

Ohio Department of Children and Youth  
**CHILD ENROLLMENT AND HEALTH INFORMATION  
 FOR CHILD CARE**

**This form shall be completed prior to the child's first day of attendance and updated annually and as needed.**

Child's Name		Date of Birth		First Day at Program/Home	
Home Address				City	
State		Zip Code		Home Telephone Number	
Parent/Guardian Name #1				Relationship to Child	
Home Address <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> Same as Child's		
City			State		Zip
Email Address (if applicable)			Cell Phone (if applicable)		
Parent's Work/School Name			Parent's Work/School Telephone Number		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email Where can you be reached while your child is in this program/home?					
Parent/Guardian Name #2				Relationship to Child	
Home Address <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> Same as Child's		
City			State		Zip
Email Address (if applicable)			Cell Phone		
Parent's Work/School Name			Parent's Work/School Telephone Number		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email Where can you be reached while your child is in this program/home?					
<b>Emergency Contacts:</b> Parents <b>cannot be listed</b> as emergency contacts. List the name <u>of at least one person</u> who can be contacted in the event of an emergency or illness <b>if you cannot be reached</b> . Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.					
Name			Name		
City		State	City		State
Telephone Number		Relationship to Child	Telephone Number		Relationship to Child
Other numbers where emergency contact can be reached (if applicable)			Other numbers where emergency contact can be reached (if applicable)		
Name of Physician or Clinic/Hospital					
Street Address					
City		State	Telephone Number		

Child's Name

**Allergies, Special Health or Medical Conditions, and Medical Foods**

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the DCY 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - *check all that apply*    ☐ Food    ☐ Medication    ☐ Environmental    Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a DCY 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a DCY 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

☐ No

☐ Yes - a DCY 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a DCY 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on file.

☐ N/A - program does not provide meals or snacks to the child.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

☐ Not applicable

Child's Name
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**Diapering Statement**

Is your child toilet trained? <input type="checkbox"/> Yes ( <i>If yes, skip to Emergency Transportation Authorization section</i> ) <input type="checkbox"/> No (If no, fill out the following:)	
The program's policy is to check diapers every ____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:	
<input type="checkbox"/> I agree with the program's schedule	<input type="checkbox"/> I do not agree, please check my child's diaper every ____ hours.

**Emergency Transportation Authorization**

Give <u>Permission</u> to Transport		OR	Do Not Give <u>Permission</u> to Transport	
Program or Home Name			Program or Home Name	
<b>has permission</b> to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			<b>does not have permission</b> to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

**Acknowledgement of Policies and Procedures**

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. <input type="checkbox"/> Yes <input type="checkbox"/> No ( <i>check one</i> )	
This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.	
Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.			
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

**Note:**

This is a prescribed form which must be used by child care providers to meet the requirements to rules 5180:2-12-15, 5180:2-13-15, and 5180:2-14-04.

This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.



9267 S.R. 43  
Streetsboro, OH 44241  
(330)626-2735  
(330)968-4873  
KidsEncounter.com

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Authorized to Pickup**

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

**Permission to photograph/video**

Occasionally, Kids Encounter staff takes pictures of the children during normal classroom activities, special occasions, field trips, etc. in order to provide pictured records and memories of these events. In order for a child to have his/her photograph taken, we must have a consent form on file.

By signing this form, I state that I understand and agree that my child (whose name is listed above) may be photographed and/or videoed while under the care of Kids Encounter. I understand and agree that these photos/videos may be used in newsletters and/or the Kids Encounter website/Facebook.

Please check ONE of the following indicating if you do or do not give permission for your child to be photographed and videoed.

☐

I HEREBY GRANT PERMISSION FOR MY CHILD TO BE PHOTOGRAPHED AND/OR VIDEOED DURING PARTICIPATION AT KIDS ENCOUNTER.

