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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  NO  IF 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  NO  IF 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**](mailto:CACFP@HEALTH.MO.GOV) | | | |
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