



**STATE OF TENNESSEE
DEPARTMENT OF HUMAN SERVICES**

CITIZENS PLAZA BUILDING
400 DEADERICK STREET
NASHVILLE, TENNESSEE 37243-1403
TELEPHONE: 615-313-4749 FAX: 615-313-6683
TTY: 1-800-270-1349
www.tn.gov/humanserv/cacfp

BILL HASLAM
GOVERNOR

RAQUEL HATTER, MSW, Ed.D.
COMMISSIONER

MEMORANDUM

TO: Child and Adult Care Food Program (CACFP) Institutions
LGH
FROM: Loretta Goldsmith-Howell, Program Manager, Child and Adult Care Food Program
DATE: August 14, 2015

SUBJECT: Income Eligibility Guidelines for the Period of July 1, 2015 through June 30, 2016

Attached are the income eligibility guidelines issued by the U.S. Department of Agriculture for the period of July 1, 2015 through June 30, 2016. The guidelines are to be used in determining eligibility for free and reduced-price meal reimbursements for the CACFP.

For child and adult care centers, please note that the new guidelines in Attachment A to this memorandum will affect free and reduced-price applications taken on and after July 1, 2015. These income guidelines do not affect the CACFP participation of After School "At Risk" Meal Programs or Emergency Shelters.

For child care home sponsoring agencies, please note that only the reduced-price guidelines contained in Attachment B to this memorandum are to be used for Tier I determinations.

If you have any questions, please contact our office at (615) 313-4749.

Thank you

LGH/

**CHILD AND ADULT CARE FOOD PROGRAM
INCOME ELIGIBILITY GUIDELINES FOR FREE AND REDUCED-PRICE MEALS
JULY 1, 2015, THROUGH JUNE 30, 2016**

(Use for eligibility determinations and for public release)

Parent, Guardian, Family Member: If your total household income is within the limits listed below, the person you are applying for may be eligible for Free or Reduced-Price meals.

ANNUAL INCOME

Household Size	Free Rate Reimbursement	Reduced Rate Reimbursement	Paid Rate Reimbursement
1	\$15,301.00 and under	\$15,301.01 - \$21,775.00	\$21,775.01 and above
2	\$20,709.00 and under	\$20,709.01 - \$29,471.00	\$29,471.01 and above
3	\$26,117.00 and under	\$26,117.01 - \$37,167.00	\$37,167.01 and above
4	\$31,525.00 and under	\$31,525.01 - \$44,863.00	\$44,863.01 and above
5	\$36,933.00 and under	\$36,933.01 - \$52,559.00	\$52,559.01 and above
6	\$42,341.00 and under	\$42,341.01 - \$60,255.00	\$60,255.01 and above
7	\$47,749.00 and under	\$47,749.01 - \$67,951.00	\$67,951.01 and above
8	\$53,157.00 and under	\$53,157.01 - \$75,647.00	\$75,647.01 and above
For Each Additional Person, Add	+\$5,408.00	+\$7,696.00	+\$7,696.00

**CACFP REIMBURSEMENT RATES
JULY 1, 2015, THROUGH JUNE 30, 2016**

MEALS SERVED IN CHILD AND ADULT CARE CENTERS			
Eligibility	Breakfast	*Lunch/Supper	Supplement
Free	\$1.66	\$3.3075	\$0.84
Reduced	\$1.36	\$2.9075	\$0.42
Paid	\$0.29	\$0.5275	\$0.07
MEALS SERVED IN CHILD CARE HOMES			
Eligibility	Breakfast	Lunch/Supper	Supplement
Tier 1	\$1.32	\$2.48	\$0.74
Tier 2	\$0.48	\$1.50	\$0.20
ADMINISTRATIVE PAYMENTS FOR CHILD CARE HOME SPONSORS			
Number of Homes		Rate	
First 50 homes		\$111.00 per home per month	
Next 150 homes		\$85.00 per home per month	
Next 800 homes		\$66.00 per home per month	
Each ADDL		\$58.00 per home per month	
MEALS SERVED IN EMERGENCY SHELTERS			
Eligibility	Breakfast	Lunch/Supper*	Supplement
Free	\$1.66	\$3.3075	\$0.84
AFTER-SCHOOL CARE FOR AT-RISK CHILDREN			
Supplement		\$0.84	
Supper*		\$3.3075	

*Rate includes Cash -in- Lieu reimbursement of .2375 per Lunch or Supper. Cash in lieu is additional assistance received by institutions for each CACFP lunch or supper served to participants.

