Imagine Me Academy
Enrollment Packet

Admissions Packet

1. Admissions Information (6 pages)
2. Childcare Rate Agreement
3. Notice to Parents
4. Nutrition Matters
5. Healthcare Statements
6. Food Center Service Enrollment

Documents needed from parent

1. Shot Record
2. Hearing and Vision Screening
3. Allergy Treatment Plan

First Day at Imagine Me Academy:
What to bring:

1. Any enrollment documents not previously submitted
2. Change of Clothes (Label with child's name)
3. Pillow (Label with child's name)
4. Blanket (Label with child's name)
5. School Supplies (18 months and up)
   a. Box of Crayons (Crayola Recommended)
   b. Plastic Shoe Box
   c. 1-inch white binder with plastic cover sleeve
   d. 50-page plastic protectors (Walmart or Dollar Tree)
   e. ream of copy paper
   f. Wipes and Diapers (if needed)
   g. Gel Hand Sanitizer
   h. Can of Lysol
6. Infants (Please label all with child's name.)
   a. Formula and Bottles
   b. Diapers
   c. Wipes
   d. Two changes of clothes
   e. Can of Lysol

TEXAS Health and Human Services

Form 2935
October 2023

Admission Information

Use this form to collect all required information about a child enrolling in day care.

Directions: The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

General Information

Operation's Name:	Director's Name:		
Child's Full Name:	Child's Date of Birth:	Child Lives With? ◯ Both parents ◯ Mom ◯ Dad ◯ Guardian	
Child's Home Address:	Date of Admission:	Date of Withdrawal:	
Name of Parent or Guardian Completing Form:	Address of Parent or Guardian *(if different from the child's)*:		
List phone numbers below where parents or guardian may be reached while child is in care.			
Parent 1 Phone No.:	Parent 2 Phone No.:	Guardian's Phone No.:	Custody Documents on File? ◯ Yes ◯ No
In case of an emergency, call:			
Name of Emergency Contact:	Relationship:	Area Code and Phone No.:	
Address:			

I authorize the child care operation **to release** my child to leave the child care operation **ONLY** with the following persons. Please list name and phone number for each. Children will only be released to a parent or guardian or to a person designated by the parent or guardian after verification of ID.

Name:	Area Code and Phone No.:
Name:	Area Code and Phone No.:
Name:	Area Code and Phone No.:

Consent Information

1. Transportation:

I give consent for my child to be transported and supervised by the operation's employees (Check all that apply).

☐ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school

2. Field Trips:

◯ I give consent for my child to participate in field trips. ◯ I do not give consent for my child to participate in field trips.

Comments:

3. Water Activities:

I give consent for my child to participate in the following water activities (Check all that apply).

☐ water table play ☐ sprinkler play ☐ splashing or wading pools ☐ swimming pools ☐ aquatic playgrounds

Is your child able to swim without assistance?

◯ Yes ◯ No

Does your child have any physical, health, behavioral or other condition that would put them at risk while swimming?

◯ Yes ◯ No

Do you want your child to wear a life jacket while in or near a swimming pool?

◯ Yes ◯ No

4. Receipt of Written Operational Policies:

I acknowledge receipt of the facility's operational policies, including those for (Check all that apply).

☐ Discipline and guidance
☐ Suspension and expulsion
☐ Emergency plans
☐ Procedures for conducting health checks
☐ Safe sleep
☐ Procedures for parents to discuss concerns with the director
☐ Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions
☐ Procedures for parents to participate in operation activities
☐ Procedures for release of children
☐ Illness and exclusion criteria
☐ Procedures for dispensing medications
☐ Immunization requirements for children
☐ Meals and food service practices
☐ Procedures to visit the center without securing prior approval
☐ Procedures for supporting inclusive services
☐ Procedures for parents to contact Child Care Regulation (CCR), DFPS, Child Abuse Hotline, and CCR website

5. Meals:

I understand that the following meals will be served to my child while in care (Check all that apply):

☐ None ☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack

6. Days and Times in Care:

My child is normally in care on the following days and times:

Day of the Week	A.M.	P.M.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

7. Receipt of Parent's Rights:

I acknowledge I have received a written copy of my rights as a parent or guardian of a child enrolled at this facility.

Signature — Parent or Legal Guardian

Date Signed

8. Child's Special Care Needs (check all that apply)

- ☐ Environmental allergies
- ☐ Food intolerances
- ☐ Existing illness
- ☐ Previous serious illness
- ☐ Injuries and hospitalizations *(past 12 months)*
- ☐ Other: ____________________
- ☐ Limitations or restrictions on child's activities
- ☐ Reasonable accommodations or modifications
- ☐ Adaptive equipment *(include instructions below)*
- ☐ Symptoms or indications of complications
- ☐ Medications prescribed for continuous long-term use

Explain any needs selected above:

Does your child have diagnosed food allergies? ○ Yes ○ No Food Allergy Emergency Plan Submitted Date: ____________

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit https://www.ada.gov/resources/child-care-centers/. 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 Signed**

9. School Age Children

My child attends the following school:	School Area Code and Phone No.:

My child has permission to *(check all that apply)*:

☐ walk to or from school or home ☐ ride a bus ☐ be released to the care of his or her sibling under 18 years old

Authorized pick up or drop off locations other than the child's address:

☐ Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

Authorization For Emergency Medical Attention

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

Name of Physician	Address	Phone No.
Name of Emergency Care Facility	Address	Phone No.

