, driver's license, Medicaid card, crib card or shot record)
- All family members applying for WIC services
- If pregnant, a doctor's statement showing due date
- Children's shot records

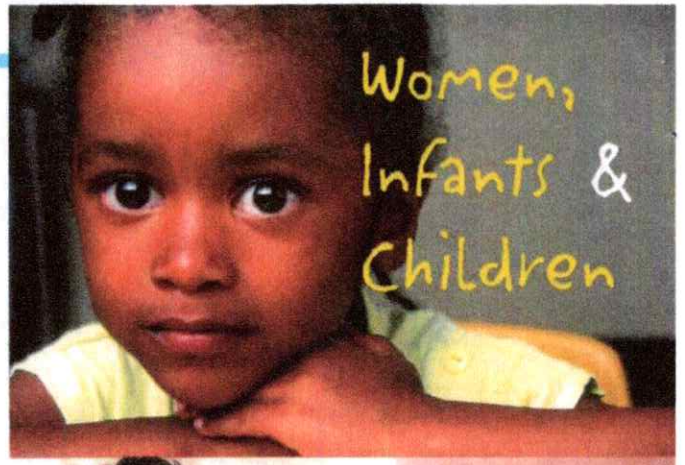


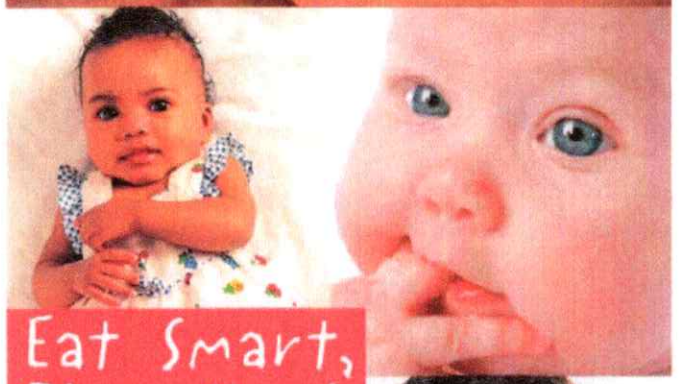
Healthy Ohio
The State of Living Well.

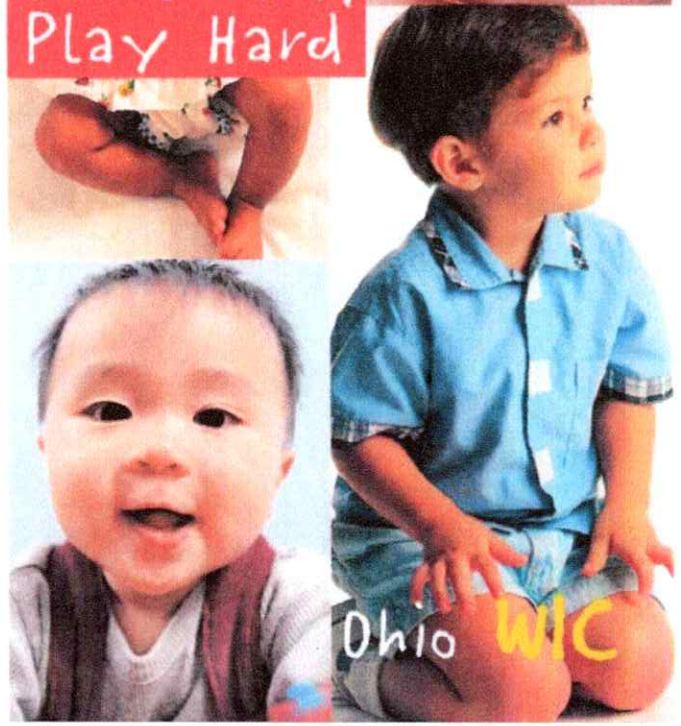
The mission of the WIC program is to improve the health status and prevent health problems among Ohio's at-risk women, infants and children.

Visit our Web site: http://www.odh.ohio.gov

0700 13







What is WIC?

WIC is a nutrition education program. WIC provides nutritious foods that promote good health for pregnant women, women who just had a baby, breastfeeding moms, infants and children up to age 5.

Who is Eligible For WIC?

Women who are pregnant, breastfeeding or have a baby less than 6 months old, and infants and children up to 5 years old are eligible to apply for WIC. Fathers are welcome to apply for WIC for their children up to age 5.

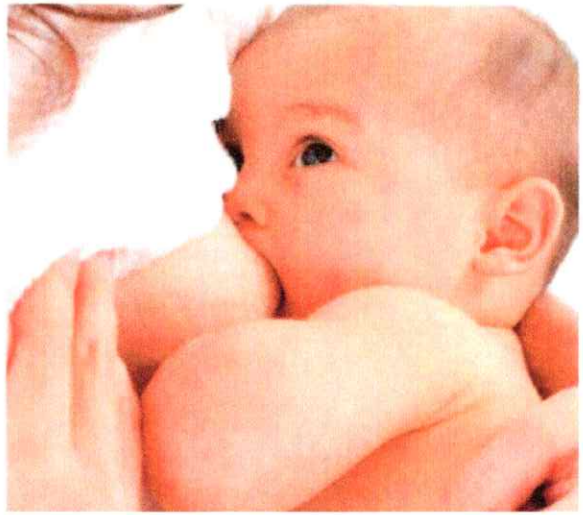
To qualify for services you must:

- Live in Ohio
- Meet WIC income guidelines
- Have certain nutritional or health risks

What Does WIC Provide?

- Nutrition education and support
- Breastfeeding education and support
- Referral for health care
- Immunization screening and referral

- Supplemental foods such as:
  - Cereal
  - Eggs
  - Milk
  - Whole-grain foods
  - Fruits and Vegetables
  - Infant formula



How Do I Apply?

