



# NEW MEXICO

*Department of Children Youth and Families  
Family Nutrition Bureau  
1920 Fifth Street  
Santa Fe, New Mexico 87502*

**Child and Adult Care Food Program**

## **Management Plan**

**CACFP Plan for Administration of the Food Program**



**Form #A-2     CACFP MANAGEMENT PLAN INSTRUCTIONS**

Please include your agreement number on all pages (if you have one) and complete all items on pages 1-5. New applicants receive an agreement number when the organization is approved.

**ORGANIZATIONAL STRUCTURE SECTION:** *Responses to this section provide information about the organization that is responsible for administering the CACFP.*

1. List the official name of the organization that is formally incorporated and recognized by the IRS and NM Public Corporation Commission. This is the entity that will be listed on the W-9 form and is officially the party named in the agreement between CYFD and a sponsoring organization or independent center.
3. All organizations must furnish a DUNS number. If your organization does not have one you can request a number from the Dun and Bradstreet Corporation.
4. Official in Charge: Principal person who is authorized to make repayments to USDA, if the need arises; This is the person authorizing the organization to participate in CACFP. Typically this is the Owner if the organization is proprietary, the Chairman of the board of directors if the organization is private non-profit, For government organizations the person will vary depending on the structure. ie; Tribal Governor, Division Director or Department Head.
6. If Private Non-profit, 501(c)3 is checked for Non-profit organizations, please insure that all board of directors personal information is submitted on Form 001. Additional sheets may be used for additional board members as necessary.

**FINANCIAL VIABILITY SECTION** *The responses to this section establish the organization's financial viability in accordance with the requirements 7CFR 226.6(b)1(xviii) (A) Standard #1, Financial Viability and Financial Management.*

1. The organization must have an established 12 month period for tracking financial information such as income and expenses for the entire organization. Any 12 month period is acceptable and is referred to as the organization's fiscal year.
2.
  - a.) List Primary business activities the organization is engaged in: For example; Headstart, Child care, Afterschool programs, Emergency Housing, Education, Community Social Services, Community Development or Advocacy, Government, Youth recreation, or similar
  - b.) List main programs that provide the bulk of funding and effort for the organization
  - c.) Any other publically funded programs (city, county, state or federally funded operations)
  - d.) If there are any other publically funded programs the organization used to participate in during the past seven years that are not listed, please list those here.
3. Organizations receiving more than \$750,000 in federal funding are required to have an annual audit. This is usually referred to as a A-133 Audit or Single Audit. The results must be posted to the Federal Audit Clearing House website with 9 months of the end of the organization's fiscal year. A Program specific audit does not usually meet this qualification.

**PROGRAM ACCOUNTABILITY SECTION** *The responses to this section identify the organization's policies and procedures for checks and balances to ensure accountability in accordance with the requirements 7CFR 226.6(b)1(xviii)(C) Standard #3 Program Accountability*

1. Please attach copies of the organization's policies and procedures for processing payroll, purchasing, making payments to vendors, cash management & budget tracking.
3. List all sites currently operating where food service will be provided and complete a facility/site information page for each one. Include your policy on outside employment. The policy should explain under what conditions (if any) your organization allows employees to have second or part time jobs, what is allowed in terms of conducting unrelated business (sales, calls or other work) during hours of employment and in which cases employees would need to report conflicts of interest that might arise from additional employment including self-employment.

