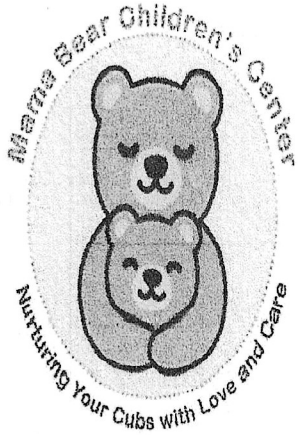
Mama Bear Children's Center
10700 E Iliff Ave, Aurora CO, 80014

mamabearchildrencenter@gmail.com

Cell: (720) 775-1825
Work: (303) 954-0926
Fax: (303) 954-0483



ADMISSION PROCEDURES

Child's Name: _____ Enrollment Date: _____

Nickname: _____ Date of Birth: _____

Sex: M F Age When Enrolled: _____

Child's Home Address (Street/City/State/ Zip code):

_____

_____

Home Phone: _____

Parent/Guardian 1 Name: _____

Cell Phone _____ Home Phone: _____

Email Address: _____

Home Address (Street/City/State/ Zip code)- if different from child's:

_____

_____

Employer/School

_____

Employer/School Address: (Street/City/State/ Zip code)

_____

Employer/School Phone Number _____

Instructions to reach Parent (1):

_____

Parent/Guardian 2 Name: _____

Cell Phone _____ Home Phone: _____

Email Address: _____

Home Address (Street/City/State/ Zip code)- if different from child's:

_____

_____

Employer/School _____

Employer/School Address: (Street/City/State/ Zip code)

_____

_____

Employer/School Phone Number _____

Instructions to reach Parent (2):

_____

_____

_____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Office Staff Name/ Signature/ Date: _____

Family Members Live with the Child:

_____

_____

Emergency Contact:

(1) Name:_____ Phone Number:_____

Address:_____

(2) Name:_____ Phone Number:_____

Address:_____

(3) Name:_____ Phone Number:_____

Address:_____

Authorized to Pick up Child (Must show photo ID)

(1) Name:_____ Relationship to Child:_____

Phone Number:_____ Address:_____

(2) Name:_____ Relationship to Child:_____

Phone Number:_____ Address:_____

(3) Name:_____ Relationship to Child:_____

Phone Number:_____ Address:_____

Anybody NOT authorized to pick up your child?

_____

_____

_____

EMERGENCY INFORMATION & AUTHORIZATION FOR TREATMENT & TRANSPORTATION

Child's Name:_____ Date of Birth:_____

Chronic Medical Conditions:_____

Does your child have a health care plan?_____

If yes, the health care plan must be provided on or before the first day the child is in care.

Is your child fully immunized? _____

Complete immunization records must be provided on or before the first day the child is in care.

Does your child have any allergies? Please provide detailed information:

_____

_____

Allergies Reactions?_____

Does your child have any Special Needs that need an individual care plan or special accommodations?_____

_____

Is your child on any medications? (Explain):

_____

If yes, please describe:

_____

_____

Insurance Information:

Name:_____ Policy Number: _____

Health History (Chronic or Recurring)

Ear Infections: _____

Diabetes: _____

Heart disease/defect: _____

Convulsions/seizures: _____

Asthma: _____

Nosebleeds: _____

Measles: _____

Mumps: _____

Chicken Pox: _____

Flu or Flu Shot: _____

Other: _____

Allergies (Nature of Reaction)

Hay Fever: _____

Plant Poisoning: _____

Insect Stings: _____

Penicillin: _____

Other drugs: _____

Animals: _____

Food: _____

Operations or serious injuries (dates): _____

Physical Limitations: _____

Describe if yes: _____

Dietary Limitations: _____

Describe if yes: _____

Last Vision Exam: _____

Last Hearing Exam: _____

Are there any activities that you prefer that your child NOT participate in?

If so, please list:

_____

_____

Name, address and phone number of the Health Care Facility (Hospital of Preference):

_____

_____

Name, address and phone number of child's doctor:

_____

_____

Name, address and phone number of child's dentist:

_____

_____

Authorization for emergency medical care and transportation:

In the event of an emergency, I hereby give my permission for Mama Bear Children's Center to access emergency medical services (call a doctor or emergency medical services and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child_____ including transport to the nearest health care facility, to receive emergency medical or surgical care and treatment. It is understood that a conscientious effort will be made to locate me. I/we will accept the expense of any emergency transportation, medical or surgical treatment.

