Family Enrollment

316-202-8865 | VerboseLLC.com

Registration Date _____

Child Information

1st Child

Last Name	First Name	M.I.	Nickname

Entering grade	[ ] Male [ ] Female [ ] Prefer not to specify	Birth Date	Birth City/State City: State:	Social Security #

Existing medical conditions, medications and/or special attention your child may require

Allergies

Pediatrician's Name	Phone	Address

Photos: May we take, maintain, and use photos and/or video of your child? [X] Yes [ ] No

2nd Child

Last Name	First Name	M.I.	Nickname

Entering grade	[ ] Male [ ] Female [ ] Prefer not to specify	Birth Date	Birth City/State City: State:	Social Security #

Existing medical conditions, medications and/or special attention your child may require

Allergies

Pediatrician's Name	Phone	Address

3rd Child

Last Name	First Name	M.I.	Nickname

Entering grade	[ ] Male [ ] Female [ ] Prefer not to specify	Birth Date	Birth City/State City: State:	Social Security #

Existing medical conditions, medications and/or special attention your child may require

Allergies

Pediatrician's Name	Phone	Address

Photos: May we take, maintain, and use photos and/or video of your child? [X] Yes [ ] No

Additional Comments & Information: _____

Parent Updates: Date - _____ Date - _____ Date - _____ Date - _____ Date - _____

Primary Guardian Information

Name(s) of person(s) with whom child is living

1st Primary Guardian				
Last Name	First Name		M.I.	Relationship to Child
Email Address	Work Phone			Cell Phone
Occupation	Employer	Work Address		Work Hours

2nd Primary Guardian				
Last Name	First Name		**M.I.**	Relationship to Child
Email Address	Work Phone			Cell Phone
Occupation	Employer	Work Address		Work Hours

Which Guardian Should be Called First?	Home Phone		Preferred language for written communication:
Home Resident Street Address	Apt #	City	Zip Code
Mailing Address (if different than above)	Apt #	City	Zip Code

Second Guardian Information

Non-primary custodial parent

1st Non-primary Guardian			
Last Name	First Name	M.I.	Relationship to Child
Email Address	Work Phone		Cell Phone

2nd Non-primary Guardian			
Last Name	First Name	**M.I.**	Relationship to Child
Email Address	Work Phone		Cell Phone

Which Guardian Should be Called First?	Home Phone		Should mailings be sent to this household also? [ ] Yes [ ] No
Second Household Mailing Address	Apt #	City	State	Zip Code

Additional Comments & Information: _____

Emergency Contacts and Authorized Pickups

1st Contact/Pickup		
Last Name	First Name	Relationship to Child
Home Phone / Cell Phone	[ ] Able to pick up all children in the family [ ] Not able to pick up the following children: _____	

2nd Contact/Pickup		
Last Name	First Name	Relationship to Child
Home Phone / Cell Phone	[ ] Able to pick up all children in the family [ ] Not able to pick up the following children: _____	

3rd Contact/Pickup		
Last Name	First Name	Relationship to Child
Home Phone / Cell Phone	[ ] Able to pick up all children in the family [ ] Not able to pick up the following children: _____	

Additional Comments and Information

Is there is any other information that that would be helpful to our management and teaching staff?

All Parents/Guardians have recieved a copy and reviewed the emergency plan. If enstance of emergency evacacuation occurs all Verbose enrollees will evacuate to Discount Tires located at 7236 W 21st Wichita, KS 67205 316.347.2590 or wherever directed by Emergency Personnel. All emergency contacts will be called when it safe to make calls.

Signature

Parent / Guardian Signature

Date

CCL 010
Rev. 3/2017

Kansas Department of Health and Environment
Bureau of Family Health
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Child Care Program: (785) 296 -1270 Fax: (785) 559-4244
Website: www.kdheks.gov/kidsnet

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A). School Age Programs reference K.A.R. 28-4-582(e)(2).

