FOR OFFICE USE: Assigned Classroom _____ FT/ MWF/ TR

Enrollment Start Date: _____

MARY'S LITTLE LAMBS PRESCHOOL
STUDENT ENROLLMENT APPLICATION (Please print legibly)

Child's Full Name _____ Gender: Male Female

Date of Birth _____ Age by months: _____

Home/Cell Phone # (Best contact number) _____

My child is **allergic** to _____

My child takes medication for _____ Name of medication _____

Special Needs _____

Parent/Guardian Information:

Mother's Name _____

Address: _____ Cell # _____

_____ Phone Carrier (e.g. AT&T)_____

Email:_____ Employer _____

Work Schedule/Hours: _____ Work # _____

Father's Name _____

Address: _____ Cell # _____

_____ Phone Carrier (e.g. AT&T)_____

Email:_____ Employer _____

Work Schedule/Hours: _____ Work # _____

Marital Status? _____

Custody Information_____

Names of those who are <u>authorized</u> to pick up your child:

1. Name _____ Home/Cell # _____ Work # _____
   Relation to child _____
2. Name _____ Home/Cell # _____ Work # _____
   Relation to child _____
3. Name _____ Home/Cell # _____ Work # _____
   Relation to child _____

*** We will ask to see a photo ID for any individual we do not recognize. A person must be at least 18 years of age to be allowed to pick up your child.**

Non-Authorized Pick-up (Court Documents Required) _____

MLLP program cannot withhold a child from his/her parent without a court order. If you have custody and do not wish for your child's other parent to be allowed to pick him/her up, we must have a copy of the court order stating no contact.

EMERGENCY CONTACT INFORMATION

Name: _____ Home # _____

Relationship: _____ Work # _____

Address: _____ Cell/Pg. _____

Name: _____ Home # _____

Relationship: _____ Work # _____

Address: _____ Cell/Pg. _____

Name: _____ Home # _____

Relationship: _____ Work # _____

Address: _____ Cell/Pg. _____

No one other than the above listed names may remove a child unless I receive an emergency phone call, or I am presented with an authorization signed by the Parent/Guardian.

Parent/ Guardian Signature _____ **Date** _____

Medical Information:

Immunizations: **Please provide an updated copy of your Child's Immunization Record** or if your child was immunized in the State of Arkansas, we request your permission to access a copy of your child's immunization record through the Arkansas shot records database for licensed preschools.

Parent/ Guardian Signature_____**Date**_____

Family Doctor _____ Phone # _____

Location and Address: _____

_____

Family Dentist _____ Phone # _____

Address: _____

Insurance Company _____ Policy # _____

Authorization and permission given for: **(Please Initial)**

A. Emergency aid medical and/or dental care and transportation Of your child for emergency treatment..... _____

B. Administer first aid or CPR in event of emergency..... _____

C. Parent responsible for medical costs for injuries occurred on Mary's Little Lambs Preschool premises..... _____

D. Your child to participate in water activities..... _____

E. Apply sunscreen as needed for outdoor activities..... _____

CONSENT FOR EMERGENCY MEDICAL CARE WHEN PARENTS CANNOT BE REACHED

I/We, _____, parent/guardian, of _____, do hereby request and give consent to the Director/Caregiver of Mary's Little Lambs Preschool, or his/her duly representative, for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parents cannot be reached. Consent is also given for the Director/Caregiver or his/her duly appointed representative to transport said child for emergency medical treatment, if the parents cannot be reached. Parents will be responsible for all medical costs.

Parent/ Guardian Signature _____ **Date** _____

RELEASE OF PUBLICATION

Video or still pictures are at times part of our program and only for our program which includes our web pages, social media pages, magazines or tv, and/or classroom project activities. Your permission for pictures is requested.

I/We give permission for Mary's Little Lambs Preschool to photograph me and/or my child and use for publicizing activities.

Parent/ Guardian Signature _____ **Date** _____

NOTE: Pictures are used for your child's portfolios or Procare app communication. If this is the only consent for classroom activity use only, please make a notation in the provided space.

I acknowledge that I have received Mary's Little Lambs Preschool Parent Handbook as well as a copy of the Kindergarten Readiness Indicators Checklist prepared by the Arkansas State Department. I have read and accept all policies and procedures and the enrollment conditions of Mary's Little Lambs Preschool. I understand that I may ask for a conference with caregiver(s) as needed.