Parent/Guardian Signatures:

_____ Date: _____

_____ Date: _____

Parent/Guardian Name: _____

Office Staff Name/ Signature/ Date:

_____

_____

Immunization
Certificate of Nonmedical Exemption

Colorado law C.R.S. § 25-4-902 requires all students attending any school in the state of Colorado to be vaccinated against certain vaccine-preventable diseases, as established by Colorado Board of Health rule 6 CCR 1009-2, unless an exemption is filed. This law applies to students attending public, private and parochial kindergarten, elementary and secondary schools through 12th grade, colleges or universities, and child care facilities licensed by the Colorado Department of Human Services including child care centers, school-age child care centers, preschools, day camps, resident camps, day treatment centers, family child care homes, foster care homes, and Head Start programs. "Nonmedical exemption" means an immunization exemption based upon a religious belief whose teachings are opposed to immunizations or a personal belief that is opposed to immunizations. Prior to kindergarten, a nonmedical exemption must be filed each time a student is due for vaccines according to the schedule developed by the ACIP.[1,2] From kindergarten through 12th grade, a nonmedical exemption must be filed every year during the student's school enrollment/registration process.[1] Students with a recorded immunization exemption may be kept out of a child care facility or school during a disease outbreak; the length of time will vary depending on the type of the disease and the circumstances of the outbreak.

Please complete all required fields below and obtain all required signatures; incomplete forms will not be accepted.

Student Information:

Last Name:	First Name:	Middle Name:
Date of Birth:	Sex: ☐ Female ☐ Male ☐ X	

Parent/Guardian Completing This Form: ☐ Check if an emancipated student or student over 18 years old

Last Name:	First Name:	Middle Name:
Relationship to student: ☐ Mother ☐ Father ☐ Legal Guardian		

School/Licensed Child Care Facility Information:

School Name/Licensed Child Care Facility:		
School District:		☐ Check if Not Applicable
Address:		
City:	State:	Zip Code:

Required Vaccines for School Entry - Place an "X" next to each vaccine for which you are claiming a nonmedical exemption.

	Diphtheria, tetanus, pertussis (DTaP)		Inactivated poliovirus (IPV)
	Tetanus, diphtheria, pertussis (Tdap)		Measles, mumps, rubella (MMR)
	Haemophilus influenzae type b (Hib)		Pneumococcal conjugate (PCV13)
	Hepatitis B		Varicella (chickenpox)

Statement of Exemption

I am the parent/guardian of the above-named student or am the student themself (emancipated or over 18 years of age) and am claiming a nonmedical exemption from the vaccine(s) indicated above. The information I have provided on this form is complete and accurate. I can review evidence-based vaccine information at _____ for additional information on the benefits and risks of vaccines and the diseases they prevent. I can contact the Colorado Immunization Information System (CIIS) at _____ or my health care provider to locate my child's/my immunization record.[3]

REQUIRED Signature: _____ Date: _____
Parent/Legal Guardian/Student (emancipated or over 18 years old)

REQUIRED Provider Signature Section:

REQUIRED Print Name, Title, and Signature: _____ Date: _____
Physician (MD, DO), Advanced Practice Nurse (APN), Physician Assistant, Registered Nurse (RN) or Pharmacist (authorized pursuant to section 12-240-107 (6), C.R.S.)
REQUIRED Colorado Professional License Number: _____

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[1] Colorado Board of Health rule 6 CCR 1009-2:

[2] 2021 Recommended Immunizations from Birth through 6 Years Old: . Based on this schedule, a nonmedical exemption would be submitted at 2 months, 4 months, 6 months, 12 months and 18 months of age.

[3] Under Colorado law, you have the option to exclude your child's/your information from CIIS at any time. To opt out of CIIS, go to Please be advised you will be responsible for maintaining your child's/your immunization records to ensure school compliance.