ATTACHMENT B

**INCOME ELIGIBILITY GUIDELINES FOR REDUCED-PRICE MEALS
EFFECTIVE JULY 1, 2015 THROUGH JUNE 30, 2016**

(Use for attaching to parent/guardian letters)

Parent, Guardian, Family Member: If your total household income is within the limits listed below, the person you are applying for may be eligible for Reduced-Price meals.

ANNUAL INCOME

Household Size	Reduced Rate Reimbursement
1	\$15,301.01 - \$21,775.00
2	\$20,709.01 - \$29,471.00
3	\$22,117.01 - \$37,167.00
4	\$31,525.01 - \$44,863.00
5	\$36,933.01 - \$52,559.00
6	\$42,341.01 - \$60,255.00
7	\$47,749.01 - \$67,951.00
8	\$53,157.01 - \$75,647.00
For Each Additional Person, Add	+\$7,696.00



Child and Adult Care Food Program (CACFP)
INCOME ELIGIBILITY APPLICATION FOR CHILD CARE CENTER PARTICIPANT(S)

PART 1A – NAME OF CHILD CARE CENTER (Enter the name of the child care center):

PART 1B – PARTICIPANT(S) SERVED BY CENTER (Enter the information below for all children from your household that are enrolled for care at the child care center):

Name	Age	Check if Foster Child
		<input type="checkbox"/>

PART 2A – HOUSEHOLDS WHICH ARE CURRENTLY RECEIVING BENEFITS THROUGH THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP), OR FAMILIES FIRST (FF) CASH ASSISTANCE OR FAMILIES FIRST (FF) CHILD CARE ASSISTANCE (If your household is now receiving benefits under one or more of these programs, complete this part, and sign the statement in Part 4 – Do not complete Part 2B.): ACCENT Case No. for SNAP or FF Cash Assistance: _____ **OR** FF Child Care Assistance Case No.:

PART 2B – ALL OTHER HOUSEHOLD MEMBERS (If no information is entered in Part 2A above, complete this part for all household members not identified in Part 1B above and sign the statement in Part 4. Attach additional sheets as necessary)

Names of All Other Household Members	Earnings from Work (Before Deductions)	Child Support, Alimony or Other Income	Payments Received from Pensions, Retirement, & Social Security
1.	\$ _____ per year	\$ _____ per year	\$ _____ per year
2.	\$ _____ per year	\$ _____ per year	\$ _____ per year
3.	\$ _____ per year	\$ _____ per year	\$ _____ per year
4.	\$ _____ per year	\$ _____ per year	\$ _____ per year

Total Number of Household Members: ____ **Total Yearly Income for Household from All Sources:** \$ _____ Yearly income is calculated as follows: Multiply Weekly income by 52, Bi-weekly income (received every two weeks) by 26, Semi-monthly income (received twice a month) by 24, and Monthly income by 12. Do not round up any numbers.

PART 3 – Medicaid and State Children’s Health Insurance Programs – Please check if you do **not** want the information in this application to be shared with the Medicaid and State Children’s Health Insurance Programs: ____ **DO NOT WANT APPLICATION INFORMATION TO BE SHARED WITH THE MEDICAID AND STATE CHILDREN’S HEALTH INSURANCE PROGRAMS.**

PART 4 – SIGNATURE (An adult household member must sign the application.) **PENALTIES FOR MISREPRESENTATION:** I certify that all of the above information is true and correct. I understand that this information is being given for the receipt of Federal Funds; that institution officials may verify the information on the statement; and that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Printed Name of Adult :	Signature of Adult:	Social Security Number (only last four digits):
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Street:	City:	State and Zip Code:	Home Telephone:
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PART 5 – ETHNIC/RACIAL IDENTITY (You are not required to answer this question.): For Ethnicity, please check one of the following: ____ Hispanic or Latino ____ Not Hispanic or Latino. For Race, please check one or more of the following: ____ American Indian or Alaskan Native ____ Asian ____ Black or African American ____ Native Hawaiian or Other Pacific Islander ____ White. Please see the definitions of Ethnicity and Race on the back of this application.