Parent/Guardian Signature _____ **Date** _____

PRIVATE PAYER FEE AGREEMENT (NON-VOUCHER)

(please initial)

_____A $100.00 non-refundable registration fee must be paid at the time your child is enrolled and reenrolled into the program. Additional fee may apply for siblings.

_____I understand that payment is due on Friday *before* the week of service. There will be a $10.00 late fee charge for payments made thereafter. Additional $10.00 late fee will be assessed after each week for open balances. There is a $15.00 fee for any returned checks or insufficient funds.

_____There are no refunds or credits for absences, illness, or holidays. Tuition must be paid in full.

_____I understand that there is a supply fee of $125.00 to be paid in the first Monday of March and first Monday in September. $100.00 for each additional child. Pro-rated supply fee is $25.00 per month.

_____I understand that there will be a $5.00 charge per every 5-minute increments for early drop-off before 7:00a.m. or for late pick-up after 6:00 p.m. as according to the facility clock.

_____I understand my child's tuition rate and agree to pay in full for each week of service, including weeks that the center may be closed for holidays (see Parent Handbook for specific closing dates).

_____I understand I may be charged for no full two weeks' notice of withdrawal from the center.

In the event that I default on the above agreement and do not make a payment within two weeks, my child's enrollment may be terminated, and I will be responsible for the costs of collection.

Parent/ Guardian Signature _____ **Date** _____

VOUCHER PARTICIPANT FEE AGREEMENT (If applicable)

(please initial)

_____A $100.00 non-refundable registration fee must be paid at the time your child is enrolled or reenrolled into the program. Additional fee may apply for siblings.

_____I understand that payment is due on Friday before the week of service. There will be a $10.00 late fee charge for payments made thereafter. Additional $10.00 late fee will be assessed after each week for open balances. There is a $15.00 fee for any returned checks or insufficient funds.

_____There are no refunds or credits for absences, illness, or holidays. Tuition must be paid in full.

_____ I understand that there is a supply fee of $50.00 to be paid on the first Monday of March and first Monday in September. $40.00 for each additional child. This fee does not apply to Foster care or TEA programs.

_____I understand that there will be a $5.00 charge per every 5-minute increments for early drop-off before 7:00a.m. or for late pick-up after 6:00 p.m. as according to the facility clock.

_____I understand & agree to pay tuition or co-pay for each week of service, including weeks that the center may be closed for holidays (see Parent Handbook for specific closing dates).

_____I understand that I may be financially responsible for days that exceed the allotted number of absent days or holidays per voucher agreement. DHS requires all families to sign child in/out daily. Failure to do so may be deemed an absent day.

_____I understand I will default to Private Payer tuition & fees should vouchers become cancelled or void.

In the event that I default on the above agreement and do not make a payment within two weeks, my child's enrollment may be terminated and I will be responsible for the costs of collection.

Parent/ Guardian Signature _____ **Date** _____

SHAKEN BABY SYNDROME

I have read information on Shaken Baby Syndrome in the Mary's Little Lambs Parent Handbook.

Parent/ Guardian Signature _____ **Date** _____

MARY'S LITTLE LAMBS PRESCHOOL
DISCIPLINE POLICY

Discipline will be appropriate to the developmental level of the child. Positive guidance and redirection will be enforced. Children will be given choices when resolving a situation and will also be asked for their own input on how to make the situation better. This will help them to learn to make positive, responsible choices and to get along with other children. Children will always be praised when they are doing something positive.
If it becomes necessary, time-out or time-away will be administered for one minute per age of child (only applies to children 2 years and up). Discipline will never be physical or associated with food or toileting.

I have read and understand the discipline policy of the childcare facility. I give my permission for the use of all methods set out in the handbook.

Parent/ Guardian Signature _____ **Date** _____

HIPAA Release For Allergy and Medical Postings

I authorize Mary's Little Lambs Preschool to post my child's allergy/medical alert/diet restrictions in their assigned classroom, in the kitchen and other areas as needed. I understand that this information will be posted to ensure all staff members are aware of my child's allergy/medical needs.

Parent/Guardian Signature _____ **Date** _____

CONSENT FOR CHILD DEVELOPMENT SCREENING

Our center offers free developmental screening by our trained staff members using the assessment tool Ages and Stages, an approved provider of Continuing Education. This is an opportunity for parents to be informed of your child's developmental skills in early childhood education. All results will remain confidential and released only upon parental request and Parent/Teacher Conferences.