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

Signature — Parent or Legal Guardian **Date Signed**

Requirements for Exclusion from Compliance

◯ I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.

◯ I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

Vision Exam Results

Right Eye 20/ Left Eye 20/ ◯Pass ◯Fail

Signature **Date Signed**

Hearing Exam Results

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				◯ Pass ◯ Fail
Left				◯ Pass ◯ Fail

Signature **Date Signed**

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. *(Select **only one** option.)*

◯ Health Care Professional's Statement: I have examined the above named child within the past year and find that he or she is able to take part in the day care program.

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

◯ 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.

◯ 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 submit it to the child care operation.

Name of Health Care Professional, if selected Address of Health Care Professional, if selected

Signature — Health Care Professional Date Signed

Signature — Parent or Legal Guardian Date Signed

Vaccine Information

The following vaccines require multiple doses over time. Please provide the date your child received each dose.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose)	
	1–2 months (second dose)	
	6–18 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15–18 months (fourth dose)	
	4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6–18 months (third dose)	
	4–6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12–15 months (first dose)	
	4–6 years (second dose)	
Varicella	12–15 months (first dose)	
	4–6 years (second dose)	
Hepatitis A	12–23 months (first dose)	
	The second dose should be given 6 to 18 months after the first dose.	

Varicella (Chickenpox)

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.

Signature **Date Signed**

Additional Information Regarding Immunizations

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

TB Test (If required)

◯ Positive ◯ Negative Date:

Gang Free Zone

Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: https://hhs.texas.gov/policies-practices-privacy#security

Signatures

Child's Parent or Legal Guardian **Date Signed**

Center Designee **Date Signed**

Physician or Public Health Personnel Verification

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

Signature **Date Signed**

TEXAS
Health and Human Services

Form 1099
September 2023

Operational Discipline and Guidance Policy

This form provides the required information per 26 Texas Administrative Code (TAC) minimum standards Sections 744.501(7), 746.501(a)(7), and 747.501(5).

Directions: Parents will review this policy upon enrolling their child. Employees, household members and volunteers will review this policy at orientation. A copy of the policy is provided in the operational policies.

Discipline and Guidance Policy

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) grabbing or pulling a child;
4) putting anything in or on a child's mouth;
5) humiliating, ridiculing, rejecting or yelling at a child;
6) subjecting a child to harsh, abusive or profane language;
7) placing a child in a locked or dark room, bathroom or closet;
8) placing a child in a restrictive device for time out;
9) withholding active play or keeping a child inside as a consequence for behavior, unless the child is exhibiting behavior during active play that requires a brief supervised separation or time out that is consistent with 746.2803(4)(D); and
10) requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

Additional Discipline and Guidance Measures

(Only Applies to Before or After School Program (BAP)/School Age Program (SAP) that Operates under 26 TAC Chapter 744)

A program must take the following steps if it uses disciplinary measures for teaching a skill, talent, ability, expertise or proficiency:

- ensure that the measures are considered commonly accepted teaching or training techniques;
- describe the training and disciplinary measures in writing to parents and employees and include the following information:
  - (A) the disciplinary measures that may be used, such as physical exercise or sparring used in martial arts programs;
  - (B) what behaviors would warrant the use of these measures; and
  - (C) the maximum amount of time the measures would be imposed;
- inform parents that they have the right to ask for additional information; and
- ensure that the disciplinary measures used are not considered abuse, neglect, or exploitation as specified in Texas Family Code Section 261.001 and TAC Chapter 745, Subchapter K, Division 5, of this title (relating to Abuse and Neglect).

Signature

This policy is effective on the following date: ____________________

Signed by: ____

Role: ◯ Parent ◯ Caregiver or Employee ◯ Household Member (CH. 747 only)

Minimum Standards Related to Discipline

- **Title 26, Chapter 746 Subchapter L:** http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=746&sch=L&rl=Y
- **Title 26, Chapter 747 Subchapter L:** http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=747&sch=L&rl=Y
- **Title 26, Chapter 744 Subchapter G:** http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=744&sch=G&rl=Y

Childcare Rate Agreement (General)

Payments

Tuition is due on the Monday. Payments are late on Tuesday. A **late fee of $10** will be added for any payment received after Tuesday at 10am. An additional late fee will be **$5.00 per day will be charged day.** If payment is not received by **Tuesday morning, your child will not be able to stay in care.** No exceptions.____________ **(initial)**

Parent may pay in biweekly or monthly intervals. However, payments are due before care is provided.

