



Open Arms Learning Center
222 E. Wade St.
Mountain Home, AR 72653
(870) 424-5758



Noah's Ark Preschool
202 Springwood Ave.
Mountain Home, AR 72653
(870) 425-6204

Child's Name: _____
Allergies: _____
Home Address: _____
City: _____
Email address: _____

Birth Date: _____
Medical Conditions: _____
Home Phone: _____
State: _____ Zip Code: _____
Enrollment Date: _____

Days of the Week Scheduled (Circle):
Method of Tuition Payment (Circle):

M T W T H F Hours: _____
Private - DHS - ABC - Pathways

Father's Name: _____ (Authorized to pick up child) Yes _____ No _____
Cell Phone: _____ Work Phone: _____
Father's Employer: _____ Work Hours: _____ to _____
DL#: _____ Social Security#: _____
Father's Signature: _____ Date: _____

Mother's Name: _____ (Authorized to pick up child) Yes _____ No _____
Cell Phone: _____ Work Phone: _____
Mother's Employer: _____ Work Hours: _____ to _____
DL#: _____ Social Security#: _____
Mother's Signature: _____ Date: _____

Persons (other than parent/guardian) authorized to pick up the child from the center:

Name: _____
Cell Phone: _____
Name: _____
Cell Phone: _____
Name: _____
Cell Phone: _____
Name: _____
Cell Phone: _____

Relationship: _____
Home Ph#: _____ Work Ph#: _____
Relationship: _____
Home Ph#: _____ Work Ph#: _____
Relationship: _____
Home Ph#: _____ Work Ph#: _____
Relationship: _____
Home Ph#: _____ Work Ph#: _____

Child's Physician: _____ PH#: _____
Address: _____ City: _____ State: _____
Insurance Carrier: _____

Please tell us about any beliefs, culture or childbearing practices your child might have:

Hippa: I, _____ the parent/guardian of _____ give permission for my child's allergy or allergies to be posted in **Open Arms Learning Center** on classroom walls, in the kitchen and other areas as may be needed. I understand that this information will be posted to ensure all staff members are aware of my child's allergy/medical needs.

Sunscreen: I give written permission for sunscreen to be applied to exposed areas on hot sunny days. I understand that sunscreen will be provided by the center and that if my child has an allergy to any brand of sunscreen, I will provide sunscreen for my child. Permission must be given yearly.

Developmental Screening: Children ages birth through 5 years of age will be screened annually free of charge using the ASQ.

Special needs: I have been informed in writing that all childcare facilities are required by IDEA to refer a child with any suspected delays or disabilities to the appropriate lead agency (as determined by the child's age).

Photography and video permission: I give permission for **Open Arms Learning Center** to photograph/video my child and display photographs/videos throughout the center. I also give permission for my child's photographs/videos to be utilized in an education manner for training purposes and to be submitted to the Baxter Bulletin for special occasions to inform the community about the Open Arms Preschool program and on the Facebook page and/or website.

Photos/Video recordings permission on Social Media/Websites: I give permission for photographs or video recordings of my child to be placed on social media or any other web-sites. This is in accordance with Minimum Licensing Requirements.

YES _____ or NO _____ please check your preference.

Shaken Baby Syndrome: I have been offered the brochure on Carter's Law from Open Arms Learning Center. (www.purplecrying.com)

Discipline: I understand that Open Arms Learning Center has the goal to help children learn acceptable behavior and develop self-control. By signing below you are agreeing the to the discipline policy as stated in the handbook. No physical punishment shall be administered.

Handbook for Families: I have received, read, understand the handbook of **Open Arms Learning Center** and agree to adhere to the said policies and procedures.

Interviews by DHS and Other Agencies: Any staff member or children in attendance may be interviewed by Child Care Licensing, by the Division of Child and Family Services, and/or by law enforcement officers for the purpose of investigations or to determine compliance with licensing requirements. Child interviews do not require parental notice or consent.