General Health Appraisal Form

Parent: *Please complete*

Child's Name: _____ **Birthdate:** _____

Allergies: ❑ None ❑ Describe: _____

Type of Reaction: _____

Diet: ❑ Breast Fed ❑ Formula: _____ ❑ Age Appropriate

❑ Special Diet: _____

❑ **Preventive creams/ointments/sunscreen** may be applied as requested in writing by parent, unless skin is broken or bleeding.

Sleep: Your health care provider recommends all infants less than 1 year of age be placed on their back for sleep.

I, _____ *give consent for my child's health provider, school or camp personnel* to discuss my child's health concerns. My child's health provider may fax this form (and applicable attachments) to my child's childcare provider, school, or camp. FAX Number: _____

Parent or Legal Guardian Signature _____ Date: _____

Authorization expires 365 days after this date

Health Care Provider: *Please complete after parent section has been completed*

Date of Last Exam: _____ **Recent Weight:** _____ ****HCT:** _____ **** B/P:** _____ ****Lead Level:** _____

Physical Exam: ❑ Normal ❑ Abnormal *(see explanation of significant health concerns:)*

Significant Health Concerns: ❑ None ❑ Reactive Airways Disease ❑ Seizures ❑ Diabetes ❑ Developmental Delays ❑ Vision ❑ Hearing ❑ Hospitalizations ❑ Severe Allergies ❑ Other *(dental, nutrition, behavior, etc.)* _____

Explain above concerns (if necessary, include instructions to childcare providers): _____

Current Medications/Special Diet: ❑ None ❑ Describe: _____

(Separate medication authorization form required for medications given in Child Care)

Fever reducer or pain reliever ***(mark only one product: max. 3 consecutive days without additional medical authorization)***

❑ Acetaminophen (Tylenol®) may be given for pain or fever over 102° every 4 hours as needed:
Dose _____ ❑ See attached Dosage Schedule from our office

OR

❑ Ibuprofen (Motrin®, Advil®) may be given for pain or fever over 102° every 6 hours as needed:
Dose _____ ❑ See attached Dosage Schedule from our office

Immunizations: ❑ Up-to-date ❑ See attached immunization record ❑ Administered today: _____

Signature:

Next Well Visit: ❑ Per AAP Guidelines* or ❑ Age: _____

This child is healthy and may participate in all routine activities, sports, camps, and child care. Any concerns or exceptions are identified on this form.

Signature of Health Care Provider (certifying form was reviewed) _____ Date _____

Office Stamp: *Or write Name, Address, Phone Number*

The Colorado Chapter of the American Academy of Pediatrics (AAP), Healthy Child Care Colorado, and Headstart have approved this form 04/04.

* The AAP recommends that children from 0-12 years have health appraisal visits at: 2, 4, 6, 9, 12, 15, 18 and 24 months, and age 3, 4, 5, 6, 8, 10 and 12 years.

** Required by Head Start programs only per state EPSDT schedule

Internet and Television Use Permission

I give permission for my child, _____, to view television shows, movies, and use the internet during child care hours.

Internet use will be for educational purposes and will include assignments for learning as well as supplemental educational games, websites, and videos.

Television and movies will be limited to educational shows that do not include violence, inappropriate language, or inappropriate references or topics. It may also include Cosmic Kids Yoga, Moose Tube music and videos, or other kid-friendly videos or music.

Children will not have more than 1 hour of screen time on a regular basis. Children who are not interested in media activities will have other activities available, such as reading books, doing puzzles, drawing, or playing quietly.

If I have any questions or concerns regarding something my child has viewed, I will discuss it with the program's director.

Signature: _____ Date: _____

Print Parent/Guardian's Name: _____

Cot Permission Form

I give my child, _____ permission to sleep on a cot that is provided by Mama Bear Children's Center during nap/ rest time. I understand that each cot is individually assigned and has clean linens that is only used by my child.

_____ _____

Parent/ Guardian Signature Date

TOPICAL PREPARATIONS (PREVENTATIVE PERMISSION FORM)

This form covers a variety of preventive topical preparations that may be applied to the skin with parent/guardian permission

Child's Name: _____ Parent/Guardian's Name: _____

I understand that I must provide the topical preparation in the original container labeled with my child's name and that no topical preparations will be applied to broken skin or if a skin reaction has been observed. It is my responsibility to check the ingredients to make sure my child is not allergic to it. Any skin reaction observed by staff will be reported promptly to the parent/guardian.