Late Pick-Up Fees

As a courtesy, we have a 5-minute grace period. The grace period will be revoked after your 3rd late pick-up. A late pick-up fee of **$1.00 per minute** will be assessed after the 5-minute grace. The late fee must be paid in CASH that evening. This will be strictly enforced.____________ **(initial)**

Delinquent Payment

Imagine Me Academy LLC will seek legal action for delinquent balances for the original fees, late fees and any legal fees accrued. ____________ **(initial)**

Student Name	Age	Date of Birth	Enrollment Date	Registration Fee	Weekly Rate
1.					
2.					
3.					
4.					
			Total	**$**	**$**

Parent Name__________________ Parent Signature__________________

Date________________________ Phone # ______________________

Director/Management Signature ___________________ Date __________

Credit Card Authorization Card #_____-______-______-______

Expiration ___/___ **Zip Code**_______________ **3 Digit Code**__________

Pay Frequency: Weekly Biweekly Monthly

Healthcare Statement

Child's Name ____________________ D.O.B ____________

Please have your child's physician complete this form. In compliance with the Family and Protective Services, we must have a health statement for every child enrolled in Imagine Me Academy.

The Section below is to be completed by a physician.

The child is free from communicable disease. ( )Yes ( )No

I have examined the child in the past year. ( )Yes ( )No

The child is able to participation in group care. ( )Yes ( )No

List any medication taken regularly by child

____

____

Allergies and Treatment Plan

____

____

Physician Signature________________________ Date__________

Physician Address ____

Physician Phone # ____

Nutrition Matters

Child's Name ______________________________

Parent Acknowledgement

I acknowledge that Imagine Me Academy has provided the following documentation and discussed the following:

1. Discipline and Guidance Policy
2. Center Release of Children Policy
3. Child Enrollment Form
4. CACFP Enrollment Form
5. Parent Handbook
6. Childcare Rate Agreement
7. WIC Qualification Information
8. Building for the Future
9. _________ Other
10. _________ Other

______________________ ____________
Parent Signature Date

______________________ ____________
Center Representative Signature Date

Center: IMAGINE ME ACADEMY

Enrollment

Child First Name	Child Last Name	Date of Birth	Hour In	Hour Out	Days In Care	Meals Attending
			06:00	06:00	MON [X] TUE [X] WED [X] THR [X]	breakfast [X] am snack [ ] lunch [X] pm snack [X]
Optional: Race: White [ ] Black [ ] Asian [ ] Native Amer Indian [ ] Alaska Native [ ] Hawaiian or Pacific Islander [ ] Other [ ] Ethnicity: Hispanic [ ] Non Hispanic [ ]			AM [X] PM [ ]	AM [ ] PM [X]	FRI [X] SAT [ ] SUN [ ]	supper [X] ev snack [ ]

Parent/Guardian First Name: **Parent/Guardian Last Name:**

Date of Enrollment: **Date Dropped:**

Address ____________________

City, State, Zip ____________________

Home Phone **Work**

Email

THIS SECTION MUST BE COMPLETED IF YOUR CHILD IS UNDER 12 MONTHS OLD: THIS CENTER SUPPLIES THE IRON FORTIFIED INFANT FORMULA:____________________

Under the policies of the USDA CACFP, the childcare center is required to supply the iron-fortified infant formula of the center's choice. Please select your preferences below:

[ ] The center will supply formula	[ ] I will bring the breastmilk	I will bring the iron fortified infant formula listed here:____________________(if this formula is low-iron or non iron fortified a medical statement is necessary.)

New instructions: *example:change formula to IF Similac*

Today's Date:

Age 0-5 mo____ Age 6-11 mo___

Center must update this information as the situation changes, such as a change in the infant's formula or foods. Update in the space provided above.

When your child is developmentally ready, the center is required to supply solid foods such as iron-fortified infant cereal, fruits, vegetables, meat/meat alternates as they become developmentally ready to accept according to the Infant Meal Pattern. Please select your food preference:

[ ] The center will supply solid foods	[ ] I will bring solid foods when my child is developmentally ready to accept

Dear Parent, Because your day care provider cares about good nutrition, they have chosen the benefits of the Child and Adult Care Food Program. This program is sponsored by PERITY COMMUNITY OUTR Under the regulations of the CACFP, your provider may not charge you separate fees for rmeals, nor may you be asked to provide food for your child for those meals claimed under the program. In accordance with Federal civil rights law and U.S. Department of Agriculture civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, disability, sex, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. To file a complaint of discrimination, write: USDA, Director, Office of Assistant Secretrary for Civil Rights, 1400 Independence Avenue, SW, Washington D.C. 20250-9410 fax: 202-690-7442; email: program.intake@usda.gov This institution is an equal opportunity provider and employer.

Signature X **Date of Signature**

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

IMAGINE ME ACADEMY

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 eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:______________________________ ELIGIBILITY 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 eligibility number: NAME: ______________________________ ELIGIBILITY NUMBER: ______________

Check here if no eligibility 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 ☐ Not Hispanic or Latino	☐Asian ☐White ☐Black or African American	☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

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) eligibility 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:

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

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

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

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

(2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.