Kindergarten Readiness Skills: I have received information of Kindergarten Readiness Skills Calendar for my child (Only for children ages 3 and 4 years old).

Medical Homes: I have received information of medical homes for children for my provider.

Emergency Medical Consent

I, _____ Father – Mother – Guardian (circle one) of _____ (child's name) do hereby give my consent to the Director of **Open Arms Learning Center** or his/her duly appointed representative, for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed recognized physician or surgeon in case of an emergency when the parents or guardian cannot be reached. I also give consent for the Director or his/her duly appointed representative to transport said child for emergency medical treatment. I have also submitted an updated immunization record for my child.

Parent/Guardian Signature: _____

Date: _____

Witness: _____

Date: _____

We are an equally opportunity provider.

Disease History (list the dates of each)

Measles _____ Mumps _____ German Measles _____ Chicken Pox _____

Whooping Cough _____ Contracted Tuberculosis _____ yes _____ no

Frequent ear infection _____ yes _____ no Frequent throat infections _____ yes _____ no

Medications _____ Allergies _____

Other conditions or comments: _____

Developmental Needs

Physical or emotional problems the child may have: _____

Child's special food needs: _____

Special Information

Temper tantrums _____ Diabetes _____ Frequent colds _____ Biting _____ Sun Sensitivity _____ Seizures _____

Fainting spells _____ Bed wetting _____ Other _____

Requires help with: Dressing _____ Undressing _____ Toileting _____ Eating _____ Hand washing _____

Is the child toilet trained? _____ yes _____ no Toileting words used _____

Favorite games _____ Favorite toys _____

Siblings _____ yes _____ no Names & Ages _____

Type of childcare used before _____

Special Customs or Beliefs _____

Other useful information about your child _____

Does your child have health insurance _____ yes _____ no

If yes, who is your health insurance carrier _____

Behavior Guidance Discipline Policy

Our goal is to help children learn acceptable behavior and develop self-control. Our program is designed to promote positive and enjoyable learning experiences and to build trusting, respectful relationships. A well-planned schedule, classroom arrangement, and curriculum, along with well-trained staff, significantly reduces instances of inappropriate behavior. However, when children do make mistakes in behavior, we use the following guidance techniques.

- Tell the child what he/she CAN do
- Give choices whenever possible, but only when the child really has a choice
- Support children in learning to solve their own problems and work out conflicts
- Re-direct a child to another activity
- Help the children learn how to play with friends

Physical punishment and threats are never used by our staff. Teachers will provide schedules and maintain curriculum to reinforce positive behavior.

Limits of Behavior

Respect others.

Respect yourself.

Respect toys and equipment.

Guidance Policy

At enrollment, parents will be given a written copy of our behavior guidance policy. Parents will also sign an acknowledgement that they have been informed of the policy.

Pattern of Inappropriate Behavior

When a pattern of inappropriate behavior emerges, parents are required to meet with our staff. The goal will be to work together to find a solution to the problem behavior and resolve the difficulty. If outside professional consultation or evaluation is necessary, the center director will invite an appropriate consultant to join the parent-staff partnership.

In cases of biting, if the child bites three times or attempts to bite three times, the parent will be called and the child will be removed from the center for the remainder of that day. If biting continues to be an issue the situation will be reviewed. If all attempts to change that behavior are unsuccessful, we will refer to number 3 on the child dismissal policy.

Child Dismissal

The director reserves the right to dismiss any child.

A child may be dismissed if

1. The parent or child refuses to follow the policies and procedures of the center.
This may include situations in which repeated requests for updated immunization records, emergency contact information, required paperwork, etc. are ignored by parents.
2. Center staff is not able to meet the needs of the child for any reason.
3. The child becomes an endangerment in any way to other children or the staff
It is not the intent of the director to dismiss any child; every reasonable effort will be made to ensure that dismissal is not necessary.

Please know that No child shall be dismissed from ABC without Division approval for behavior.

Please Sign and Date _____

Parent Questionnaire

Help us to know about your child!

