ADMISSION INFORMATION

Operation Name	Director's Name	
Happy Trails Learning Center	Tristen Floyd	
Child's Full Name	Child's Date of Birth	Child's Home Telephone No.
Child's Home Address		
Date of Admission	Date of Withdrawal	
Parent's or Guardian's Name	Address (if different from child's address)	

List telephone numbers below where parents/guardian may be reached while child will be in care:

Mother's Telephone No.	Father's Telephone No.	Guardian's Telephone No.	Cell Phone No

Give the name, address and phone number of person to call in case of an emergency if parents / guardian cannot be reached:	Relationship

I hereby authorize the childcare operation to allow my child to leave the childcare operation **ONLY** with the following persons. Please list name & telephone number for each. Children will only be released to a parent or a person designated by the parent/guardian after verification of ID.

CHECK ALL THAT APPLY: I hereby ☐ give ☐ do not give – consent for my child to be transported and supervised by the operation's employees:

1. ☐ **TRANSPORTATION:**
   Walk home ☐ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school
2. ☐ **FIELD TRIPS:** I hereby ☐ give ☐ do not give – my consent for my child to participate in Field Trips:
   Parent's Comments:
3. ☐ **WATER ACTIVITIES:** I hereby ☐ give ☐ do not give – my consent for my child to participate in Water Activities:
   ☐ sprinkler play ☐ splashing/wading pools ☐ swimming pools ☐ water table play
4. ☐ **RECEIPT OF WRITTEN OPERATIONAL POLICIES:**
   I acknowledge receipt of the facility's operational policies including those for discipline and guidance.
5. **I UNDERSTAND THAT THE FOLLOWING MEALS WILL BE SERVED TO MY CHILD WHILE IN CARE:**
   ☐ None ☒ Breakfast ☐ AM Snack ☒ Lunch ☒ PM Snack ☐ Supper ☐ Evening Snack
6. **MY CHILD IS NORMALLY IN CARE ON THE FOLLOWING DAYS AND TIMES:**

☐ Mondays	from:	to:
☐ Tuesdays	from:	to:
☐ Wednesdays	from:	to:
☐ Thursdays	from:	to:
☐ Fridays	from:	to:
☐ Saturdays	from:	to:
☐ Sundays	from:	to:

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician:	Address:	Ph.#:
Name of Emergency Medical Care Facility:	Address:	Ph.#:

I give consent for the facility to secure any and all necessary emergency medical care for my child.

X _____
Signature - Parent or Legal Guardian

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregiver's should be aware of:

Child daycare operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800)-514-0383 (TTY).

_____ _____
Signature – Parent or Legal Guardian Date

ADMISSION INFORMATION

SCHOOL AGE CHILDREN:

☐ My child attends the following school:

_____ _____
Name of School and Address School Ph.#

CHECK ALL THAT APPLY:

☐ His / her immunization record is on file at the school and all required immunizations and/or tuberculosis test are current. Vision and Hearing screening records are also on file.

Name of sibling(s):

My child has permission to:
☐ walk to or from school or home,
☐ ride a bus, and/or
☐ be released to the care of his/her sibling(s) under 18 years old.

IMMUNIZATION RECORD:

☐ I have provided the childcare operation with a copy of my child's most current immunization record.

ADMISSION REQUIREMENT: If your child does not attend pre-kindergarten or school away from the child-care operation, one of the following must be presented when your child is admitted to the child-care operation or within one week of admission.

Please check only one option:

1. ☐ HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he / she is able to take part in the day care program.

_____ _____
Health Care Professional's Signature Date

2. ☐ A signed and dated copy of a health care professional's statement is attached.

3. ☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

4. ☐ My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the child-care operation.