Name of facility exactly as stated on the license.	**License #**
Verbose Language Learning Center	78154

I hereby authorize Verbose LLC Administration (Name of individual/staff member) and/or employees and volunteers (Name of individual/staff member) who is (are) representative(s) of the above named facility to give consent for any and all necessary emergency medical care for my child or youth _____ _____ (First and Last Name of Child or Youth) while said child or youth is in said facility's custody between the dates of June 1st 2019 (MM/DD/YYYY) and Dissenrollment (MM/DD/YYYY).

Signature of Parent or Guardian	**Date Signed**

Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	**Date Signed**

Notarization of Parent's or Guardian's signature if required by local hospital or clinic. **(Only required if not witnessed)**

State of Kansas
County of _____

Signed or attested before me on _____ (MM/DD/YYYY) by _____ (Name of Person).

(Seal, if any.)

_____
Signature of notarial officer

_____
Title (and Rank)

My appointment expires: _____

List any known allergies or other information about the medical status of this child or youth pertinent in case of emergency:

_____

_____

Is child covered by health insurance? ☐ Yes ☐ No

If yes, complete the following:

Health Insurance Policy Name _____ Policy Number _____

Medical Assistance Program _____ Card Number _____

Military Medical Care I.D. Number _____

If known, date of last Tetanus inoculation: _____

THE MEDICAL RECORD/ASSESSMENT FORM (OR HEALTH STATUS HISTORY FORM FOR SCHOOL AGE PROGRAMS) AND THE AUTHORIZATION FOR EMERGENCY MEDICAL CARE MUST BE TAKEN TO THE EMERGENCY ROOM. BOTH FORMS MUST ALSO BE IN A VEHICLE WHEN THE CHILD OR YOUTH IS TRANSPORTED BY THE FACILITY.

CCL. 358
Rev. 3/2017

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: (785) 296-1270 Fax (785) 559-4244
Website: www.kdheks.gov/kidsnet

HEALTH HISTORY FOR CHILDREN AND YOUTH ATTENDING SCHOOL AGE PROGRAMS

As required by K.A.R. 28-4-590(d) (1), each operator shall obtain a health history for each child or youth, on a form supplied by the department or approved by the secretary. Each health history is to be maintained in the child's or youth's file on the premises. As required by K.A.R. 28-4-590(d)(2), each operator shall require that each child or youth attending the program has current immunizations as specified in K.A.R. 28-1-20 or has an exemption for religious or medical reasons.

Complete one form for each child or youth attending the School Age Program.

First and Last Name of the Child or Youth	Gender (M or F)	Date of Birth (MM/DD/YYYY)	First day at this program: (MM/DD/YYYY)

First and Last Name of the Child's or Youth's Mother or Guardian

Mother/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Mother/Guardian's Work Place Name & Street Address REQ	City	Zip Code	Work Phone # ( )

First and Last Name of the Child's or Youth's Father or Guardian

Father/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Father/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )

Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.)

Person(s) authorized to pick up the Child or Youth in case of emergency. Include first and last name and Street Address. Attach additional page if needed.	City	Zip Code	Phone Number (during program hours):
1.			
2.			
3.			

First and Last Name of Physician & Street Address	City	Zip Code	Phone Number ( )

Name of Hospital Preference in case of emergency.
St. Theresa is nearest to facility Circle Yes or write another:

Yes	No	N/A	Complete the following information about medications for this child or youth.
			Will this child or youth need to take any nonprescription or prescription medication during their time at the program?
			If yes above, is there signed permission on file?

Circle any of the following conditions or difficulties that affect this child or youth.			
Allergies	**Frequent sore throats/ colds**	**Ear Infections or Aches**	**Heart or Lung Conditions**
Skin Problems	**Asthma**	**Headaches**	**Diabetes**
Vision	**Speech/Communication**	**Hearing**	**Emotion/Behavior**
Other: Please describe.			

If you circled any of the above conditions, please provide additional information that will help the staff members meet the child's or youth's needs while attending the program. (Attach additional page, if needed.)

Provide additional information about your child or youth that might affect him/her while at the School Age Program including any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.