1. child's FULL name: _____ DOB _____
2. parent's or guardian's names and numbers:
mom: _____ phone: _____ lives with: yes ☐ no ☐
mom work: _____ phone: _____
dad: _____ phone: _____ lives with: yes ☐ no ☐
dad work: _____ phone: _____
siblings names and ages: _____

any allergies: yes ☐ no ☐ if yes what are they _____
special medical conditions: _____
any languages besides English spoken at home:
yes ☐ no ☐ if yes what language: _____
What are two goals you have for your child for this school year?
1. _____
2. _____

Tell us about your child!
favorite toy: _____ favorite food: _____
pet/pets: _____ favorite color: _____
favorite outdoor activity: _____ favorite family activity: _____
favorite book: _____
any special assistance they may need: _____

What would you like us to know? (describe your child)

parent/guardian signature: _____ date: _____

Thank you for taking the time to tell us about your child and welcome to Open Arms Learning Center!

PARENT AGREEMENT

For the Use of Non-standard Playground Items/Activities

My child care provider _____ has discussed the "plan-of-use" that is attached to this agreement. This plan covers the intended use of playground items/activities that are not commercially manufactured and therefore have not been certified as safe for playground activities and have no manufacturer's installation instructions or recommended use guidelines. Because of this, these items/activities involve some degree of added risk. The plan for each activity has been discussed with me and I understand the risks involved. The Child Care Licensing Unit has reviewed the equipment/activities outlined in this plan and has approved the plan based on the providers agreement that the plan will be implemented and supervised as specified in the plan. The Child Care Licensing Unit will monitor these items/activities to ensure on-going compliance with all of the terms and conditions of the plan.

The use of all items/activities covered by this plan has been explained to me and I have received a copy of the approved plan. Based on this information, I am in agreement that any possible risk to my child is acceptable to me.

I agree to allow my child _____ to participate in the listed activities.

Parent Signature

Date

Dear Parent/Caregiver:

Welcome to our screening and monitoring program. Because your child's first 5 years of life are so important, we want to help you provide the best start for your child. As part of this service, we provide the Ages & Stages Questionnaires, Third Edition (ASQ-3), to help you keep track of your child's development. A questionnaire will be provided every 2-, 4-, or 6-month period. You will be asked to answer questions about some things your child can and cannot do. The questionnaire includes questions about your child's communication, gross motor, fine motor, problem solving, and personal-social skills.

If the questionnaire shows that your child is developing without concerns, we will provide some activities designed for use with ASQ-3 to encourage your child's development and will provide the next questionnaire at the appropriate time.

If the questionnaire shows some possible concerns, we will contact you about getting a more involved assessment for your child. Information will only be shared with other agencies with your written consent.

We look forward to your participation in our program!

Sincerely,

Director OALC

Consent Form

The first 5 years of life are very important for your child because this time sets the stage for success in school and later life. During infancy and early childhood, your child will gain many experiences and learn many skills. It is important to ensure that each child's development proceeds well during this period.

Please read the text below and mark the desired space to indicate whether you will participate in the screening/monitoring program.

- ☐ I have read the information provided about the Ages & Stages Questionnaires®, Third Edition (ASQ-3™), and I wish to have my child participate in the screening/monitoring program. I will fill out questionnaires about my child's development and will promptly return the completed questionnaires.
- ☐ I do not wish to participate in the screening/monitoring program. I have read the provided information about the Ages & Stages Questionnaires®, Third Edition (ASQ-3™), and understand the purpose of this program.

