Ohio Department of Children and Youth

CHILD ENROLLMENT FORM FOR EARLY CARE AND EDUCATION PROGRAMS

Parents: Complete this form or an electronic version in its entirety prior to the child's first day of attendance, review annually, and update as needed. The program may supplement or substitute this document with their own content equivalent form and request additional information from the parent/guardian.

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

Parent #1 Name	Parent #1 Phone Number		
Parent #1 Address ☐Same as Child's	City	State	Zip Code
Parent #1 Email Address (if applicable)	Parent #1 Cell Phone (if applicable)		
Parent #1 Work/School Name (if applicable)	Parent #1 Work/School Phone Number (if applicable)		

Check here if Not Applicable ☐ Parent #2 Name	Parent #2 Phone Number		
Parent #2 Address ☐Same as Child's	City	State	Zip Code
Parent #2 Email Address (if applicable)	Parent #2 Cell Phone (if applicable)		
Parent #2 Work/School Name (if applicable)	Parent #2 Work/School Phone Number (if applicable)		

Primary Emergency Contact #1 Name (cannot be parent/guardian)	Check here if Not Applicable ☐ Optional Emergency Contact #2 Name (cannot be parent/guardian)
Primary Emergency Contact #1 Phone Number	Optional Emergency Contact #2 Phone Number
Primary Emergency Contact #1 Other number or email address for emergency contact *(if applicable)*	Optional Emergency Contact #2 Other number or email address for emergency contact *(if applicable)*
My child may be released to this emergency contact ☐ Yes ☐ No	Optional My child may be released to this emergency contact ☐ Yes ☐ No

Does your child have a chronic health condition or diagnosis that requires the program to: observe or monitor symptoms, administer medication, serve medical foods, perform medical procedures, avoid specific foods/environmental conditions/activities, or allow a school age child to carry and administer their own medication?

☐ Yes (complete or provide a Health Care Plan, documentation from a licensed physician, or an electronic equivalent)
☐ No

Child's Name	Date of Birth

Information on my child's development: (personal, behavior, patterns, habits, and individual needs, etc.)

☐ N/A

The following accommodation(s) may be helpful to most effectively meet my child's needs while at the program:

☐ N/A

My child will receive specialized/individual services at the program:

☐ Yes
☐ No

Name of service provider(s) and frequency

☐ N/A

Emergency Transportation Authorization

☐ **The program 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.

☐ **The program 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:

SIGNATURE

This form should be reviewed 12 months from the date the parent acknowledges accuracy and receipt of policies and procedures.

Parent Acknowledgement of Accuracy and Receipt of Policies and Procedures

By signing this form, I attest that the information is accurate and that I have reviewed and received a copy of the program's policies and procedures (parent handbook).

Parent Signature	Date

Program Acknowledgement of Completion

By signing this form, I attest that I have reviewed for completeness and that this form has been signed by the parent/guardian. This form is to be completed prior to the child receiving care.

Program Administrator/Designee Signature			Date
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

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 USDA civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

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 state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination 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, Mail Stop 9410, Washington, D.C. 20250-9410;
2. Fax: (202) 690-7442; or
3. Email: program.intake@usda.gov.

USDA is an equal opportunity provider, employer, and lender.

Revised 8/2025

CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICE MEALS Fiscal Year 2026-2027

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.

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

Total Household Size: _____

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

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

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

Signature of Sponsor / Center Representative	Date Sponsor Certified/Categorized Form	Effective Date	Expiration Date
		(From the first of month of date signed)	(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 the same 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 no income.

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

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, regarding 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 was received.
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 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 not required.

PART 5 – RACIAL/ETHNIC IDENTITY – OPTIONAL

You are not required to answer this part 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 USDA civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

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 state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination 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:

Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Mail Stop 9410, Washington, D.C. 20260-9410; **Fax**: (202) 690-7442; or **Email**: program.intake@usda.gov.

USDA is an equal opportunity provider, employer, and lender.

REDUCED-PRICE INCOME ELIGIBILITY GUIDELINES

Guidelines to be effective from July 1, 2026 through June 30, 2027.

Households with incomes less than or equal to the reduced-price values below are eligible for free or reduced-price mealbenefits.

Number of Members	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	$29,526	2,461	1,231	1,136	568
2	$40,034	3,337	1,669	1,540	770
3	$50,542	4,212	2,106	1,944	972
4	$61,050	5,088	2,544	2,349	1,175
5	$71,558	5,964	2,982	2,753	1,377
6	$82,066	6,839	3,420	3,157	1,579
7	$92,574	7,715	3,858	3,561	1,781
8	$103,082	8,591	4,296	3,965	1,983
Each Additional Member Add	$10,508	876	438	405	203

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:

Child Medical Statement Policy

We here at Chosen Kids Learning Center promote and strive for total health and wellness of the whole child and family. When a child is healthy, it allows them to learn at their greatest potential.

As it is our priority to assist parents in the enrollment process we must also follow state rules and regulations. It is the policy of Chosen Kids Learning Center that parents must submit a valid and current child medical statement stamped and signed by a physician within ten days of the start date of each child enrolled.