**ADMINISTRATIVE CAPABILITY SECTION:** *The responses to this section identify the organization's personnel and qualifications to administer the food program in accordance with the requirements 7CFR 226.6(b)1(xviii)(B) Standard #2 Administrative Capability*

3. Provide information on the years of experience that the Point of Contact or person in charge has had with administering publically funded programs of any kind.
4. Mark one box to indicate highest level of education for point of contact or person in charge
7. Provide information on who will be assigned to complete the various CACFP tasks listed. Complete the columns to arrive at a total dollar cost per person for the year. Total labor cost supported by CACFP should be included in the agency's budget request.
8. Training Plan: Complete items a)-e) to identify the plans for staff training to ensure compliance with program regulations. Training agenda developed by the state agency is Form #070

**DAILY OPERATIONS SECTION:** *The responses to this section identify the organization's policies and procedures that are in place to administer the food program in accordance with the requirements 7CFR 226.15, 16 & 17*

1. How is claim information collected? Daily?, weekly? Mailed?, Picked up? Hand delivered? faxed?
2. Mark one; If other, explain method in detail.
3. Mark one: POS is Point of Service: which means at the time the participants receive the meal. If other explain in detail how meal counts are taken to ensure accuracy.
6. How is meal service delivered? Unitized meals means all the components are given out together as a single unit. Cafeteria style means the items are served as the participant walk through a service line, Family style involves bowls or platters of food being passed around a table. If other is marked, provide specific details about the process; such as; cafeteria line plus self serve salad bar.

**NUTRITION EDUCATION:** Attach a completed Nutrition Education Planning Form unless the organization is an At Risk Supper/Snack Program or Emergency Housing Shelter.

(Please type your responses)

**For Administration of CACFP at Independent Centers and Sponsors of Centers**

1. **LEGAL NAME OF ORGANIZATION:** \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ County \_\_\_\_\_

Location: \_\_\_\_\_ Zip: \_\_\_\_\_

(Use if mailing address does not describe physical location)

2. **Number of centers/facilities under the organization's administration:** \_\_\_\_\_ **Years in business?** \_\_\_\_\_

3. Please provide the organization's Dun & Bradstreet (DUNS) Number \_\_\_\_\_

4. **OFFICIAL INFORMATION:** (Owner, Chairman of the Board/President, Dean, Tribal governor, Pastor, etc.)

Salutation: \_\_\_\_\_ Name: \_\_\_\_\_

Title: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**D.O.B** \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

(Note: Name of sponsor official must match the person providing claiming authorization on Certificate of Authority)

5. a). **PRINCIPAL ADMINISTRATOR OVERSEEING THE OPERATION OF THE CACFP:**

(This person must have attended a training session provided by the State Agency, and will receive all correspondence pertaining to CACFP operations) **Include a copy of training certificate**

Salutation: \_\_\_\_\_ Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**D.O.B** \_\_\_\_\_

Describe all duties assigned to this person: \_\_\_\_\_

b). **NAME OF REPRESENTATIVE(S) AUTHORIZED TO SUBMIT CLAIMS**

Full Name: \_\_\_\_\_

Full Name: \_\_\_\_\_

Full Name: \_\_\_\_\_

Full Name: \_\_\_\_\_

(Note: Name of representatives must be the same as on the Certificate of Authority)

6. **Organization Approval Type:**  **For - Profit** (Submit Form 055 TITLE XX Proprietary Certification Statement)

**Non - Profit** (if Private Non-profit, submit a copy of your 501(c)3 Notification Letter from IRS and Form 001 Board of Directors Information)

a) Non-Profit, Subtype:

Tribal – Attach copy of tribal letter

School Authority (Public, Private)

Government Entity

Private- Non Profit, 501-C-3 exemption

**Financial Viability**

1. Give a start date DD/MM\_ and end date DD/MM\_ of the organization's fiscal year
2. a) List the primary business activities of the organization:
  - b) List all Major Programs the organization is operating: \_\_\_\_\_
  - c) List all publicly funded programs that the organization is currently participating in not listed in b) above.
   
\_\_\_\_\_
   
\_\_\_\_\_
   
\_\_\_\_\_
  - d) List ANY additional publicly funded programs that the organization has participated in during the past seven (7) years that were not been listed above.
   