Parent's or guardian's signature

Date

Child's name: _____

Child's date of birth: _____

If child was born 3 or more weeks prematurely, # of weeks premature: _____

Child's primary physician: _____



ARKANSAS DEPARTMENT OF HUMAN SERVICES
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name: Childs Name: Client ID #: _____
Mailing Address: _____ Date of Birth: _____
Case Head: _____

I, Parent/Guardian _____ hereby authorize
(Client or Personal Representative)

Open Arms Learning Center, INC. or Noah's Ark Preschool to disclose specific health information
(Name of Provider/Plan)

from the records of the above named client to: Open Arms Learning Center Noah's Ark Preschool
222 E. Wade Ave 202 Springwood Ave
Mountain Home AR 72653 Mountain Home AR 72653
(870) 424 5758 (870) 425 6204
(Recipient Name Address/Phone/Fax)

for the specific purpose(s): IMMUNIZATION REQUIREMENTS

Specific information to be disclosed: _____

If you use "All Medical Records" this will include any and all written information DHS may have concerning your health care and any illness or injury you may have suffered, including, but not limited to, medical history, consultations, prescriptions, treatment, medical evaluations, x-rays, results of tests, and copies of hospital or medical records pertaining to you.

I understand that this authorization will expire on the following date, event or condition:

January

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, sexually transmitted diseases, alcohol abuse, drug abuse, psychological or psychiatric conditions, genetic testing, family planning, or women, infant, & children (WIC) this disclosure will include that information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization. A copy of this authorization shall be as binding as the original.

_____ (Signature of Client)	_____ (Date)	_____ (Witness-If Required)
_____ (Signature of Personal Representative)	_____ (Date)	_____ (Personal Representative Relationship/Authority)

NOTE: This Authorization was revoked on _____
(Date) _____
(Signature of Staff)

Open Arms Learning Center
222 E. Wade Ave.
Mountain Home, AR 72653
(870) 424-5758



Tuition Chart

Effective October 1, 2025

Previous Increase January 1, 2025, October 1, 2023

Hours of Operation

7:00-5:00

Noah's Ark Preschool
202 Springwood Ave.
Mountain Home, AR 72653
(870) 425-6204

INFANTS/TODDLERS (6 weeks – 3years)

\$45.00/Day - \$225/week

Half-Day Rate

\$25.00 - 4 Hours or less

*(excluding lunch)

PRE-SCHOOL (3years – 5years)

\$40.00/day-\$200 week

Half-Day Rate

\$25.00 - 4 Hours or less

*(excluding lunch)

Before school only (7:00-8:00a.m.)

\$10.00/day - \$50.00/week

After school only (3:00-5:00p.m.)

\$10.00/day - \$50.00/week

SCHOOL-AGE (K-6th) (full time)

\$35.00/day-\$175.00/week

Half-Day Rate

\$25.00 - 4 Hours or less

*(excluding lunch and field trip)

SCHOOL-AGE (K-6th)

After school only(3:00-5:00p.m.)

\$10.00/day - \$50.00/week

DROP-IN (based on availability) Must call in advance of 24 hours at minimum to check for spots available.

Any Age \$50.00/day

*** A one time \$50 registration fee is due upon enrollment.

*** Tuition is due each Friday for the next week of service. **Policy is to pay whether your child is here or not.** A late fee of \$25.00 will be assessed to your account if tuition is paid any later than Monday by 10:00 am or if you pick up your child any later than 5:00 p.m. (an additional \$10.00 for every 10 minutes after that).

***The following 10 days will be paid holidays. No childcare service will be provided: New Year's Day, Good Friday, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Friday after Thanksgiving, Christmas Eve, Christmas Day & New Year's Eve.

***Closures or hours of operation may altered be due to inclement weather.

*** Any day which your child either attends over 4 hours or eats lunch will be considered a full day, which is less than 10 hours of care total per day.

***Although hours of operation are 7:00 am to 5:00 pm, due to ratios we only have limited space available for the early and late hour. Please see the office if you need to adjust time to check for availability.

***Rates will be increase periodically to keep up with the cost of living.

**Employees will be offered half price after denial of school readiness assistance.

*****Any account not kept current on private payments will be required to enroll in automatic bank draft.

Parent/Provider Contract

Child's Name: _____

Payment Type: _____

Days: M T W R F Hours: _____ - _____

Weekly Tuition: _____

Voucher Co-pay amount weekly: _____ Voucher over absence amount: _____

By signing this agreement, you are accepting all terms. _____

Parent Signature/date

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.