Parent/Guardian Signature: _____ Date: _____

SUNSCREEN

I give my permission for the staff at _____ to assist with applying or apply sunscreen to my child's exposed skin including the face, tops of ears, bare shoulders, arms, legs, and feet 30 minutes before outdoor activities. It is my responsibility to provide sunscreen with a minimum 15 SPF.

In the event that my child does not have sunscreen with them, the school may apply

_____ (name of sunscreen & SPF) to my child.

☐ My child may NOT use any sunscreen other than the one that s/he brings.

Parent/Guardian Signature: _____ Date: _____

MOISTURIZING LOTION/CREAM/BALM

I give my permission for the staff at _____ to assist with applying or apply skin lotion/cream to my child.

Name of product: _____

Special instructions: _____

☐ My child may NOT use any other skin lotion/cream/balm than the one s/he brings.

Parent/Guardian Signature: _____ Date: _____

DIAPER OINTMENT/CREAM

I give my permission for the staff at _____ to apply over the counter diaper rash ointment/cream to my child. I understand that I may only provide diaper ointment or cream, free of antibiotic, antifungal, or anti-inflammatory components without a written prescription from my doctor.

Name of product: _____

Special instructions: _____

☐ My child may NOT use any other skin lotion/cream/balm than the one s/he brings.

Parent/Guardian Signature: _____ Date: _____

Use of Pacifiers for Infants

Dear Parents:

To reduce the risk of a Sudden Unexpected Infant Death Syndrome (SUIDS) and Sudden Infant Death Syndrome (SIDS), the Colorado department of human services requires all schools/ childcare providers to offer the use of pacifier to all infants one month and older for every sleep time. Pacifiers will be offered for all infants one month and older for every sleep time unless the parent has signed a waiver that the infant is not to be given a pacifier. The infant will only be provided a clean, dry pacifier and the pacifier will not be coated in any sweet solution.

_____ I DO grant permission.

_____ I DO NOT grant permission.

Child's Name: _____

Parent/ Guardian Name: _____

Parent/ Guardian Signature: _____

Date: _____

Crib Permission Form/ Infants

I give my child, _____ permission to sleep in a crib that is provided by Mama Bear Children's Center during nap time. I understand that individual crib and bedding are provided and cleaned daily or more often when necessary.
All cribs used by Mama Bear Children's Center are in compliance with the CPSC and ASTM standards, and all crib construction is in good repair and free of hazards.

_____ _____

Parent/ Guardian Signature Date

Safe Sleep Practices

Childs name: _____ Birthdate: _____

Parents name: _____ Classroom: _____

The American Academy of Pediatrics recommends that healthy, full-term infants sleep on their back to reduce the risk of Sudden Infant Death Syndrome (SIDS). This is considered to be primally important during the first six months of age, when a baby's risk of SIDS is greatest. In order to reduce the risk of SIDS, staff follows the Safe Sleep Practices as listed below.

Safe Sleep Practices:

1. Infants are placed on their back to sleep unless the school has been provided a letter from a physician authorizing another sleep position. The authorization must include how the infant should be placed as well as a length of time for which the instructions should be followed.
2. No items or blankets are placed in or on the crib with an infant
3. No objects are attached to a crib with a sleeping infant.
4. Appropriate sleep clothing is provided by the school. Mama Bear Children's Center use sleep sacks that fit according to the commercial manufacturer's guidelines and will not slide up around infant's face.
5. Swaddling is not used unless a written physician's statement is provided including instructions and timeframe for swaddling.
6. Individual crib and bedding are provided and cleaned daily or more often when necessary.
7. Infants who fall asleep elsewhere will be moved to a crib to sleep.
8. No positioning devices or wedges are used.
9. Cribs are in compliance with the CPSC and ASTM standards.
10. Crib construction is in good repair and free of hazards.

I _____, have received a copy of the safe sleep policies and procedures. I understand that I am required to provide a physician notes that specifies instruction and timeframe for alternative care when my child needs care that may be in conflict with the above regulations.