\_\_\_\_\_
   
\_\_\_\_\_
   
\_\_\_\_\_
3. Has the organization received \$750,000 or more in Federal, State or Local Public funds during the past fiscal year?  Yes  No
   
If Yes, what was the date of the last OMB-A133 or single audit? \_\_\_\_\_ What fiscal period was covered?
   
DD/MM/YY \_\_\_\_\_ to DD/MM/YY \_\_\_\_\_
4. Has the organization ever filed for bankruptcy?  Yes  No If yes provide details \_\_\_\_\_
   
\_\_\_\_\_
5. How are Accounting functions accomplished by the organization?
   
 Contract w/ CPA firm,  Internal Accounting Dept.,  Self-Managed,  Other; If other please describe: \_\_\_\_\_
6. Which method of accounting does the organization use?  Cash  Accrual
7. Private non-profit 501 (c) 3 organizations that are not church affiliated or otherwise exempt please attach a copy of your most recent IRS 990 Report
8. All organizations except government agencies, public colleges, universities and schools please include a copy of your Profit and Loss Statement for the most recent complete 12 month fiscal year and a copy of the organization's bank statement from last month.

**Checks & Balances to Insure Accountability**

1. Attach a copy of the organization's policies which describe the checks and balances in place to ensure program accountability; Please include policies for payroll processing, purchasing, vendor payments, cash management, & budget tracking
2. Private Non-Profit [501 (c) 3 Organizations] Attach Board of Directors Information Form 001 and copy of most recent board meeting minutes.

3. Sponsors of multiple sites Attach the Multiple Site Addendum Form # 002 which includes monitoring schedule and copy of your organization's outside employment policy.
4. Proprietary Organizations; Attach an Organizational Chart.
5. Government Organizations: Please list names of individuals and their titles in the chain of command up 3 levels from the center director or Point of Contact (POC)
  - a.) POC or Center Director a.) \_\_\_\_\_
  - b.) POC/Center Director's supervisor b.) \_\_\_\_\_
  - c.) Person b's supervisor c.) \_\_\_\_\_
  - d.) Person c's supervisor d.) \_\_\_\_\_

**Administrative Capability**

1. Point of contact (POC) for FNB: \_\_\_\_\_ Title: \_\_\_\_\_

2. How many years of experience has the POC had with administering the CACFP?

Number of years	Location	CACFP Duties

3. How many years has POC administered publicly funded programs of any kind?

Number of years	Location	Name of Program and Duties

4. Please provide information on highest level of Education for POC:

- High School/GED,
  Vo-Tech / Post High
  AA,
  BA/BS,
  MA/MS,
  PhD/MD

5. Most recent CACFP training from state agency was completed on \_\_\_\_\_

6. Who will be responsible for notifying the state agency of changes? \_\_\_\_\_

7. Organizational structure for CACFP administration

List ONLY the personnel who will be administering the Child & Adult Care Food Program in this table, Attach additional sheets if necessary.

Yearly conversion for total salary: (Hr per Day) x (Hrly Wage) x (# of Day per week) x (# of wks in Operation)

CACFP Duties/Responsibilities Name of person(s) assigned to perform the following duties.	Is this person being claimed for labor cost from CACFP funds?	Number of hours per day spent on CACFP	Hourly Wages	Number of Days per Week	Number of Weeks in Operation	Total Labor Cost for Program Year	Total Labor Cost Supported by CACFP	Total Cost Funded by Other Source
Overseeing CACFP, Contact for State Agency	-					0.00		0.00
Conducts Monitoring of Facilities	-					0.00		0.00
Conducts Staff Training	-					0.00		0.00
Prepares & Submits Claims	-					0.00		0.00
Tracks Receipts, Monitors Budget, & Accounting	-					0.00		0.00
Menu Planning	-					0.00		0.00
Other Duties- specify	-					0.00		0.00
<b>Sub-total Admin Labor Cost</b> for salaries for program year.....						<b>0.00</b>		<b>0.00</b>

CACFP ADMIN LABOR COST request for program year .....  
(Must include this amount on Proposed Budget Line Item III. a)

0.00
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**Note:** The primary purpose of the CACFP is to provide reimbursement for food expenses, but a portion of your annual budget may be applied toward related program expenses (For example, administrative salaries, office supplies, training materials, etc.).