Name and address of health care professional:

_____ _____
Signature - Parent or Legal Guardian Date

VISION	R 20/ _____	L 20/ _____	☐ PASS ☐ FAIL
SIGNATURE _____		DATE _____	

HEARING	1000 Hz	2000 Hz	4000 Hz	☐ PASS ☐ FAIL
R				
L				
SIGNATURE _____		DATE _____		

X _____ X _____
Signature – Parent or Legal Guardian Date

ADMISSION INFORMATION

HEALTH REQUIREMENTS

Name of Child:	Date of Birth:

See Attached Record

Age ▶ Vaccine ▼	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 Mos	2-3 Yrs	4-6 Yrs
Hepatitis B											
Rotavirus											
Diphtheria, Tetanus, Pertussis											
Haemophilus influenzae type b											
Pneumococccal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningococcal											

TB TEST (if required)	☐ Positive	☐ Negative	Date:

Signature or stamp of a physician or public health personnel verifying immunization information above:

Signature — Date

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about (date) _____ and does not need varicella vaccine.

Parent's signature — Date

☐ I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.

For additional information regarding immunizations contact the Department of State Health Services at www.dshs.state.tx.us/immunize/public.shtm

Signature – Parent or Legal Guardian — Date

Updated Enrollment Information

Childs Name_____DOB_____

Childs Name_____DOB_____

Childs Name_____DOB_____

Childs Name_____DOB_____

Primary Home Address_____

Home Number_____

Mothers Name _____

Cell Phone _____

Place of Employment_____

Work Phone _____

Email _____

Fathers Name _____

Cell Phone _____

Place of Employment_____

Work Phone _____

Email _____

Name and phone numbers of people that we may call if you are NOT available AND who are allowed to pick up your child from Happy Trails

NAME **PHONE** **RELATIONSHIP**

_____

_____

_____

_____

Child's Doctor:_____Phone Number_____

Hospital Preference:_____Phone Number_____

- My child's immunizations are up to date and I have given Happy Trails Learning Center the most current copy of these records. (We must have current copy per state standards) We DO NOT need after school aged children's shot records.
- If my child attends the after school or Kindergarten Readiness program, I give them permission to go on field trips and medical authorization for emergency by signing below.
- I **give, do not give** (circle one), Happy Trails Learning Center permission to post my child's picture to their Facebook page.

Parents Signature:_____Date:_____

Be sure to "Like" us on Facebook-Happy Trails Learning Center!

Happy Trails Learning Center
14865 W. Hwy 29
Liberty Hill, TX 78642
(512) 515-0555

Discipline and Guidance Policy for _____

Name of Operation

- Discipline must be:
  (1) Individualized and consistent for each child;
  (2) Appropriate to the child's level of understanding; and
  (3) Directed toward teaching the child acceptable behavior and self-control.

- A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control, and self-direction, which include at least the following:
  (1) Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
  (2) Reminding a child of behavior expectations daily by using clear, positive statements;
  (3) Redirecting behavior using positive statements; and
  (4) Using brief supervised separation or time out from the group, when appropriate for the child's age and development, which is limited to no more than one minute per year of the child's age.

- There must be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited:
  (1) Corporal punishment or threats of corporal punishment;
  (2) Punishment associated with food, naps, or toilet training;
  (3) Pinching, shaking, or biting a child;
  (4) Hitting a child with a hand or instrument;
  (5) Putting anything in or on a child's mouth;
  (6) Humiliating, ridiculing, rejecting, or yelling at a child;
  (7) Subjecting a child to harsh, abusive, or profane language;
  (8) Placing a child in a locked or dark room, bathroom, or closet with the door closed; and
  (9) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

Texas Administrative Code, Title 40, Chapters 746 and 747, Subchapters L, Discipline and Guidance

My signature verifies I have read and received a copy of this discipline and guidance policy.

_____ _____
Signature Date

Check one please:

☒ parent ☐ employee/caregiver ☐ household member of child-care home

HAPPY TRAILS LEARNING CENTER
PARENT ACKNOWLEDGEMENT FORM

I understand that these policies describe important information regarding HAPPY TRAILS LEARNING CENTER. If at any time I have questions regarding these policies, I should consult a member of the management team.

My relationship with the HAPPY TRAILS LEARNING CENTER is voluntarily entered into and is subject to termination by me or the Center at will, with or without cause, at any time that either the Center or I believe such action is appropriate. Such termination shall be subject to all the policies relating to termination of services.