Parent/Guardian Signature _____ **Date** _____

Mary's Little Lambs Preschool is required by Arkansas State licensing to inform parents that your child(ren) is subject to interviews by licensing staff, child maltreatment investigators and/or law enforcement officials for the purpose of determining licensing compliance or for investigative purposes. **(Child interviews do not require parental notice or consent.)** We will make an effort so that a member of management can be present with your child shall this situation occur.

I/We have read and understand the above statement and will comply with the requirements necessary with Mary's Little Lambs Preschool.

Parent/Guardian Signature _____ **Date** _____

CHILD'S PERSONAL INFORMATION

Child's Name _____ **Age** _____

Birthday _____

Does your child have a special toy, blanket, song, etc…?

_____

_____

Child's favorite foods, games, videos: _____

_____

_____

Is your child toilet trained? _____

Physical or emotional problems your child might have: _____

_____

_____

Are there any cultural or child-rearing practices for us to be aware of?

_____

Special problems: Medications_____

Allergies___ Temper Tantrums___ Diabetes ___ Frequent colds___ Biting___

Sun Sensitivity___ Seizures___ Fainting Spells___ Bed wetting___ Other___

Any siblings? If so, what are their names and ages? _____

_____

Other useful information: _____

_____

_____

_____

_____

<THIS SPACE INTENTIONALLY BLANK>

Tuition Express

AUTHORIZATION AGREEMENT
AUTOMATIC PAYMENTS (ACH BANK DEBITS)

I, _____, hereby authorize **MARY'S LITTLE LAMBS PRESCHOOL**, hereinafter called COMPANY, to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my (our) account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION to credit and/or debit the same to such account. ***There is a $15.00 fee for all returned debits/checks.***

_____ _____
(Financial Institution Name) (Branch)

_____ _____
(Financial Institution Address) (City/State/Zip)

Please print legibly:

_____ _____
(Routing Number) **(Account Number)**

Type of Account: _____Checking _____Savings

This authority is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and manner as to afford COMPANY and FINANCIAL INSTITUITION a reasonable opportunity to act on it.

_____ _____
(Signature) **(Date)**

_____ _____
(PRINT Account Holder Name) **Print your child's name here**

HOW WOULD YOU PREFER YOUR ACCOUNT TO BE DEBITED?

_____WEEKLY _____BI-WEEKLY

****PLEASE ATTACH COPY OF VOIDED CHECK TO THIS FORM****

Tuition Express

AUTHORIZATION AGREEMENT
AUTOMATIC PAYMENTS BY CREDIT/DEBIT CARD

I, _____, hereby authorize **MARY'S LITTLE LAMBS PRESCHOOL**, herein after called COMPANY, to initiate charged/debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my (our) account indicated below. ***There is a $15.00 charge for all chargebacks/retrieval fee.***

Please check one and print legibly:

VISA _____ MasterCard_____ Discover_____ Amex_____

_____ _____ _____ _____

Credit Card Number **Expiration Date** **CSC (3 digit on back)** **Billing Zip code**

****NOTE: There is an added surcharge fee rate of 0.95% up to 3.50% per every swipe depending on your credit card company.**

This authority is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and manner as to afford COMPANY and FINANCIAL INSTITUITION a reasonable opportunity to act on it.

_____ _____

(Signature) **(Date)**

_____ _____

(PRINT Card Holder Name) **Print your *child's* name here**

Email receipt to: _____

HOW WOULD YOU PREFER YOUR ACCOUNT TO BE CHARGED?

_____WEEKLY _____BI-WEEKLY

OFFICE USE ONLY
Date Screener Received_____
Date Office Received_____

Regional Therapy Services, Inc.

www.regionaltherapy.net

FREE DEVELOPMENTAL SCREENING

Mary's Little Lambs Preschool

Birth to 6 years

We provide free developmental screenings as a community service for children throughout Northwest Arkansas at their childcare center. This is a great opportunity for parents to be informed of your child's skills necessary for normal development. These skills are vital to your child's educational experiences. We strive to ensure that children meet their full potential. You will receive information regarding your child's screening once it is completed- usually within 3-4 weeks. Feel free to contact us if you have further questions or concerns regarding your child's development. We are glad to serve children and families of Northwest Arkansas.