**OR**

☐

I HEREBY DO **NOT** GRANT PERMISSION FOR MY CHILD TO BE PHOTOGRAPHED AND/OR VIDEOED DURING PARTICIPATION AT KIDS ENCOUNTER.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Today's Date

Ohio Department of Children and Youth  
**FAMILY NEEDS SURVEY FOR STEP UP TO QUALITY (SUTQ)**

<b><i>We want to support any needs you or your family may have. THE INFORMATION YOU PROVIDE ON THIS FORM IS CONFIDENTIAL</i></b> Please circle Y (YES) or N (NO) to best describe your current situation for each topic. If you circle Y for an item, please briefly list the CONCERN if this is an area of need for your child or family. Our goal is to provide resources to support you and your family, based on your answers.		
Child's/Children's Name(s):	Caretaker's Name:	Date Completed:
<b>TOPICS</b>		<b>Briefly List CONCERN</b>
<b>Child Development and Education-</b> Does anyone in your family have any need for resources or support in the areas listed below?		
Y   N	Information on child growth and development.	
Y   N	Guiding and supporting a child's behavior.	
Y   N	Medical or disabilities or possible conditions for any child or adult in the family.	
Y   N	Obtaining toys or activities to use to help any child in your home.	
Y   N	Preparing your child for kindergarten.	
<b>Child and Family Health-</b> Does anyone in your family have any need for resources or support in the areas listed below?		
Y   N	Health insurance and/or access to regular medical care, dental care, or medications.	
Y   N	Medical or health supplies or supports that anyone in your family needs.	
Y   N	Accessing immunizations.	
Y   N	Finding a pediatrician, general practitioner, dentist, therapist, psychologist, optometrist, or other specialty practitioner.	
Y   N	Concerns with depression, anger, anxiety, or mental health needs.	
Y   N	Concerns with alcohol, drug, or addiction problems.	
<b>Financial and Household Supports-</b> Does anyone in your family have any need for resources or support in the areas listed below?		
Y   N	Help paying for child care.	
Y   N	Help finding housing or safe housing.	
Y   N	Help paying your mortgage or rent.	
Y   N	Help with food expenses.	
Y   N	Finding household items such as furniture, clothing, or school supplies.	
Y   N	Access to transportation or transportation expenses.	
Y   N	Attending school (such as a GED, Certifications, or college degrees)	
Y   N	Help finding work or job training	

Are there other needs you or your family have that are not listed above:	
Parent Signature	Date:
Administrator or Designee Signature:	Date:

For Staff Use:

Bronze Rating Level	Silver Rating Level	Gold Rating Level
Resources provided to the family:	Resources provided to the family:	Resources provided to the family:
Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:
	Referrals provided to the family:	Referrals provided to the family:
	Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:
		Follow-up provided to the family:
		Administrator or Designee Signature & Date:

Ohio Department of Education and Workforce - Office of Nutrition  
**CHILD AND ADULT CARE FOOD PROGRAM**  
**ENROLLMENT FORM**

**Required Form for use by Child Care Centers and Head Start Programs**

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside School Hours, Youth Development & After School at Risk

**Instructions to Complete**

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

**CENTER NAME**

**CHILD'S NAME**  
(please print)

**AGE**

**BIRTHDATE**

month / day / year

**CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE  
AND THE MEALS RECEIVED WHILE IN CARE**

Check (✓) Days Child Normally in Care	List hours child normally in care				Check (✓) meals child normally receives while in care					
	Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

☐ Yes, the schedule listed above may frequently vary due to changes in parents/guardians schedule.

**SIGNATURE OF  
PARENT/GUARDIAN**

**DATE**

**DAY PHONE  
NUMBER**

**MAILING ADDRESS  
STREET /APT.**

**CITY**

**ZIP CODE**

**PARENT BIRTHDATE** month / day / year

**PARENT EMAIL**

In accordance with federal civil rights law and 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, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

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 state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint 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, Mail Stop 9410, Washington, D.C. 20250-9410;
2. Fax: (202) 690-7442; or
3. Email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

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Revised 8/2025



# ETHNIC and RACIAL DATA FORM

Agency/Daycare Center Kids Encounter

Agency/Daycare Address 9267 State Route 43 Streetsboro, OH 44241

The agency or daycare listed above receives Federal financial assistance for participating in the Child and Adult Care Food Program (CACFP). Because they receive Federal financial assistance they are required to record and maintain the Ethnic and Racial data of all children enrolled in the CACFP. This information is used solely for the purpose of determining compliance with Civil Right laws and will be kept confidential. We are requesting for each participant to 'Self Identify' and provide this information, however it is optional to Self Identify. This ethnic and racial information will remain confidential and on file for 3 years and will only be accessible to authorized personnel.

To Self Identify, please answer the following questions.