I acknowledge that I have received, read and understand the policies contained in the parent handbook. I further agree to comply with these policies.

_____ _____

Parent Signature Date

_____ _____

Parent Signature Date

_____

Child's Name

_____

Child's Name

_____

Child's Name

_____

Child's Name

_____ _____

Signature Received by (Center Staff) Date Received

Sign and Return to office

HAPPY TRAILS LEARNING CENTER
ALL ABOUT ME!

My name is _____ , call me_____!
First and Last Nick Name

Today is _____I'll be starting in your class on _____!

My birthday is (mo)_____(day)_____(yr)_____. I am _____ years old!

I live in _____with my: (circle below)
(City)

Mom Dad Grandparent(s) Other_____

Moms name: _____ Dads Name: _____
Grandparent's names: _____

Other names of friends/family who are allowed to pick up other than you:

_____ _____
_____ _____

I have: ____younger brother/____older brother(s)_____.
name(s)
____younger sister/____older sister(s)_____.
name(s)

I have: _____Dog_____ _____Cat_____
name(s) name(s)

_____Other_____
name(s)

I like to eat _____
(i.e. Chicken, Mac & Cheese, Pizza, Fruit, etc)

I am a big kid Potty trained **working on it** being potty trained **not yet**

I have fun by _____
(playing blocks, dancing, riding my bike, balls, dress-up, making faces)

_____

HAPPY TRAILS LEARNING CENTER
Fee Agreement-Effective 1/1/15

6:30 A.M.--6:00 P.M. Monday through Friday — Ages Served: 6 weeks – 12 years
Registration Fee -- $100 per child/$200.00 per family

Fees:

Infant/Toddler Full Time (6 weeks-3 years)	$155.00 per week/$670.00 per month
PreSchool Full Time (ages 3 & up)	$145.00 per week/$628.00 per month
18 months-5 years) 3 days per week	$100.00 per week/$433.00 per month
(18 months-5 years) 2 days per week	$70.00 per week/$303.00 per month
Before/After School	$ 55.00 per week ***
Before School	$ 15.00 per week***
Summer Program	$ 160.00 per week
Daily Drop-In Rate	$35.00 per day**

(**Based upon space availability each day and you must have paid registration fee)
(*** Unless the student is here for a full day, $30.00 per day for full days such as schools out days or Christmas/Spring breaks)

- LATE FEE (After 6:00 PM) $20.00 per 15 minute increments.
- LATE PAYMENT FEE (weekly/monthly tuition) $5.00 per day beginning 2nd business day of week tuition is due.
- Fees are due whether child is in attendance or not
- All holidays and inclement weather days will be charged at the regular rate.
- Discounts: 5% discount for each additional sibling currently enrolled full time in the program (The youngest child is always counted as the first child.)

Fees are due in advance on Monday. Late payment fee weekly tuition: $5.00 per day, beginning the 2nd business day of the week. Late payment fee monthly/bi-monthly tuition: $5.00 per day, beginning the 2nd business day of the month or 2nd day past bi-monthly due date. Failure to pay on time may result in termination of services. $35.00 fee added on all returned checks. Fees for two weeks will be added if a two week written notice is not given prior to your child leaving the. HAPPY TRAILS LEARNING CENTER may seek collection of fees; clients may be required to pay a two week termination fee, and any collection costs and attorney's fees incurred by HAPPY TRAILS LEARNING CENTER to collect this amount. Interest fee for unpaid tuition balance is set at 15% per month. If HAPPY TRAILS LEARNING CENTER elects, it may immediately terminate all services provided by it including but not limited to the immediate dismissal of the children from it's facility. HAPPY TRAILS LEARNING CENTER may also prosecute under Texas Penal Code, Section 31.04-Theft of Services.

Child's Name:	Schedule: (i.e. M-F 6:30-6:00)	Rate: ($150.00 per wk)

By signing below I am stating that I understand and agree to the terms of the above fee agreement. I also understand that the fees may increase between the date this agreement is signed and my guaranteed start date. In the event this happens, I agree to pay the new rates or forfeit my deposit and my child's spot in the center. I further agree to pay all fees, interest and late fees as stated above and any and all attorney fees, court costs and collection costs related to the collection of my account. I also understand that I can be prosecuted under Texas Penal Code, Section 31.04Theft of Services.

