# APPLICATION FOR PARTICIPATION IN THE CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

| NAME OF FACILITY (CHECK IF NEW OR RE-APPLYING) | ☐ NEW FACILITY<br>☐ RE-APPLYING FACILITY | FOR PARTICIPATING FACILITIES ONLY<br>CURRENT CONTRACT NUMBER | FOR MDHSS USE ONLY<br>NEW CONTRACT NUMBER |
|---|---|---|---|
| | | | |

| STREET ADDRESS OF FACILITY | MAILING ADDRESS OF FACILITY (IF DIFFERENT FROM STREET ADDRESS) |
|---|---|
| | |

| CITY | STATE | ZIP CODE | COUNTY |
|---|---|---|---|
| | | | |

| TELEPHONE NUMBER OF FACILITY | FAX NUMBER OF FACILITY | EMAIL ADDRESS |
|---|---|---|
| (  ) | (  ) | |

NAME OF ORGANIZATION SPONSORING THIS FACILITY (IF APPLICABLE). DO NOT COMPLETE THIS SECTION IF THE CENTER IS PARTICIPATING IN THE CACFP INDEPENDENTLY.

IS THIS FACILITY LICENSED BY (CHECK ONE) (DOES NOT APPLY TO EMERGENCY HOMELESS SHELTERS OR AT-RISK PROGRAMS.)

☐ DEPARTMENT OF HEALTH AND SENIOR SERVICES-BUREAU OF CHILD CARE
☐ DIVISION OF AGING
☐ FEDERAL AGENCY (SPECIFY):_____
☐ UNLICENSED OR LICENSE-EXEMPT

IF THIS FACILITY IS NOT LICENSED BY ANY STATE OR FEDERAL AUTHORITY, IS THE FACILITY LICENSE-EXEMPT BY RELIGIOUS OR NURSERY SCHOOL AND INSPECTED BY THE BUREAU OF CHILD CARE TO MEET MINIMUM HEALTH AND SAFETY STANDARDS?

☐ YES ☐ NO (INCLUDE A COPY OF YOUR DC-100 – LICENSE EXEMPT HEALTH AND SAFETY CHECKLIST).

| LICENSE OR LICENSE-EXEMPT NUMBER | EXPIRATION DATE | LICENSE CAPACITY | AGE RANGE OF PARTICIPANTS<br>FROM TO |
|---|---|---|---|
| | | | |

IS THIS FACILITY AUTHORIZED TO PROVIDE OVERLAP CARE?

☐YES ☐**NO (INCLUDE A COPY OF YOUR OVERLAP AUTHORIZATION – FORM DC-16 CHILD CARE FACILITY OVERLAP REQUEST).**

**ENROLLMENT DATA** (indicate the number of participants enrolled by claiming category. If you are a newly participating center, please estimate).

| A. FREE CATEGORY | B. REDUCED PRICE CATEGORY | C. NOT ELIGIBLE FOR FREE OR REDUCED | D. TOTAL NUMBER OF PARTICIPANTS ENROLLED (A+B+C) |
|---|---|---|---|
| | | | |

**OPERATING DATA**

| HOURS OF OPERATION | DAYS OF OPERATION (circle all days the center will be open and serving meals) | LIST ANY MONTHS THE CENTER IS NOT IN OPERATION |
|---|---|---|
| FROM _____ TO_____ | M T W Th F S Su | |

**MEALS FOR WHICH REIMBURSEMENT IS REQUESTED** (a center may claim up to two meals and one snack per participant per day. Emergency homeless shelters may claim up to three meals per day. At-Risk After School programs may claim only after school supper and/or p.m. snack. )

| Check the meals and snacks to be claimed. | ☐ BREAKFAST | ☐ AM SNACK | ☐ LUNCH | ☐ PM SNACK | ☐ SUPPER | ☐ EVENING SNACK |
|---|---|---|---|---|---|---|
| BEGIN TIME | | | | | | |
| END TIME | | | | | | |

Note: Breakfast and snack may take no more than one hour from start to finish. Breakfast may not be served after 10:00 a.m. Lunch and supper may take no more than two hours from start to finish. Lunch may not be served before10:00 a.m. and must be over by 2:00 p.m. Supper may not begin before 4:30 p.m., except in At-Risk After School Programs. At-Risk After School programs must allow 2-1/2 hours between the start of the supper meal service and the start of the snack meal service, or vice versa, if both meal and snack are served.