Child's name

Ethnic Category: Choose one

<b>Hispanic or Latino:</b> A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino".	
<b>Non-Hispanic or Latino:</b>	

Racial Categories: Check all that apply

<b>American Indian or Alaska Native:</b> A person having origins in any of the original peoples of North and South America, (including Central America), and who maintains tribal affiliation or community recognition.	
<b>Asian:</b> A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.	
<b>Black or African American:</b> A person having origins in any of the black racial groups of Africa.	
<b>Native Hawaiian or Other Pacific Islander:</b> A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.	
<b>White:</b> A person having origins in any of the original peoples of Europe, the Middle East or North Africa	
<b>Other</b>	

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**INSTRUCTIONS:** To apply for free and reduced-price meals, read the household Letter and instructions on backside of this form. Complete application and return to the center. In accordance with the NSLA, information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure. *Part 1* is to be completed by all households. *Part 2* is to be used only for a child living in a household receiving food assistance (SNAP) or Ohio Works First (OWF) benefits. *Part 3* is only for children NOT receiving Food Assistance or OWF benefits. *Part 4*, an adult household member must sign and date form; the last 4 digits of social security number must be listed if Part 3 is completed. *Part 5* is optional. \* Asterisks indicate info that must be completed. The form must be completed annually and valid for only 12 months.

**PART 3 – TOTAL HOUSEHOLD SIZE, TOTAL HOUSEHOLD GROSS INCOME AND HOW OFTEN IT WAS RECEIVED:** List names of all household members. List all gross income: list how much and how often. If Part 2 is completed, skip to Part 4.

**PART 4 – SIGNATURE & LAST 4 DIGITS OF SOCIAL SECURITY NUMBER:** Adult household member must sign/date form. If Part 3 is completed, the adult signing the form must also list last 4 digits of his/her Social Security Number or check the “I do not have a Social Security Number” box.

<p>* _____  <b>SIGNATURE OF ADULT HOUSEHOLD MEMBER</b></p>	<p>* _____  <b>DATE</b></p>	<p><b>* If Part 3 is completed,  insert last 4 digits of Social Security Number</b> <input style="width: 30px; height: 25px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 25px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 25px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 25px; border: 1px solid black;" type="text"/></p> <p><input style="width: 30px; height: 25px; border: 1px solid black;" type="checkbox"/> (Check if applicable)  I do not have a Social Security Number</p>
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**PART 5: RACIAL/ETHNIC IDENTITY (Optional):** Please check appropriate boxes to identify the race and ethnicity of enrolled child(ren).

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program. **State Distribution: July 2025**

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Signature of Sponsor / Center Representative

Date Sponsor Certified/Categorized Form

Effective Date

Expiration Date

Note: Effective date is determined by parent or sponsor signature date as selected on CRRS application.

(From the first of month of date signed)

(Valid until last day of month in which  
form was signed one year earlier)

Note: Effective date is determined by parent or sponsor signature date as selected on ORR-10. If date of parent signature is not within month of certification or immediately preceding month, effective date must be date of sponsor certification.

## HOUSEHOLD LETTER - Dear Parent or Guardian

Please help us comply with the requirements of the U.S. Department of Agriculture's Child and Adult Care Food Program (CACFP) by completing the attached income eligibility application for free and reduced-price meals. All information will be treated with strict confidentiality. The CACFP provides reimbursement to the child care center for healthy meals and snacks served to children enrolled in child care. **The completion of the income eligibility application is optional.** Complete the application on the reverse side using the instructions below for your type of household. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center. Households with incomes less than or equal to the reduced-price values listed on the chart at the bottom of this page are eligible for free meal benefits. An application must contain complete information to be considered for free or reduced-price meals. Households are no longer required to report changes regarding the increase or decrease of income or household size or when the household is no longer certified eligible for food assistance (SNAP) or Ohio Works First (OWF). Once approved for free or reduced-price benefits, a household will remain eligible for these benefits for a period not to exceed 12 months. During periods of unemployment, your child(ren) is eligible for meal reimbursement provided the loss of income during this time causes the family to be within eligibility standards for meals. In operation of the CACFP, no person will be discriminated against because of race, color, national origin, sex, age or disability §226.23(e)(2)(iv). If you have questions regarding the completion of this application, contact the child care center.

### PART 1 – CHILD INFORMATION: ALL HOUSEHOLDS COMPLETE THIS PART (\*denotes required info)

- Print the name of the child(ren) enrolled at the child care center. All children (including foster children) can be listed on the same application.
- List the enrolled child's age and birth date.
- Check box indicating if the child is a foster child. Foster children that are under the legal responsibility of the foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Attach documentation to show foster child status.