FOR INSTITUTION USE ONLY:
To identify the eligibility classification of the enrolled children identified above, please circle: **FREE, REDUCED-PRICE** or **PAID**.
To identify the basis for classification, please circle: **CATEGORICALLY ELIGIBLE** or **INCOME ELIGIBLE**

Determining Official Signature:

Date:

INCOME ELIGIBILITY APPLICATION INSTRUCTIONS

PART 1A – NAME OF CHILD CARE CENTER: Enter the name of the child care center.

PART 1B – PARTICIPANT(S) SERVED BY CENTER: Print the name and age of the children from your household that are enrolled for care at the child care center. Also, enter a “Check” for any child(ren) who are foster children. A foster child is the legal responsibility of a state children services agency or court, and is categorically eligible for free meals.

PART 2A – HOUSEHOLDS RECEIVING SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM BENEFITS, FAMILIES FIRST CASH ASSISTANCE OR FAMILIES FIRST CHILD CARE ASSISTANCE: COMPLETE THIS PART AND PART 4.

- (1) Enter your household’s current case number for Supplemental Nutrition Assistance Program , Families First Cash Assistance or Families First Child Care Assistance. Do not complete Part 2B.
- (2) An adult household member must sign the statement in Part 3.

PART 2B - ALL OTHER HOUSEHOLD MEMBERS: COMPLETE THIS PART AND PART 4.

- (1) Write the names of everyone in your household not entered in 1B. Households with foster and non-foster children may choose to include the foster child(ren) as household members, as well as any personal income earned by the foster child(ren), on the same household application that includes the non- foster child(ren).
- (2) Write the amount of the income received on a yearly basis for each household member. The income may be for the current month, the amount projected for the first month the application is made for, or for the month prior to application. This income is the amount before taxes or any deductions are made. Also, indicate the source of the income. Refer to examples below for income to report.

INCOME TO REPORT

<u>Earnings from Work</u>	<u>Retirement/Social Security</u>	<u>Other Income Sources</u>	<u>Child Support/Alimony</u>
Wages/salaries/tips	Pensions	Disability benefits	Alimony/child support
Strike benefits	Supplemental Security Income	Cash withdrawn from savings	benefits/payments
Unemployment benefits	Retirement income	Interest/dividends	
Worker's Compensation	Veteran's payments	Income from estates/trusts/investments	
Net income from self-employment	Social Security Income	Regular contributions from persons not living in the household	
		Net royalties/annuities/net rental income	

PART 3 – MEDICAID AND STATE CHILDREN’S HEALTH INSURANCE PROGRAMS – Federal law allows the sharing of the information on this application with Medicaid and State Children’s Health Insurance Programs. At this time, no procedures are in place to share this information. Since the procedures to share this information with the Medicaid and State Children’s Health Insurance Programs may be established in the future, please indicate if you do not want this information to be shared. The Medicaid and State Children’s Health Insurance Programs can only use the information to identify children who may be eligible for free or low cost health insurance and to enroll them in either Medicaid or the State Children’s Health Insurance Program. They are not allowed to use the information for any other purpose. If this information is not shared, it will not affect the eligibility of your child(ren) for free or reduced-price meals. If you do not want to share the information with the Medicaid and State Children’s Health Insurance Programs, please indicate this decision by entering a check.

PART 4 – SIGNATURE AND SOCIAL SECURITY NUMBER: All households complete this part.

