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|  ORGANIZATION NAME (AS REGISTERED WITH SECRETARY OF STATE)      |
| STREET ADDRESS OF ORGANIZATION      |
| CITY      | STATE       | ZIP CODE      | COUNTY      |
| CONTACT NAME      |
| EMAIL ADDRESS      | PHONE NUMBER   /   -     |
| SELECT THE IRS STATUS OF YOUR ORGANIZATION[ ]  PUBLIC [ ]  FOR PROFIT [ ]  NONPROFIT [ ]  N/A GOVERNMENT, PUBLIC SCHOOL OR UNIVERSITY |
| WHAT IS YOUR FEDERAL EMPLOYER INDENTIFICATION NUMBER (FEIN)?      |
| DOES THIS ORGANIZATION CURRENTLY PARTICIPATE ON CACFP THROUGH ANOTHER SPONSORING ORGANIZATION?[ ]  YES [ ]  NOIF YES, NAME OF ORGANIZATION        |
| DOES THIS ORGANIZATION CURRENTLY PARTICIPATE IN SFSP?[ ]  YES [ ]  NO |
| HOW LONG HAS YOUR PROGRAM BEEN OPERATING?      |
| HOW MANY CENTERS/SITES DO YOU PLAN TO OPERATE ON THE CACFP?      |
| MARK THE STATEMENT THAT BEST DESCRIBES YOUR ORGANIZATION. PLEASE INCLUDE NUMBER OF CENTERS/SITES FOR EACH TYPE. MARK ALL THAT APPLY.[ ]  CHILD CARE CENTER      [ ]  ADULT DAY CARE CENTER      [ ]  EMERGENCY SHELTER      [ ]  AT-RISK AFTERSCHOOL PROGRAM      [ ]  OUTSIDE SCHOOL HOURS CARE CENTER       |
| DOES THIS ORGANIZATION CURRENTLY PARTICIPATE ON CACFP OR SFSP IN ANOTHER STATE?[ ]  YES [ ]  NOIF YES, SPECIFY STATE       |
| **STEP 2: CENTER/SITE ELIGILITY QUESTIONNAIRE FOR EACH CENTER/SITE** |
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| PLEASE NOTE, AS PART OF THE CACFP APPLICATION, SPONSOR WILL BE REQUIRED TO PROVIDE DOCUMENTATION OF FINANCIAL VIABILITY, ADMINSITRATIVE CAPABILITY, AND PROGRAM ACCOUNTABILITY. |
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| **YOU MUST SUBMIT COMPLETED POTENTIAL NEW SPONSOR QUESTIONNAIRE AND CENTER/SITE ELIGIBILITY QUESTIONNAIRE FOR EACH CENTER/SITE TO** **CACFP@HEALTH.MO.GOV** |
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