Open Arms Learning Center
Name of Day Care Facility

870-4245758
Telephone #

222 E Wade Ave Mountain Home AR 72653
Address City State Zip Code

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:	Sat. ☐	Tue. ☐	Fri. ☐		
				To:	Sun. ☐	Wed. ☐			
					Mon. ☐	Thur. ☐			
				From:	Sat. ☐	Tue. ☐	Fri. ☐		
				To:	Sun. ☐	Wed. ☐			
					Mon. ☐	Thur. ☐			
				From:	Sat. ☐	Tue. ☐	Fri. ☐		
				To:	Sun. ☐	Wed. ☐			
					Mon. ☐	Thur. ☐			

Please identify any food 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, employer, and lender.

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

AFFILI ONLINE.
 RETURN TO (School/District Name).
 ADDRESS:

ADDRESS:

Grade

Check all that apply

Write only one case number in this space.

A. All Adult Household Members (Anyone who is living with you and shares income and expenses, even if not related, including you,

Name of Adult Household Member (First and Last)	Earnings from Work	How often received?					Child Support, Alimony	How often received?					Pensions, retirement, Social Security, SSI, Veterans' All	How often received?				
		Every 2 Weeks	2x Month	Monthly	Annual	Weekly		Every 2 Weeks	2x Month	Monthly	Weekly	Every 2 Weeks		2x Month	Monthly			
	\$	☐	☐	☐	☐		☐	☐	☐	☐		☐	☐	☐	☐			
	\$	☐	☐	☐	☐		☐	☐	☐	☐		☐	☐	☐	☐			
	\$	☐	☐	☐	☐		☐	☐	☐	☐		☐	☐	☐	☐			
	\$	☐	☐	☐	☐		☐	☐	☐	☐		☐	☐	☐	☐			
	\$	☐	☐	☐	☐		☐	☐	☐	☐		☐	☐	☐	☐			

Please see application's back for list of income sources.

Email (optional)

SOURCES AND EXAMPLES OF INCOME

For additional information on income, please refer to the instructions that accompany this application.

Sources of Income			Examples of Income for Children	
Earnings from Work	Public Assistance/Alimony/ Child Support	Pensions/Retirement/ All other sources of income		
• Salary, wages, cash bonuses, tips, commissions • 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 of-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/Disability (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	• A child has a regular full- or part-time job where they earn a salary or wages • 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 • A friend or extended family member regularly gives a child spending money • A child receives regular income from a private pension fund, annuity, or trust	

Disclosure (Optional) ☐ I do not want school officials to share information from my free and reduced-price meal application with Medicaid or the State Children's Health Insurance Program (AR Kids 1st).

OPTIONAL Children's ethnic and racial identities. This information is kept confidential and may be protected by the Privacy Act of 1974.

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 free or reduced price meals.

Ethnicity (check one): ☐ Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin, regardless of race) ☐ Not Hispanic or Latino

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

Return this completed form to your child's school. *Do not mail, fax, or email completed applications to the U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights.

DO NOT FILL OUT For school use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12. Do not annualize income to determine eligibility unless more than one income frequency is listed.

Total Income	How often?	Household size	Categorical Eligibility	Eligibility
	☐ Weekly ☐ Every 2 Weeks ☐ 2x Month ☐ Monthly ☐ Annual		☐	☐ Free ☐ Reduced ☐ Denied
Determining Official's Signature	Date	Confirming Official's Signature	Date	Verifying Official's Signature

Use of Information Statement — The Richard B. Russell National School Lunch Act requires that we use information from this application to see who qualifies for free or reduced price meals. We can only approve complete forms. We may share your eligibility information with education, health, and nutrition programs to help them deliver program benefits to your household. Inspectors and law enforcement may also use your information to make sure that program rules are met.

The contact information below is solely to file a complaint of discrimination

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, 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 responsible Agency or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or 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 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, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

USDA is an equal opportunity provider, employer, and lender

Do not mail applications
to this address, only complaints of discrimination.