_____ _____

Parent's Signature Date

Photo Permission

I, _____, give permission to Mama Bear Children's Center to post photos of my child on our website and social media. We love capturing precious moments of our kiddos to share.

With my signature below, I grant permission for my child to be photographed or their images used to promote the daycare's services. I understand that it is my responsibility to update this form in the event that I no longer wish to authorize the use above.

Child's Name: _____

Parent/Guardian Signature: _____

Date: _____

Mama Bear Children's Center

10700 E Iliff Ave. Aurora, CO 80014

720-775-1825 mamabearchildrencenter@gmail.com

Parent – Family Consent

This consent is between Mama Bear Children's Center and the Parent and/or Family of _____ child(ren)'s name(s).

I hereby give my permission to Mama Bear Children's Center to share both my family and enrolled child(ren)'s information at Mama Bear Children's Center for the benefit of education, health, nutrition, and all processes which require a consent to share such information for aggregate data reporting. This data will be used by Ealy Learning Ventures/Early Head Start program to ensure important milestones are being met.

_____
Parent Name (printed)

_____
Parent Address

_____
Phone Number:

_____
Email Address

_____ _____
Parent Signature Date signed

I, the signee, hereby agree to the following term(s).

For the care providing entity, (Mama Bear Children's Center), to effortfully, and willingly provide services, I, (the signee), is obliged to comply to the financial requirement as described by the care providing entity, (Mama Bear Children's Center), through its management or its agent(s).

The terms comprise the required conditions, relevant to the signee: **Registration Fees, Tuition Fees, and parent Fees.** The terms stated, are located and provided in the Parents Handbook, found in the ELV. (Early Learning Ventures).

This contractual agreement binds the two parties involved: (the signee), and the child care service provider, (Mama Bear Children's Center).

_____

(Signature of Parent/Guardian)

_____

(Printed Name)

_____

Date:

_____

(Signature)

Child Care Service Provider
Mama Bear Children's Center

_____

Date:

Sincerely,
Mama Bear Children's Center

Daycare Policies and Procedures Acknowledgment Form

Child's Name: _____

Parent/Guardian Name: _____

Date: _____

Dear Parent/Guardian,

We are committed to providing a safe, nurturing, and educational environment for your child. To ensure a harmonious and effective operation of our daycare, it is important that all parents/guardians understand and agree to our policies and procedures.

Please read the following acknowledgment carefully, sign, and return this form to us.

1. **~~Policies and Procedures Receipt~~**
   I acknowledge that I have received a copy of the daycare's policies and procedures manual. I understand that it is my responsibility to read and familiarize myself with the information contained therein.
2. **Compliance Agreement**
   I agree to abide by all the policies and procedures outlined in the manual. I understand that these policies are in place to ensure the safety, well-being, and development of all children in the daycare.
3. **~~Communication~~**
   I understand that it is important to communicate openly and promptly with daycare staff regarding any concerns, changes in my child's health or routine, or other relevant matters.
4. **Updates and Changes**
   I acknowledge that the daycare may update or revise its policies and procedures from time to time. I agree to review any updates provided and adhere to the revised policies.
5. **Consent and Authorization**
   I ~~consent to the daycare's procedures for handling emergencies, administering medication~~ (with proper authorization), and managing behavioral issues as outlined in the manual.

By signing below, I confirm that I have read, understand, and agree to comply with the daycare's policies and procedures.

Parent/Guardian Signature: _____ **Date:** _____

Daycare Representative Signature: _____ **Date:** _____

Thank you for your cooperation and partnership.

Sincerely,

Ella Khalil

Mama Bear Children's Center

10700 E. Iliff Ave

Aurora, CO 80014

COLORADO
Department of Public Health & Environment

2024-2025 Income Eligibility Form (IEF) for Child Care

STEP 1: List ALL children in day care

Children in Foster care or Head Start and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals. Review the Dear Parent Letter for more details. If there are more than three children, please complete an additional form.