Complete the following information about this child's or youth's immunization status.

Yes	No	If no, shot record required!!!
		Did this child or youth attend a public or accredited non-public school in Kansas, Missouri or Oklahoma the previous year?
		If yes, are this child's or youth's immunizations current?
X	X	**If yes to both of these questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you must complete the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history.**

Please give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.

		1	2	3	4	5
Single Dose Only	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /			
	RUBEOLA (MEASLES)	/ /	/ /			
	MUMPS	/ /	/ /			
	RUBELLA (GERMAN MEASLES)	/ /	/ /			
	HIB (Hemophilus Influ. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

N/A allowed but no blanks!

Print the First and Last Name of the Person Completing this Health History form	Relationship to the Child/Youth	Date Completed

If the Health History form was completed by a person other than a Parent/Guardian, who provided you with this information?	What is that person's relationship to the child/youth?

I attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct.

Signature of person completing this form	Date Signed

CCL. 034
Rev. 3/2017

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 Fax: 785-559-4244
Website: www.kdheks.gov/kidsnet

PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

Name of the Facility (exactly as stated on the license)			License #
Verbose Language Learning Center			78154
Street Address of the Facility	**City**	**Zip Code**	**County**
7348 W 21st Suite #108	Wichita	KS	67205

_____may go to the following locations off the premises **with** adult supervision:
First and Last Name of Child or Youth

Place	Street Address	City	By Vehicle	Walk/Bike
Sedgwick County Park	6501 W 21st St	Wichita, KS	Car	Walking
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Fox Ridge Pool	9802 W Westlakes Ct	Wichita, KS	Car	
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Sedgwick County Zoo	5555 W Zoo Blvd	Wichita KS 67212	Car	Walk
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
West Warren Theatre	9150 W 21st	Wichita KS 67205	Car	Walking
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
NW YMCA	13838 W 21st N	Wichita KS 67235	Car	
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
All Star Sports	8333 W 21st N	Wichita KS 67205	Car	Walking
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

- -

FOR SCHOOL AGE CHILDREN OR YOUTH ONLY

I hereby authorize my **school age child** ____

First and Last Name of Child or Youth **Birth Date MM/DD/YYYY**

To walk/bike to and from the following location(s) **without** adult supervision:

Place	Street Address	City	By Vehicle	Walk/Bike
Verbose Language Center	7348 W 21st N Suite #108	Wichtia KS 67205	Car	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Water Play & Swimming Permission Slip

Child's Name

I, the undersigned, have legal custody of the child named above, a minor, and have given mu consent forhim/her to participate in the swimming and water play organized by the Verbose Language Learning Center and supervised by a Staff Member who has determined the suitability of the site and activity at the time of use.

Off-Site Swimming ☐

By signing this form, I acknowledge that there are inherent risks involved in swimming and I hereby release the Verbose Language Learning Center, its Staff, Employees, Administrators, Agents, Ownership and Volunteers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my child's involvement.

In the event that my child is injured or hurt and requires medical attnetion, I consent to any reasonable medical treatment as deemed necessary by a licensed [hysician or medical professional. In the event treatment is required from a physician and/or hospital personnel designated by the Center, I agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent.

I acknowledge that I will be ultimately responsible for the cost of any medical care should the cost of that medicl care not be reimbursed by my health insurance provider. I also agree to pick my Child up from the Center and transport him/her home at my own expense if he/she becomes ill or if deemed necessary by school staff.

Parent/Guardian Signature: Date:

January 1st, 2020

Dear Parents,

At the Verbose Language Learning Centerwe pride ourselves in providing a safe, clean, fun and educational environment for children to gain global perspective while growing and learning. Keeping your child healthy by providing a nutritional snacks daily is a top priority at the Verbose LLC. In order to provide the best possible nutrition Verbose LLC is participating in a USDA program called Child and Adult Food Care Program (CACFP) which allows us to recieve federal support for meals and snacks.