- (1) All income eligibility statements must have the signature of an adult household member.
- (2) The adult household member who signs the statement must include the last four digits of his/her Social Security Number. If he/she does not have a Social Security Number, write "none". If you listed an ACCENT case number for Supplemental Nutrition Assistance Program or Families First cash assistance, or a case number for Families First Child Care Assistance, the last four digits of the Social Security Number are not needed.
- (3) The income eligibility application is valid for one calendar year from the date of the signature of the Determining Official. You will be contacted by the staff of the child care institution serving your child(ren) to update the information contained in this application before the close of the eligibility period. The staff of the child care institution is required to verify and certify the eligibility of your household every 12 months. Section 9 of the National School Lunch Act requires that, unless the participant's Supplemental Nutrition Assistance Program or Families First case number is provided, you must include the last four digits of the Social Security Number of the household member signing the statement or an indication that the household member signing the statement does not possess a Social Security Number. Provision of the last four digits of a Social Security Number is not mandatory, but if this Social Security information is not provided or an indication is not made that the adult household member signing the statement does not have a Social Security Number, the statement cannot be approved.

PART 5 - RACIAL/ETHNIC IDENTITY: You are **not required** to answer this question to receive meal benefits. However, this information will help ensure that everyone is treated fairly.

Definition of Ethnicity: *Hispanic or Latino* means a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Definition of Race: *American Indian or Alaskan Native* means 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 attachment. *Asian* means 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. *Black or African American* means a person having origins in any of the black racial groups of Africa. *Native Hawaiian or Other Pacific Islander* means a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. *White* means a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

No person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the CACFP on the grounds of race, color, sex, age, disability, national origin, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual’s income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and /or employment activities) or any other classification protected by Federal, Tennessee State constitutional, or statutory law.

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ENROLLMENT FORM

Maintain enrollment forms required by child care licensing and CACFP federal regulations for each participant. Enrollment Forms must:

1. Be updated annually and signed by a parent or guardian of the participant
2. Identify the "normal" days and hours in care for each enrolled participant
3. Identify the meals to be received by each enrolled participant

ADDENDUM TO ENROLLMENT FORM FOR CHILD CARE

Name of Child Care Facility

Instructions: This Addendum may be used to meet the enrollment data requirements of the Child and Adult Care Food Program as mandated by the Interim Rule issued on September 1, 2004, by the U.S. Department of Agriculture. The Addendum will be valid for one calendar year following the date of the parent or guardian's signature.

Participant Name: _____
Last First Middle Initial

Normal Days of Care (Circle as Appropriate):

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Normal Hours of Care during School Year: _____ to _____
_____ to _____

Normal Hours of Care during Summer: _____ to _____
_____ to _____

Meals to be Received (Circle as Appropriate):

Breakfast AM Supplement Lunch
PM Supplement Supper Evening Supplement

Parent/Guardian name: _____
Last First Middle Initial

Parent/Guardian Daytime Telephone Number: Area Code: _____ **Number:** _____

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

**CHILD AND ADULT CARE FOOD PROGRAM
SAMPLE PARENT/GUARDIAN LETTER FOR
NONPRICING CHILD CARE CENTER**

Dear Parent/Guardian:

This child care center participates in the Child and Adult Care Food Program (CACFP) administered by the Tennessee Department of Human Services and funded by the U.S. Department of Agriculture. The CACFP provides reimbursements to our facility for the costs of serving nutritious meals to all enrolled children. This allows our facility to better serve your child(ren).

As provided by the program's regulations, the amount of reimbursement which we may receive for our meal services is dependent upon the income eligibility of your child(ren). The eligibility categories for enrolled children are free, reduced-price and paid. The highest meal reimbursement is provided for children who are eligible for the free meal category. The lowest meal reimbursement is provided for children in the paid meal category. The eligibility of each enrolled child must be updated at least once each year.

To determine the amount of meal reimbursements to be received by our facility for your child(ren), we need your assistance. Copies of the income eligibility application and income guidelines for the reduced-price meal category are attached. Please complete and sign this application, and return it to our facility. Your application will be placed in a secured file at our facility and treated as confidential information. The application may be verified by authorized state and federal officials.

For clarification purposes in completing the application, "household" is defined as a group of related or non-related individuals (not residents of an institution or boarding house) who are living as one economic unit. If you have more than one child enrolled at our facility, please complete a separate application for each child.