- Deedra Branscum, Lead Therapist, Call or text (479) 790-7979
- Meghan Delaney, BS, Certified Child Dev. Specialist, Call or text (417) 343-2997

Child's Name _____ Date of Birth_____

Parents Name _____ Phone #_____

Insurance Type: Medicaid/AR Kids ____yes ____no Other Insurance Type_____

NOTE: We do not bill for the free screening service. This information is used to determine type of testing and qualifying criteria for the screening as different insurances have different requirements.

Child's main language: English _____ Other (please list) _____

Concerns:

_____ _____

Legal Guardian/Parent Signature Date

Special Nutrition Programs
Child and Adult Care Food Program
Letter to Parents

Dear Parent/Guardian:

The Mary's Little Lambs Preschool participates in the Child and Adult Care Food Program (CACFP) administered by the United States Department of Agriculture (USDA). Please help us comply with the requirements of the CACFP by completing, signing, and returning the attached statement as soon as possible. This information is necessary so that we may receive CACFP reimbursement for the meals served to children in our program. This form will be placed in our files and treated as confidential information. All children in our program receive their meals free of charge, but the determination of eligibility category affects the amount of Federal funding received by us.

A foster child who is the legal responsibility of a welfare agency or court may be certified as eligible for free meals regardless of your household income Please contact us for additional information if you have a foster child enrolled in our program.

If you receive food stamps, then you need to only list your food stamp case number. In addition, you must complete Section 5 of the form including all required information with signature, Social Security Number of an adult household member, and date form was completed.

If a food stamp case number is not reported, you must complete Section 4 and Section 5 of the eligibility statement. Section 4 should include the names of all household members and the total current household income by source. Section 5 must include all required information with signature, Social Security Number of an adult household member, and date form was completed.

USDA defines a household as a group of related or unrelated individuals (not residents of an institution or boarding house) who are living as one economic unit (i.e., sharing living expenses). The income you report must be last month's total gross household income listed by source, for each household member. If last month's income does not accurately reflect your circumstances, you may provide a projection of your annual income, and you may use lasts year's income as a basis for making this projection if no significant changes have occurred. If your household's income is equal to or less than the amounts indicated for your household's size on the chart below, the center will receive a higher level of reimbursement.

You are required to notify us if there is a change in household size or an increase in income that exceeds $50 per month or $600 per year. If you list a food stamp case number, you must notify us when you no longer receive food stamps. Similarly, you should notify us if you become unemployed and the loss of income during the period of unemployment causes your family to be within the eligibility standards.

All meals served to children under the Child and Adult Care Food Program are served free regardless of race, color, sex, age, disability, or national origin.

There is to be no discrimination in admissions policy, meal service, or the use of facilities. Any complaints of discrimination should be submitted in writing to USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

USDA CHILD NUTRITION PROGRAM
INCOME GUIDELINES

July 1, 2022 - June 30, 2023

Household Size	Annual	Monthly	Weekly
1	17,667	1,473	340
2	23,803	1,984	458
3	29,939	2,495	576
4	36,075	3,007	694
5	42,211	3,518	812
6	48,347	4,029	930
7	54,483	4,541	1,048
8	60,619	5,052	1,166
Each additional Household member add	+6,136	+512	+118

Thank you for your cooperation.

Institution Representative
(NPC-4 Rev. 07/18)

CHILD CARE FOOD PROGRAM
ENROLLEMENT FORM

Provider's Initials: ________
Date: ________

To be completed by Parent or Guardian

You have chosen a daycare that participates on the USDA Child and Adult Care Food Program (CACFP). It is our goal to assist in providing your child with nutritious meals/snacks. This enrollment information must be verified. The mealtime patterns and the daily menus should always be posted and available for parents. If you have questions, comments, or would like to learn more about the Child and Adult Care Food Program, contact our office at (505) 682-8869.

Name of Day Care Facility: Mary's Little Lambs Preschool
Telephone #: 479-273-1011

Address: 506 SE Moberly Lane
City: Bentonville
State: AR
Zip Code: 72712

The following information is required by USDA Federal Regulation CFR 226.15(e)(2).

I wish to enroll my child(ren), whose names and enrollment information are specified below, in the USDA Child and Adult Care Food Program. I understand this program reimburses day care facilities for serving nutritious and well-balanced meals/snacks to day care children.