We are asking all parents to support our effort to provide quality nutritionat Verbose LLC by completing an income eligibility form. The amount of federal funds we recieve is based on information you provide. All children ino ur care benefit from the reimbursements we recieve for providing healthy snacks daily.

Completing this form should only take a couple minutes of your time. Please be assured that yoru informationis always kept confidential and is only used for (CACFP) food program eligibility.

VerboseKanguage Learning Center is proud to administer this program and we appreciate your support! Please feel free to ask you Director any questions pertaining to food program participation.

Respectfully,
Andrie Krahl, Executive Director

In accordance with Federal Civil Rights Law and U.S. Department of Agriculture (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, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any progam or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g Braile, large print, audion tape, 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 Fedeal Relay Service at (800) 877-8339. Additionally, program information may be made available inlanguages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form (AD-3027) found online at: 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 oft he information requested in the form. To request a copy of the complaint form call (866) 632-9992. Submit your completed form letter to USDA by: Mail to: 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.

CACFP Enrollment and Income Eligibility Form (E/IEF) Instructions

This organization offers healthy meals and snacks to children as part of the Child and Adult Care Food Program (CACFP). We receive support from CACFP to serve those meals. The CACFP makes healthy food a regular part of your child's day care!

Please fill out the *CACFP Enrollment and Income Eligibility Form (E/IEF)*. This lets us know how much money CACFP will give to support your day care home or center. CACFP gives more support if your household income is less than or equal to the limits on this chart:

Federal Income Standards for Reduced-Price Meals for July 1, 2019 - June 30, 2020		
Household size	Yearly Income	Monthly Income
1	$23,107	$1,926
2	$31,284	$2,607
3	$39,461	$3,289
4	$47,638	$3,970
5	$55,815	$4,652
6	$63,992	$5,333
7	$72,169	$6,015

As you fill out the *CACFP Enrollment and Income Eligibility Form (E/IEF)*, please be sure to read the instructions carefully. Fill in all the information we request. We can only accept complete forms.

Points to Remember:

If:	Then:
Your income isn't always the same	List the amount of money that you normally get. For example, do not include overtime pay, if you do not normally get it. If your income is normally higher or lower, you can report annual income instead.
Your household includes members who aren't citizens	You or your children do not have to be U.S. citizens to qualify for meal benefits.
You are in the military	Do not include your Family Subsistence Supplemental Allowance (FSSA), combat pay, or the money you receive for privatized housing. If deployed, count the amount of pay that is made available to your household as income.

Thank you for taking the time to fill out the form. We hope your child enjoys CACFP meals!

This institution is an equal opportunity provider.

Child and Adult Care Food Program
ENROLLMENT/INCOME ELIGIBILITY FORM

PART 1 – CHILDREN'S INFORMATION—Required for all children in care.

Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

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

☐ A family member in our household receives benefits from Food Assistance (FA), Temporary Assistance for Families (TAF), or Food Distribution Program on Indian Reservations (FDPIR). (Please complete Part 2 and 5.)

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

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

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

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

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

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

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

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

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED

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

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

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

Signature of Adult	**Today's Date**	**Print Name of Adult Signing**
X______________________________	________________	**Social Security Number (SSN) (last four digits)** XXX-XX- ☐ Check if no SSN

Address	**City/State/Zip Code**	**Daytime Phone**

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

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

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

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

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

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

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

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

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

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

This institution is an equal opportunity provider.

DO NOT FILL OUT - CENTER USE ONLY

☐ Child(ren) are categorically free based on FA/TAF/FDPIR.

☐ Homeless, migrant, runaway or head start documentation from school, emergency shelter or agency.

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

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

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

Household Size: _____

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

X_____ _____
Signature of Determining Official **Today's Date**

X_____ _____
Signature of Confirming Official **Today's Date**

NOT VALID WITHOUT SIGNATURE AND DATE.
E/IEF Effective Date: If the institution is using the parent/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the parent signed the form or the immediately following month. If the institution representative does not evaluate and sign the E/IEF within these guidelines, the institution representative's signature date must be used as the effective date.