PARENT'S SIGNATURE: _____ Social Security #_____ DATE: _____

PARENT'S SIGNATURE: _____ Social Security #_____ DATE: _____

Happy Trails Learning Center

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. **Happy Trails Learning Center** offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

1. Do I need to fill out a Meal Benefit Form for each of my children in day care? You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household **only** if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to: Happy Trails Learning Center 512-515-0555**

2. Who can get free meals without providing income information? Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) can get free meals. Foster children (reference question #8 for more information on foster children) and children enrolled in a Head Start Program (HSP), Early Head Start Program (EHSP), or Even Start Program (ESP) and have not entered kindergarten) are also eligible for free meals. Households with children enrolled in a HSP, EHSP or ESP can provide a certification letter from the program of the child's enrollment and do not need to complete the CACFP Meal Benefit Income Eligibility Form.

3. Who can get reduced price meals? Your children can get low cost meals if your household income is within the reduced price limits on the Income Chart, sent with this application. Children in households participating in WIC may be eligible for reduced price meals.

4. May I fill out a form if someone in my household is not a U.S. citizen? Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.

5. Who should I include as members of my household? You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.

6. How do I report income information and changes in employment status? The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.

7. What if my income is not always the same? List the amount that you normally get. For example, if you normally get $1000 each month, but you missed some work last month and only got $900, put down that you get $1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.

8. What if I have foster children? Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children can provide the Texas Department of Family and Protective Services Form 2085FC, *Placement Authorization Foster Care/Residential Care*, to their child's caregiver and do not need to complete the CACFP Meal Benefit Income Eligibility Form.

9. We are in the military, do we include our housing and supplemental allowances as income? If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

10. ***(Pricing program only)*** **Will the information I give be verified?** Maybe. We may ask you to send written proof to verify the information you submitted on the form. **What if I disagree with the decision about the information I complete on this form?** You can talk to **[enter name of staff person that handles complaints/disagreements]**, either in person or by telephone at **[enter phone number for the staff person above]**. You may ask for a hearing by calling or writing to: **[name, address, phone number].**

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, call **512-515-0555.**

Sincerely,

Justen Hoepl

Food Program Enrollment Form for FP Assistance (02328)

Center Name: Happy Trails Learning Center CODE: H-180

Child's Name: _____ Date of Birth: _____

Admission date: _____ Withdrawal Date: _____

1. Circle the days that your child will normally attend the center:

Mon Tue Wed Thu Fri Sat Sun

2. Circle the meals normally served to your child in the center:

Breakfast AM Snack Lunch PM Snack Supper Evening Snack

3. What hours will your child normally be in the center:

____:____ to ____:____

4. Participant's ethnic and racial identities (optional)

Ethnicity (choose one ethnic identity):

☐ Hispanic or Latino

☐ Not Hispanic or Latino

Race: (choose one or more racial identities):

☐ Asian ☐ American Indian or Alaska Native

☐ White ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American

_____ _____

Parent Signature Date of Signature

(_____) _____-_____

Day Time Phone Number

The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren): _____

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR, provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ CASE NUMBER: _____

Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and case number: NAME: _____ CASE NUMBER: _____

Check here if no case number ☐

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** **Note:** Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$200/bi-monthly
	$____/____	$____/____	$____/____	$____/____
	$____/____	$____/____	$____/____	$____/____
	$____/____	$____/____	$____/____	$____/____
	$____/____	$____/____	$____/____	$____/____
	$____/____	$____/____	$____/____	$____/____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the next page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City:_____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _ _ _ - _ _ - _ _ _ _ ☐ I do not have a Social Security Number

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

☐ **I do elect to allow my household information to be disclosed.**

☐ **I do not elect to allow my household information to be disclosed.**

Don't fill out this part. This is for official use only.

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

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date:_____

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.

Non-discrimination Statement:

The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.