Child's First and Last Name	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received	Check all that apply: Foster Child	Migrant	Runaway	Homeless	Head Start
		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					

STEP 2: Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

IF YES → Write the case number here & proceed to STEP 4 (Do not complete STEP 3) **CASE NUMBER:** _____ (Write only one case number in this space.)
IF NO → Go to STEP 3

STEP 3: Report Income for ALL Household Members (Skip this step if you answered Yes to Step 2)

Flip the page for information on sources of income for child income and Household Members.

A. Child Income

Sometimes children in the household earn or receive income.
Please include the TOTAL income received by any children listed in STEP 1.

Child Income:		Circle one: Yearly Monthly Bi-weekly Weekly

B. All other Household Members (including yourself)

List other household members not listed in STEP 1 (include yourself) even if they do not receive income. For each household member listed, if they do not receive income, report total gross income (before taxes) for each source in whole dollars (no cents). **If they do not receive income from any source, write '0'. If you enter '0', you are certifying that there is no income to report.**

Name of other Household Members (First and Last Names)	Earnings from Work	How Often? Yearly (Y) Monthly (M) Bi-Weekly (B) Weekly (W)	Welfare/ Child Support/ Alimony	How Often? Yearly (Y) Monthly (M) Bi-Weekly (B) Weekly (W)	Pensions/ Retirement/ Social Security/SSI/VA Benefits	How Often? Yearly (Y) Monthly (M) Bi-Weekly (B) Weekly (W)
	$		$		$	
	$		$		$	
	$		$		$	
Total household Members (Children and Adults)		Last Four Digits of Social Security Number (SSN) of primary wage earner or other adult household member.			XXX-XX-	Check if no SSN

STEP 4: Contact Information and Adult Signature

"I certify 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 that information. I am aware that is I purposely give false information, the participant/center may lose meal benefits and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form | Signature of Adult | Today's Date

Address | City, State, Zip | Phone/Email

COLORADO
Department of Public Health & Environment

2024-2025 Income Eligibility Form (IEF) for Child Care

Source of Income for Children	
Sources of Child Income	Examples
Earnings from work	A child has a regular full or part-time job where they earn a salary or wages.
Social Security • Disability Payments • Survivors Benefits	A child is blind or disabled and receives Social Security benefits. A parent is disabled, retired or deceased, and their child receives Social Security benefits.
Income from person outside of household	A friend or extended family member regularly gives a child spending money.
Income from any other source	A child receives regular income from a private pension fund, annuity or trust.

Source of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**
Salary, wages or cash bonuses Net income from self-employment (farm or business) If you are in the U.S. Military Basic pay and cash bonuses (DO NOT include combat pay, FSSA or privatized housing allowances) Allowances for off-base housing, food and clothing	Unemployment benefits Workers compensation Supplemental Security Income (SSI) Cash assistance from State or local government Alimony payments Child support payments Veterans benefits Strike benefits	Social Security (including railroad retirement and black lung benefits) Private Pensions or disability benefits Income from trusts or estates Annuities Investment income Earned interest Rental income Regular cash payments from outside household

STEP 5: Children's Ethnic and Racial Identities

We are required to ask for information about your children's race and ethnicity.
Responding does not affect your children's eligibility for receiving meals during care. Check all boxes that apply to the child(ren) in care.

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ White (Includes Hispanic and Latino) ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaskan Native

Nondiscrimination Statement **Revised May 2022**

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at 202-720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at 800-877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online, from any USDA office, by calling 866-632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: Mail: US Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or fax: (833) 256-1665 or (202) 690-7442; or email: program.intake@usda.gov This institution is an equal opportunity provider.

For center staff use only

Household Last Name:

Annual Income Conversion: Weekly x 52, Biweekly x 26, Monthly x 12

Total Income	$	**How Often?** (Circle One)	Yearly Monthly Bi-Weekly Weekly	**Household size:**		**Eligibility**	**Free**	**Reduced**	**Paid**

Determining Official's Signature Month/Year Expiration Date* (Month/Year) Today's Date

*This form expires 12 months after the month in which the institution makes the determination.

Example: If the determination is **July 2023, the form is valid from July 1, 2023 through July 31, 2024.** The institution may use the date the participant/guardian signs the Income Eligibility Form **OR** the date the institution's official make the determination and signs the Income Eligibility Form. The same approval method selected must be used for all forms approved by the institution.

Revised 04/2025