Make an appointment

Call your local clinic to schedule an appointment to meet with a WIC staff member or call **1-800-755-GROW (4769)** for locations and more information.

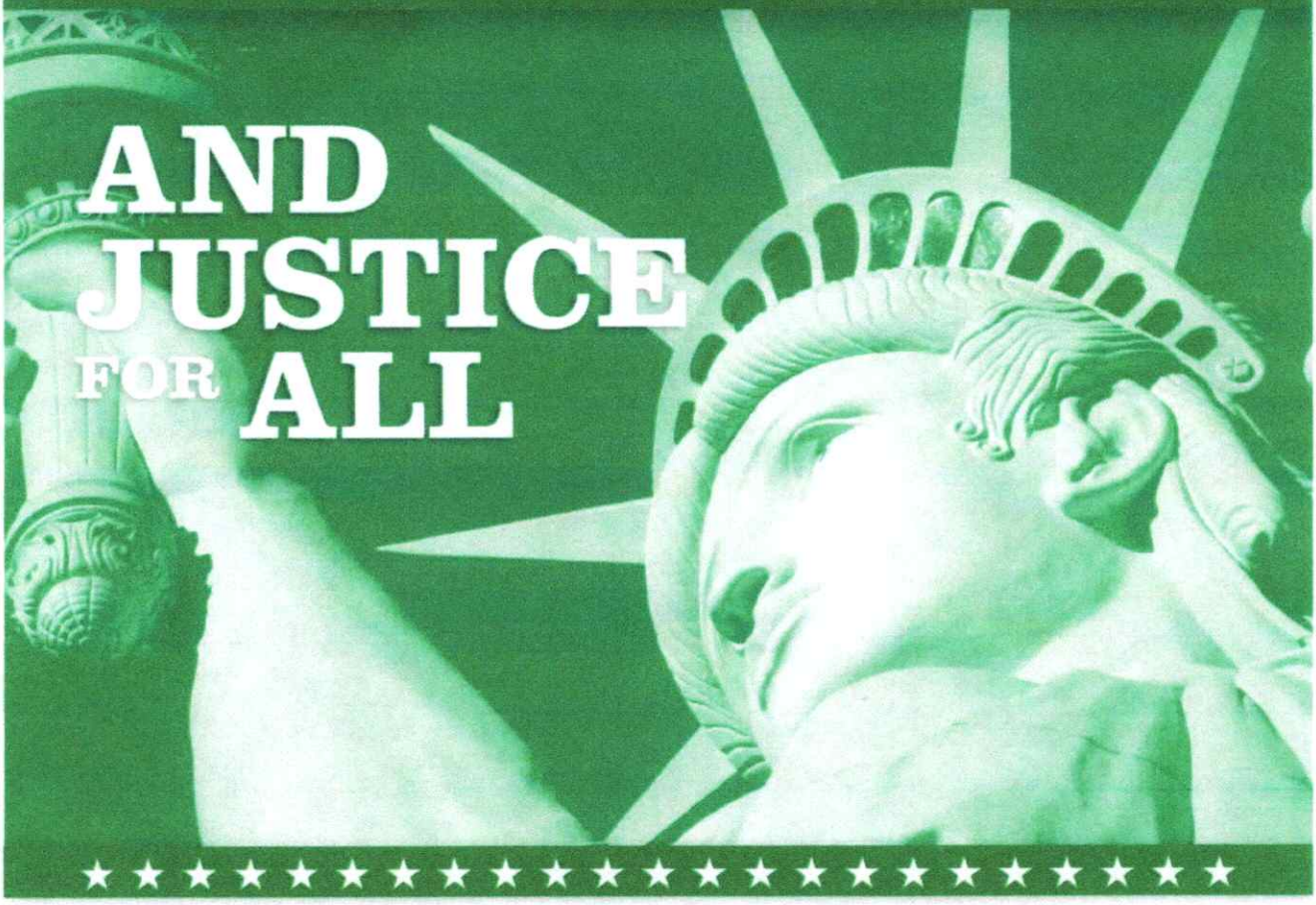
See if you qualify

All it takes is a visit to your local WIC clinic to see if you qualify for services.

Receive WIC coupons

If you are eligible, you will receive coupons to buy healthy foods at local WIC-approved grocery stores.

USDA
United States Department of Agriculture



AND JUSTICE FOR ALL

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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 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**. Additionally, program information is available in languages other than English.

To file a complaint alleging discrimination, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at **http://www.ascr.usda.gov/complaint_filing_cust.html**, or 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; or

email:
program.intake@usda.gov.

This institution is an equal opportunity provider.

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Las personas discapacitadas que requieran medios alternos para que se les comunique la información de un programa (por ejemplo, braille, letra agrandada, grabación de audio, lenguaje de señas estadounidense, etc.) deberán comunicarse con la agencia estatal o local responsable de administrar el programa o el TARGET Center del USDA al **(202) 720-2600** (voz y TTY) o comunicarse con el USDA a través del Servicio Federal de Transmisión de Información al **(800) 877-8339**. La información del programa también está disponible en otros idiomas además del inglés.

Para presentar una queja por alegada discriminación, complete el formulario de quejas por discriminación del programa del USDA, AD-3027, que podrá encontrar en línea en **http://www.ocio.usda.gov/sites/default/files/docs/2012/Spanish_Form_508_Compliant_6_8_12_0.pdf** o en cualquier oficina del USDA o escriba una carta dirigida al USDA que incluya toda la información solicitada en el formulario. Para solicitar una copia del formulario de presentación de quejas, comuníquese al **(866) 632-9992**. Envíe su formulario o carta completos al USDA por

correo:
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; o

correo electrónico:
program.intake@usda.gov.

Esta institución ofrece igualdad de oportunidades.