If you now receive benefits under the Supplemental Nutrition Assistance Program, Families First Cash Assistance or Families First Child Care Assistance Programs for your child(ren), you do not have to enter any income information on the application. If these benefits are received, please only provide your case number(s) for these programs, and the name of your child who is enrolled at our facility. Please note that the receipt of Families First Child Care Assistance is identified by the code "FF" in the category section of the child care certificate. You are required to notify our facility if the benefits under the Supplemental Nutrition Assistance Program, Families First Cash Assistance or Families First Child Care Assistance Programs are terminated for your child(ren).

If you do not receive benefits under the Supplemental Nutrition Assistance Program, Families First Cash Assistance or Families First Child Care Assistance Programs, please provide income information for your household. Also, if codes of AR, TFF or CCD appear in the category section of your child care certificate(s), please provide the income information as requested on the application. The income to be reported on the application should include the gross income of all members of your household. If your household income is equal to or less than the attached income guidelines, your child(ren) are eligible for the free or reduced-price meal reimbursements. The loss of income through the unemployment of any members of your household may qualify your child(ren) for the free or reduced-price meal categories during the period of unemployment. In completing the attached application, please enter the names of all members of your household, the yearly amount of income each member.

Parent/Guardian
Date
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now receives and the source of the income, and the last four digits of the Social Security Number of the primary wage earner or the adult household member who signs the application. If the adult household member does not have a Social Security Number, please enter "none". Please be sure that an adult member of your household signs the application. To enter yearly income amounts, you will need to convert your income as follows: Multiple Weekly income by 52, Bi-weekly income (received every two weeks) by 26, Semi-monthly income (received twice a month) by 24, and Monthly income by 12. Do not round up any numbers during the conversion.

Foster children are categorically eligible for free meals. If your household has both foster and non-foster children, please include the foster child(ren) as household members, as well as any personal income earned by the foster child(ren), on the same household application that includes your non-foster child(ren). This may help your family's non-foster child(ren) to qualify for free or reduced price meals based on household size and income.

Federal law allows the sharing of the information on your income eligibility application with the Medicaid and State Children's Health Insurance Programs. At this time, no procedures are in place to disclose this information. Since the procedures to share this information with the Medicaid and State Children's Health Insurance Programs may be established in the future, please indicate if you do not want this information to be shared. The Medicaid and State Children's Health Insurance Programs can only use the information to identify children who may be eligible for free or low cost health insurance and to enroll them in either Medicaid or the State Children's Health Insurance Program. They are not allowed to use the information for any other purpose. If this information is not shared, it will not affect the eligibility of your child(ren) for free or reduced-price meals. If you do not want to share the information with the Medicaid and State Children's Health Insurance Programs, please indicate this decision by entering a check in Part 3 of the income eligibility application.

The meal services provided by our child care institution are available to all enrolled children regardless of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department in the Child and Adult Care Food Program. If you believe that you or your child(ren) have been discriminated against, you may file a grievance. The grievance procedures are attached. You may also immediately write to one or both of the following addresses:

U.S. Department of Agriculture
Director, Office of Adjudication
Whitten Building, Room 326-W
1400 Independence Avenue, SW
Washington, DC 20250-9410
(866) 632-9992
Telephone: (800) 877-8339, (800) 845-6136 (TDD and Spanish)

Tennessee Department of Human Services
Child and Adult Care Services
400 Deaderick Street
Nashville, Tennessee 37243-1403
Telephone (615) 313-4749

Parent/Guardian
Date
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You may also file a complaint with our institution.

Please return the completed and signed application by _____

to _____

Name of Authorized Official for Child Care Institution

Name of Child Care Institution

Street Address

City

State

Zip Code

Thank you for your cooperation.