8. a) Outline of **Training Plan for all CACFP staff**, administrative and food service personnel listed on (CACFP Site Info page 2 of 2). Training must consist of civil rights and CACFP requirements. [**Specify training date(s) and check all topics being covered**] this does not include CACFP training provided to the sponsor by the State Agency.

b) Planned training Date(s): \_\_\_\_\_

c) Who will conduct the training session(s)? [*Person(s) must have attended State Agency Training*]  
\_\_\_\_\_

d) Topics to be covered (please check all that apply or indicate you are using the state agency developed agenda):

- |   |  |
|---|--|
| <input type="checkbox"/> Menu Record Book- food production              | <input type="checkbox"/> Monitoring Center Facilities        |
| <input type="checkbox"/> Meal Counts & Attendance                       | <input type="checkbox"/> Family Style Dining                 |
| <input type="checkbox"/> Income Eligibility Applications                | <input type="checkbox"/> Financial – Claim for reimbursement |
| <input type="checkbox"/> Nutrition Education                            | <input type="checkbox"/> Civil rights                        |
| <input type="checkbox"/> Income & Expense Tracking – Receipts, Invoices | <input type="checkbox"/> State Agency developed Agenda       |
| <input type="checkbox"/> Menu planning, Meal Pattern & Creditable foods |  |

e) Any other topics or plans (please specify):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Daily Operations of CACFP**

1. Describe the process for collecting claim information each month. \_\_\_\_\_
2. Method for taking daily attendance:  Electronic system,  Parent sign-in,  Staff sign-in,  Student sign-in, Other Describe: \_\_\_\_\_
3. Method of taking meal counts:  Manual POS,  Electronic system:  Other \_\_\_\_\_
4. Meal Preparation method:  Self Prep,  Central Kitchen,  Vended,  Food Service Management Co, Limited Foodservice
5. Documentation of Meal Eligibility:  MRB,  Delivery Tickets,  Portioned menu,  Other: \_\_\_\_\_
6. Meal Service;  Unitized,  Cafeteria service,  Family Style dining,  Combination of styles, OR Other  Describe \_\_\_\_\_
7. How will IEAs be processed?  One time a year compilation (for October)  Re-calculate every month?
8. Please enclose a copy of enrollment policies and procedures.
9. Anticipated date of begining CACFP operations? -

**Nutrition Education**

Child care Centers, Head Start Programs, Preschools, Pre-K, Kindergarten, Before and After school programs and Adult day care facilities, please enclose a copy of your Nutrition Education Activity Planning Form. At-Risk, and Emergency Housing Shelters are exempt from this requirement.

\*\*\*\*\* (Please certify form by signing below) \*\*\*\*\*

**I CERTIFY THAT** the information on this application is true to the best of my knowledge; that reimbursement will be claimed only for eligible meals served to eligible participants and; that the CACFP will be available to all enrolled participants regardless of race, color, national origin, sex, age, disability or previous civil rights activities. I, further certify the organization has not been terminated from any publicly funded program for failure to comply with program requirements within the past 7 years.

**I UNDERSTAND THAT** this information is being given in connection with the receipt of Federal funds, and that a deliberate misrepresentation may subject me to prosecution under applicable State and federal criminal statutes.

**I CERTIFY THAT** no board members or principals of the organization have been convicted of a crime which would indicate a lack of business integrity at any time during the past 7 (seven) years.

\_\_\_\_\_  
Name and Title of Authorized Sponsoring Organization Representative (print or type)

\_\_\_\_\_  
Signature of Authorized Organization Representative

\_\_\_\_\_  
Date