

Child and Adult Care Food Program

New Center Application   
 Renewal Application

Type or print clearly

Facility Site Information

INSTRUCTIONS: (Complete one form for each Center/Facility location)

1. NAME OF CENTER/SITE:	Agreement Number:
2. MAILING ADDRESS	CITY
	STATE
	COUNTY
	ZIP
<b>PHYSICAL LOCATION:</b> <i>Please give specific directions or enclose a map. (No P.O. Box numbers please)</i>	

3. NAME & TITLE OF PERSON IN CHARGE AT THE FACILITY:

E-mail:

Telephone Number at the Center:

4. APPROVAL TYPE:

State Licensed  Tribal  Public School

Military  Exempt

5. TYPES OF CARE at this CENTER- Check all that apply

Child Care Center or Preschool

Head Start

Pre-K Program

Emergency Shelter-serving homeless children

"At Risk" After School Program

Outside School-hours/Before & After School Program

Adult day care center

Hospital or Clinic

Other Specify-

6. LICENSE NUMBER: \_\_\_\_\_ (Attach Copy)

Expiration Date: \_\_\_\_\_ Capacity: \_\_\_\_\_

7. ATTACH CURRENT ENVIRONMENT DEPT PERMIT AND SURVEY REPORT

Permit Attached  No Permit

Survey Report Attached  No Current Inspection

8. MEAL PREPARATION METHOD  Limited Foodservice

Self-Prep on site w/ permit  Vended contract (attach)

Central Kitchen; Delivery  Other

Shared Kitchen: Plate cost  FSMC

Name of company \_\_\_\_\_

10. MONTHS OF OPERATION:

JAN  FEB  MAR  APR  MAY  JUN

JUL  AUG  SEPT  OCT  NOV  DEC

11. DAYS OF THE WEEK & HOURS OF OPERATION

	Opening time	Closing time
<input type="checkbox"/> Monday		to
<input type="checkbox"/> Tuesday		to
<input type="checkbox"/> Wednesday		to
<input type="checkbox"/> Thursday		to
<input type="checkbox"/> Friday		to
<input type="checkbox"/> Saturday		to
<input type="checkbox"/> Sunday		to
<input type="checkbox"/> Check here if center is open 24 hrs/day 7 days a week		

**[Attach separate page with information if meal service is provided by more than one method (both vended & self prep for example)]**

12. MEAL SERVICE

	TIME MEAL SERVICE BEGINS	TIME 1ST SHIFT BEGINS	TIME 2ND SHIFT BEGINS
<input type="checkbox"/> Breakfast, 7:00-9:00 am	_____	_____	_____
<input type="checkbox"/> AM Snack, 9:00-11:00 am	_____	_____	_____
<input type="checkbox"/> Lunch, 11:00 am- 1:00 pm	_____	_____	_____
<input type="checkbox"/> PM Snack, 1:30-4:30 pm	_____	_____	_____
<input type="checkbox"/> Supper, 5:00-7:00 pm	_____	_____	_____
<input type="checkbox"/> Late Snack, 7:00-9:00 pm	_____	_____	_____

Shifts?  No  YES \*\* (list each shift beginning time)

At Risk Facilities serving outside of normal range; Please list start times: Snack Supper

13. NUMBER OF PARTICIPANTS ENROLLED

Free Category \_\_\_\_\_

Reduced Price Category \_\_\_\_\_

Not Eligible for Free or Reduced Price \_\_\_\_\_

**Total Number of Enrolled Children** \_\_\_\_\_

CYFD Child Care Assistance Programs \_\_\_\_\_

14. AGE RANGE OF ENROLLED PARTICIPANTS

From: \_\_\_\_\_ To: \_\_\_\_\_

Do you have infants enrolled at the center?  NO  YES

If yes, do you claim infants?  NO  YES

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

\_\_\_\_\_  
SIGNATURE OF CENTER REPRESENTATIVE

\_\_\_\_\_  
DATE

**INSTRUCTIONS:** (Complete one form for each Center Facility)

**CENTER/SITE:** \_\_\_\_\_  
**NAME & TITLE OF PERSON IN CHARGE:** \_\_\_\_\_

**Operational expenses for labor costs to provide food services**

(List ONLY the personnel who will be assigned duties in the Child & Adult Care Food Program, Attach additional sheets if necessary.)  
Submit a copy of the organizational structure chart if needed for clarification.

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

<u>CACFP Duties/Responsibilities</u> Name of person(s) assigned to perform these 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	<b>Total Labor Cost for Program Year</b>	Total Labor Cost Supported by CACFP	Total Cost Funded by Other Source
<u>Menu Planning</u>								
<u>Prepares Food for the Center</u>								
<u>Completes the Menu Record Book</u>								
<u>Ordering and/or Purchasing of Groceries</u>								
<u>Approves and Tracks IEA's</u>								
<u>Conducts Monthly Nutrition Education Activity</u>								
<u>Takes Meal Counts/Attendance</u>								
<u>If applicable, (oversee vended meals contract).</u>								
<u>Other Duties- specify</u>								
<u>Other Duties- specify</u>								
<u>Other Duties- specify</u>								
<u>Other Duties- specify</u>								
<b>Total Labor Cost [Sum] sub-total salaries for program year.....</b>								

**CACFP OPERATING LABOR COST:** Request for program year .....   
 (Include this amount on the Proposed Budget "Operational Labor" line item)

*Organizations with Multiple-Centers must sum-up all CACFP Operating Labor Costs for all sites before including the requested amount on the Proposed Budget Operational Labor line item:*

**Note:** The primary purpose of the CACFP is to provide reimbursement for food expenses. FNB approves up to 40% of the annual reimbursement for operational labor expenses such as cook's and/or cooks helper's salaries).