Sincerely,

Name of Title of Facility Representative

Date

Attachments: Income Eligibility Application
 Income Eligibility Guidelines for Reduced-Price Meals
 Grievance Procedures

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**TENNESSEE DEPARTMENT OF HUMAN SERVICES (TDHS)
CHILD AND ADULT CARE FOOD PROGRAM (CACFP) AND
SUMMER FOOD SERVICE PROGRAM (SFSP)
CIVIL RIGHTS GRIEVANCE PROCEDURES
REVISED JULY 31, 2014**

In accordance with U.S. Department of Agriculture, Food and Nutrition Service Instruction 113.4, the Tennessee Department of Human Services provides a grievance procedure in the event a person believes he/she or their children have been discriminated against and/or denied benefits on the basis of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or if all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department (in the Child and Adult Care Food Program or Summer Food Service Program). *Not all prohibited bases will apply to all programs and/or employment activities.*

General Instructions

All complaints, written or verbal, alleging discrimination on the basis of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department (in the Child and Adult Care Food Program or Summer Food Service Program) shall be processed within ninety (90) days of receipt in the manner prescribed in this document.

Procedure for Filing Complaints of Discrimination:

1. Right to File a Complaint:

Any person alleging discrimination based on race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department has a right to file a complaint within 180 days of the alleged discriminatory action. Under special circumstances this time limit may be extended.

2. Acceptable:

All complaints, written or verbal, shall be accepted by the Tennessee Department of Human Services and forwarded to the U.S. Department of Agriculture. It is necessary that the information be sufficient to determine the identity of the CACFP or SFSP facility or individual toward which the complaint is directed, and to indicate the possibility of a violation. Anonymous complaints shall be handled as any other complaint.

3. Verbal Complaints:

In the event that a complainant makes the allegation verbally or through a telephone conversation and refuses or is not inclined to place such

allegations in writing, the person to whom the allegations are made shall document in writing the elements of the complaint for the complainant. Every effort shall be made to have the complainant provide the following information:

- a. Name, address, telephone number or other means of contacting the complainant;
- b. The specific location and name of the facility administering the Child and Adult Care Food Program or Summer Food Service Program;
- c. The nature of the incident(s) or action(s) that led the complainant to believe discrimination was a factor;
- d. The bases on which the complainant feels discrimination exists (i.e., basis of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department);
- e. The names, titles and addresses of the persons who may have knowledge of the discriminatory incident(s) or action(s); and
- f. The date(s) during the alleged discriminatory incident(s) or action(s) occurred, or if continuing, the duration of such discriminatory incident(s) or action(s).

For complaints other than discrimination complaints, please contact the director of the local facility operating the CACFP or SFSP, or submit the complaint in writing or by telephone to the following address and telephone number:

**Tennessee Department of Human Services
Child and Adult Care Services
400 Deaderick Street
Nashville, Tennessee 37243-1403
Telephone: (615) 313-4749**

**TENNESSEE DEPARTMENT OF HUMAN SERVICES
CHILD AND ADULT CARE FOOD PROGRAM (CACFP) AND
SUMMER FOOD SERVICE PROGRAM (SFSP)
CIVIL RIGHTS GRIEVANCE REPORT PROCEDURES**

To report alleged discrimination in the Child and Adult Care Food Program or Summer Food Service Program based on bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department, these are the guidelines listed. *Not all prohibited bases will apply to all programs and/or employment activities.* If you believe that you or your children have been discriminated against and/or denied benefits based on the above mentioned protected bases funded through the Department in the Child and Adult Care Food Program or Summer Food Services Program, please follow these procedures:

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form.

**You may also write a letter containing all of the information requested in the form.
Send your completed complaint form or letter to us by mail at**

**U.S. Department of Agriculture
Director of Office of Adjudication
1400 Independence Avenue, SW
Washington, D.C. 20250-9410**

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Relay Service at (800) 877-8339 or (800) 845-6136 (Spanish).

Information may be returned by fax to (202) 690-7442 or email at program.intake@usda.gov.
Telephone Toll Free (866) 632-9992 (Voice)*

Please provide the following information so you may be contacted concerning your complaint:

Name _____ Date of Complaint: _____
Address _____ Telephone _____

Identify the Name of the CACFP or SFSP Facility, Date(s) of Incident(s) or Action(s), and Name(s) of Facility Personnel Involved with Incident(s) or Action(s):

Describe the Incident(s) or Action(s) which You Believe Were Discriminatory Against You or Your Children:

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