### PART 2 – HOUSEHOLDS RECEIVING FOOD ASSISTANCE OR OHIO WORKS FIRST: COMPLETE THIS PART AND PART 4 – If a child is a member of a food assistance (SNAP) or OWF household, they are automatically eligible to receive free CACFP meal benefits.

Circle the type of benefit received: Food Assistance (SNAP) or Ohio Works First (OWF).

- List a current food assistance or OWF case number for each child. This will be a 7-digit number. Do not list a swipe card number.

### SKIP PART 3 – Do not list names of household members or income if you listed a valid Food Assistance (SNAP) or OWF case number for each child in Part 2.

### PART 3 – TOTAL HOUSEHOLD SIZE, GROSS INCOME AND HOW OFTEN RECEIVED: ALL OTHER HOUSEHOLDS COMPLETE PARTS 3 & 4.

- a) Write the names of all household members including yourself and the child(ren) that attends the child care center, noting any income received. A household is defined as a group of related or unrelated individuals who are living as one economic unit that share housing and/or significant income and expenses of its members. This might include grandparents, other relatives, or friends who live with you. Attach another piece of paper if you need more space to list all household members.
- b) Check the box for any person listed as a household member (including children) that has no income.
- c) For each household member, list each type of income received during the last month and list how often the money was received.
  1. Earnings from work before deductions: Write the amount of total gross income each household member received the last month, before taxes/deductions or anything else is taken out (not the take-home pay) and how often it was received (weekly, every two weeks, twice per month, monthly, annually). Income is any money received on a recurring basis, including gross earned income. Households are not required to include payments received for a foster child as income. If any amount during the previous month was more or less than usual, write that person's usual monthly income. If you normally get overtime, include it, but not if you only get it sometimes. If you are in the military and your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, regarding deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.
  2. List the amount each person got the last month from welfare, child support or alimony and list how often the money was received.
  3. List the amount each person got the last month from pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits or disability benefits and list how often the money was received.
  4. List all other income sources. Examples include: Worker's Compensation, strike benefits, unemployment compensation, regular contributions from people who do not live in your household, cash withdrawn from savings, interest/dividends, income from estates/trusts/investments, net royalties/annuities or any other income. Self-employed applicants should report income after expenses (net income) in column 1 under earnings from work. Business, farm or rental property report income should be entered in column 4. Do not include food assistance payments.

### PART 4 – SIGNATURE AND LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: ALL HOUSEHOLDS COMPLETE THIS PART (\* denotes required info)

- a) \* All applications must have the signature of an adult household member.
- b) \* The adult signing the application must also date the form.
- c) \* Only an application that lists income in Part 3 must have the last four digits of the social security number of the adult who signs. If the adult does not have a social security number, check the box marked, "I do not have a Social Security Number." If you listed food assistance or OWF number for each child or if you are applying for a foster child, the last four digits of the social security number are not required.

### PART 5 – RACIAL/ETHNIC IDENTITY – OPTIONAL

You are not required to answer this part for the application to be considered complete. This information is collected to make sure that everyone is treated fairly and will be kept confidential. No child will be discriminated against because of race, color, national origin, gender, age or disability.

**NON-DISCRIMINATION STATEMENT:** In accordance with federal civil rights law and 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, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotope, American Sign Language, etc.) should contact the state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, [AD-3027](#), found online at How to File a Program Discrimination Complaint 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, Mail Stop 9410, Washington, D.C. 20250-9410; **Fax:** (202) 690-7442; or

**Email:** [program.intake@usda.gov](mailto:program.intake@usda.gov).

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### REDUCED-PRICE INCOME ELIGIBILITY GUIDELINES

Guidelines to be effective from July 1, 2025 through June 30, 2026.

Households with incomes less than or equal to the reduced-price values below are eligible for free or reduced-price meal benefits.

Number of Members	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	\$28,953	2,413	1,207	1,114	557
2	\$39,128	3,261	1,631	1,505	753
3	\$49,303	4,109	2,055	1,897	949
4	\$59,478	4,957	2,479	2,288	1,144
5	\$69,653	5,805	2,903	2,679	1,340
6	\$79,828	6,653	3,327	3,071	1,536
7	\$90,003	7,501	3,751	3,462	1,731
8	\$100,178	8,349	4,175	3,853	1,927
Each Additional Member Add	\$10,175	848	424	392	196