My Child(ren) will be served the following meals:

Breakfast: ☐ AM Snack: ☐ Lunch: ☐ PM Snack: ☐ Supper: ☐ Late Snack: ☐

Please Print Child(ren)'s Information

First Name	Last Name	Age	Birthdate	Hours of Care	Days of Week	Gender
				From: To:	Sat. ☐ Tue. ☐ Fri. ☐ Sun. ☐ Wed. ☐ Mon. ☐ Thur. ☐	
				From: To:	Sat. ☐ Tue. ☐ Fri. ☐ Sun. ☐ Wed. ☐ Mon. ☐ Thur. ☐	
				From: To:	Sat. ☐ Tue. ☐ Fri. ☐ Sun. ☐ Wed. ☐ Mon. ☐ Thur. ☐	
				From: To:	Sat. ☐ Tue. ☐ Fri. ☐ Sun. ☐ Wed. ☐ Mon. ☐ Thur. ☐	

Please identify any fool allergies or special needs your child(ren) require:

Doctor's Name: ________________ Doctor's Telephone: ________________

Racial and Ethnic data is optional and is collected in accordance with FNS Instruction 113-1 Section XII (a)(2). This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of your application and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this program as administered in a nondiscriminatory manner.

***OPTIONAL* Participant's ethnic and racial identities**			**Please select all that apply**					
Name of Enrolled Child(ren)	Age	Foster Child?	Hispanic or Latino	American Indian or Alaskan Native	Asian	Black or African American	Hawaiian Native or Other Pacific Islander	White
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐

I understand my child(ren) will receive meals at no extra charge to me when they are in care during any scheduled meal service and receive meals. I understand that the day care facility cannot and will not discriminate for reasons of race, color, national origin, sex (including gender identity or sexual orientation), or disability. There is to be no discrimination in admission policy, meal service, or use of facility. Any complaints should be addressed to: USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

EMERGENCY CONTACT INFORMATION:

Home Telephone #: _____ Work Telephone #: _____

_____

Parent's Address City State Zip Code

Parent's Signature: _____ Date: _____

*Form expires one (1) year from this date

Revised 07/2022

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Facility Name _____

PART 1. NAME OF ENROLLED CHILDREN ***OPTIONAL – Participant's ethnic and racial data**

Racial and Ethnic data is optional and is collected in accordance with FNS Instruction 113-1 Section XII (a)(2). This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of your application and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this program is administered in a nondiscriminatory manner.

NAME OF ENROLLED CHILDREN	AGE	DATE OF BIRTH	FOSTER CHILD?	HISPANIC OR LATINO Yes / No	American Indian or Alaskan Native	Asian	Black or African American	Hawaiian Native or Other Pacific Islander	White
				☐ ☐					
				☐ ☐					
				☐ ☐					
				☐ ☐					

ADDITIONAL HOUSEHOLD CHILDREN _____ **TOTAL NUMBER OF CHILDREN AND ADULTS IN HOUSEHOLD:** _____

PART 2. Benefits: If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], 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**	
1. _____	_____	**NOTE: A Case number is not the number found on the EBT card or an individual's Social Security number.**
2. _____	_____	
3. _____	_____	

PART 3. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call Your School, Homeless Liaison, or Migrant Coordinator ☐ Homeless ☐ Migrant ☐ Runaway

PART 4. TOTAL HOUSEHOLD GROSS INCOME: Please identify your income.

*** Weekly / Every 2 Weeks / Twice a Month / Monthly / Annual ***

Names of all Household Members, except children listed above	Earnings from work before deductions	Welfare, Child Support, Alimony	Pensions, SSI, VA Benefits, Social Security, Retirement	All other income	Check here if No Income
	$_____	$_____	$_____	$_____	
	$_____	$_____	$_____	$_____	
	$_____	$_____	$_____	$_____	
	$_____	$_____	$_____	$_____	

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Facility Name _____

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

An adult household member must sign this form. **If Part 3 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 Statement on the back of this 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: _____ (form valid for one (1) year from this date)

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _*_*_*-_*_*-____ (required) ☐ **I do not have a Social Security Number**

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_____ ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year Household Size: _____

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

Reason: _____

Temporary: Free_____ Reduced_____ Time Period: _____(expires after _____ days)

Determining Official's Signature: _____ Date: _____

If applicable, Sponsor Signature:_____ Date:_____

Refer to the current USDA Income Eligibility Guidelines for making determinations of 'Free', 'Reduced', or 'Paid".

HNP Representative Initials/Date (for use during CACFP Reviews)

_____

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: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity or sexual orientation), age, or disability. To file a complaint of discrimination, write USDA, Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired 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."