If a valid physical is not received within ten days of the start date, your child will be removed from enrollment until a valid physical is on file. Though we do not wish to turn anyone away we must implement a policy that allows us to remain compliant and meet state regulations.

Parent Signature_____ **Date**_____

Child's Name_____

*7751 E Main St Reynoldsburg, Ohio 43068 614-694-2677
*2525 Petzinger Rd Columbus, Ohio 43209 614-235-7979
*3314 Noe Bixby Rd Columbus, Ohio 43232 614-524-6114

Authorized List for Pick up

1.

2.

3.

4.

Child's first and last name:_____

Date:_____

WE HELP MOMS BE MOMS

WIC is the nation's most successful and cost-effective public health nutrition program. We provide wholesome food, nutrition education, and community support for income-eligible women who are pregnant or postpartum, infants, and children up to five years old.

FOOD. EDUCATION. SUPPORT. YOU GOT THIS.

We give moms the resources, knowledge, and tools they need to be the moms they want to be.

HEALTHY FOOD

Through WIC, moms get monthly benefits to buy healthy foods, such as:

Foods with calcium for strong bones and teeth:

- Milk.
- Cheese.
- Soy beverages.
- Yogurt.

Foods with protein for strong muscles and healthy skin:

- Dried or canned beans, peas, lentils.
- Eggs.
- Canned tuna or salmon.
- Peanut butter.
- Tofu.

Grains with iron for energy, and folic acid for healthy growth:

- Cereal.
- Brown rice.
- Soft corn or whole wheat tortillas.
- Whole grain bread.
- Whole wheat pasta.

Iron-fortified foods for infants who need it:

- Baby foods.
- Infant formula.
- Infant cereal.

Fruits and vegetables to keep your heart and weight healthy:

- Fresh, frozen, or canned fruits and vegetables.
- 100% fruit or vegetable juice.

NUTRITION EDUCATION

We support and educate moms to help them breastfeed successfully. We offer guidance on how to shop for healthy food, how to prepare it, and how to encourage children to eat it. We provide access to information, including:

- Prenatal nutrition.
- Breastfeeding tips.
- Eating tips for your child.
- Parenting tips.
- Healthy recipes.

A COMMUNITY OF SUPPORT

We're a network built for moms. We connect them, we educate them, and we learn from them. Our community consists of:

- Health providers.
- Lactation specialists.
- Peer helpers.

REFERRALS

We can introduce moms to resources outside of WIC, including:

- Healthcare providers such as pediatricians, OB/GYNs, and dentists.
- Immunization services.
- Substance use disorder counselors.
- Domestic abuse counseling.
- Social services.

BREASTFEEDING SUPPORT

We offer guidance for nursing moms:

- Advice on a range of breastfeeding issues, including positioning, latch, milk production, and returning to work.
- Nursing aids such as breast pumps.

ALL CAREGIVERS ARE WELCOME.

We talk a lot about moms. But we offer support to anyone—working or not—who cares for a child, including:

- Moms.
- Dads.
- Grandparents.
- Foster parents.
- Step-parents.
- Guardians.

WE'RE HERE FOR YOU.

We're here for more moms and caregivers than you might think—in fact, we serve over half of all infants born in the U.S. To get WIC assistance, participants:

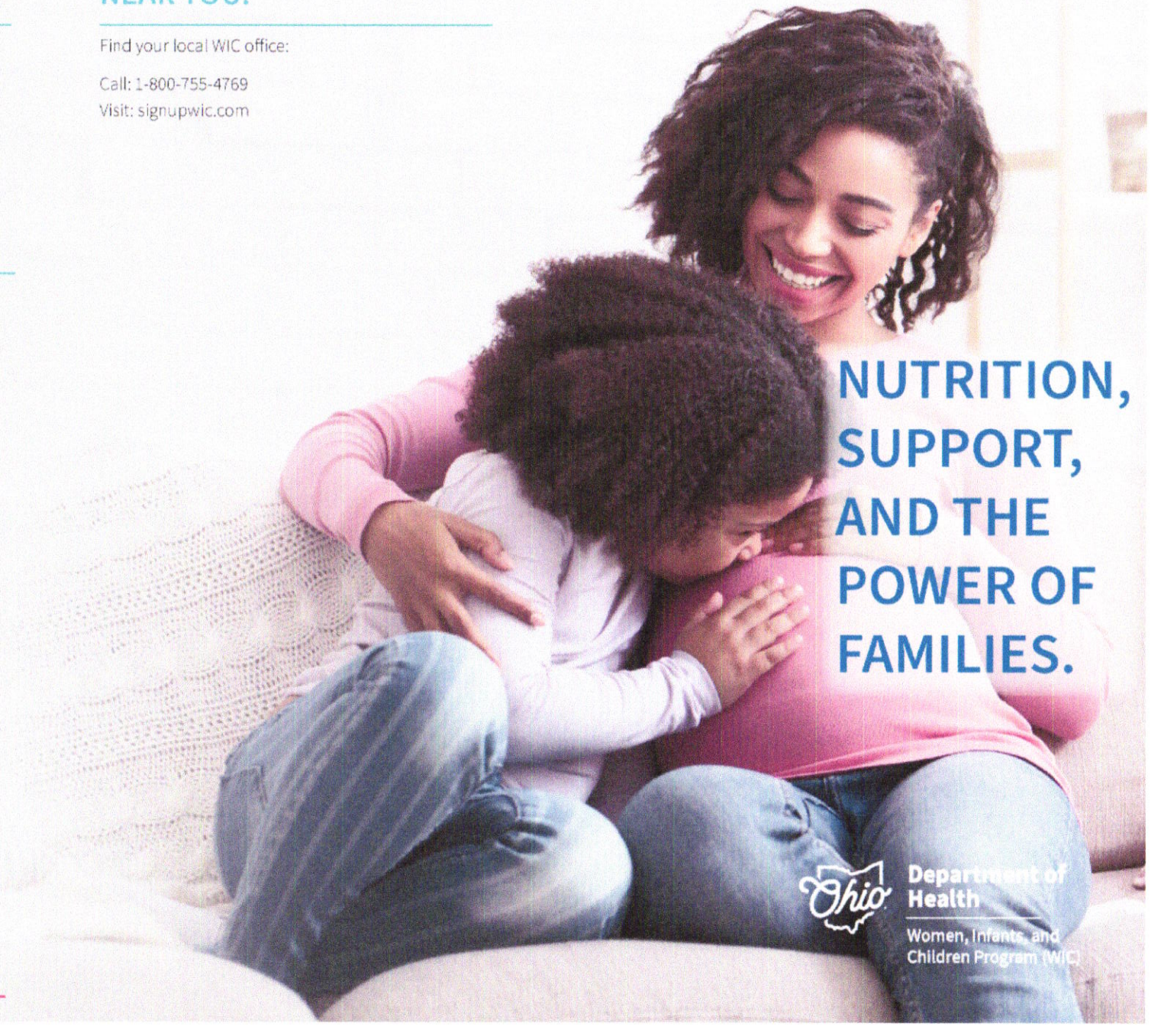
- Must be pregnant or have infants or children under 5 years old.
- May be in need of income assistance.
- Can be receiving other benefits like foster care, medical assistance, or SNAP.

HEA 8332

FIND WIC NEAR YOU.

Find your local WIC office:

Call: 1-800-755-4769
Visit: signupwic.com



NUTRITION, SUPPORT, AND THE POWER OF FAMILIES.

Ohio Department of Health
Women, Infants, and Children Program (WIC)

USDA
United States Department of Agriculture

AND JUSTICE FOR ALL

In accordance with Federal law and the 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 (including English proficiency), religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. (Not all prohibited bases apply to all programs)

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication for program information (e.g., braille, large print, audiotape, American Sign Language) should contact the responsible State or local Agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY).

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/ad-3027.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 Office of the Assistant Secretary for Civil Rights (OASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or

email:
program.intake@usda.gov

This institution is an equal opportunity provider.

De acuerdo con la ley federal y las reglamentaciones y políticas de derechos civiles del Departamento de Agricultura de los EE. UU. (U.S. Department of Agriculture, USDA), esta institución tiene prohibido discriminar por motivos de raza, color o país de origen (incluyendo dominio limitado del inglés), religion, sexo, discapacidad, edad, estado civil, estado familiar / parental, ingresos provenientes de un programa de asistencia pública, creencias políticas, represalias o venganza por haber participado anteriormente en actividades relacionadas con los derechos civiles en cualquier programa o actividad llevado a cabo o financiado por el USDA. (No todas las causas de discriminación prohibidas se aplican a todos los programas).

La información del programa puede estar disponible en idiomas distintos al inglés. Las personas con discapacidades que requieran medios alternativos de comunicación para obtener información del programa (p. ej., braille, letra grande, cintas de audio y lenguaje de señas americano) deben comunicarse con la agencia estatal o local responsable que administra el programa o comunicarse con el USDA a través del Servicio de Retransmisión de Telecomunicaciones al 711 (voz y TTY).

Para presentar una queja por discriminación en el programa, el reclamante debe completar el formulario AD-3027, el formulario de queja por discriminación en el programa del USDA, que se puede obtener en línea, en https://www.usda.gov/sites/default/files/documents/ad-3027s.pdf, desde cualquier oficina del USDA, llamando al (866) 632- 9992 o escribiendo una carta dirigida al USDA. La carta debe tener
el nombre, la dirección, el teléfono del reclamante y una descripción escrita de la supuesta acción discriminatoria con suficiente detalle para informar al subsecretario de derechos civiles (ASCR) sobre la naturaleza y la fecha de una supuesta violación de los derechos civiles. El formulario AD-3027 o la carta completos deben enviarse 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; o
correo electrónico:
program.intake@usda.gov

Esta institución ofrece igualdad de oportunidades.