**METHOD BY WHICH MEALS WILL BE PROVIDED: (check one)**

☐ PREPARATION AT MEAL SERVICE LOCATION (meals are prepared in the center where care is provided).

☐ PREPARATION AT A CENTRAL KITCHEN (meals are prepared in a kitchen off-site from the facility, and may be provided to two or more facilities).

☐ UNDER AGREEMENT WITH A LOCAL SCHOOL THAT PARTICIPATES IN THE NATIONAL SCHOOL LUNCH PROGRAM (submit a copy of the agreement.)

☐ UNDER CONTRACT WITH A FOOD SERVICE MANAGEMENT COMPANY, CATERER, HOSPITAL OR NURSING HOME (Contact MDHSS for information on procuring contracts for food service. Submit a copy of any current food service contract).

IS THIS A PRICING OR NONPRICING PROGRAM?

☐ **PRICING PROGRAM**: The center charges a fee, separate from tuition, for meals in order to make up the difference between the reimbursement provided by the CACFP and the actual cost of serving the meals. (Pricing programs must contact MDHSS for more information regarding charges for meals.)

☐ **NON-PRICING PROGRAM**: Families pay a general tuition charge that covers all areas of child or adult care services provided by the facility, including the meals. There is no separate identifiable charge for the meals.

**TYPE OF FACILITY (Only one box in this section may be checked. Be sure to choose the correct box under the appropriate heading).**

**CHILD CARE CENTER**

☐ NONPROFIT CHILD CARE CENTER OR LICENSE-EXEMPT CHILD CARE CENTER [must be tax-exempt by the Internal Revenue Service (a 501c(3) organization) or owned and operated by a faith-based organization or nursery school.] **Submit a copy of your 501c(3) letter.**

☐ FOR PROFIT CHILD CARE CENTER [must be receiving state child care subsidy money from the Division of Family Services for at least 25% of enrolled children or 25% of license capacity, whichever is less; or have 25% of enrolled children eligible for free or reduced-price meal reimbursement].

☐ HEAD START CENTER

☐ EMERGENCY OR HOMELESS SHELTER

☐ GOVERNMENT OPERATED CHILD CARE CENTER

**OUTSIDE SCHOOL HOURS CARE CENTER**

☐ NONPROFIT OUTSIDE SCHOOL HOURS CARE CENTER [a center that only cares for children before or after school, and is a tax-exempt 501c(3) organization].

☐ FOR-PROFIT OUTSIDE SCHOOL HOURS CARE CENTER [must be a for-profit center caring for children before and after school and must be receiving state child care subsidy money from the Division of Family Services for at least 25% of enrolled children or 25% of license capacity, whichever is less].

☐ NONPROFIT AT-RISK AFTER SCHOOL PROGRAM [center must be located in an area served by a school where 50% or more of children enrolled in that school are eligible for free or reduced price school lunches. Must be a tax-exempt 501c(3) organization].

☐ FOR-PROFIT AT-RISK AFTER SCHOOL PROGRAM [must be caring for children in an at-risk setting, as described above, and must be receiving state subsidized child care payments from the Division of Family Services for at least 25% of enrolled children or 25% of license capacity, whichever is less; or have 25% of enrolled children eligible for free or reduced-price meal reimbursement].

☐ GOVERNMENT OPERATED AT-RISK AFTER SCHOOL OR OUTSIDE SCHOOL HOURS PROGRAM

**ADULT DAY CARE CENTER** [Adult day care centers may not receive Title III of the Older Americans Act funding if participating in the CACFP].

☐ NONPROFIT ADULT DAY CARE CENTER [must be a licensed, tax-exempt, 501c(3) organization, caring for adults in a nonresidential setting].

☐ FOR-PROFIT ADULT DAY CARE CENTER [must be receiving Title XX or Title XIX payments for at least 25% of enrolled adults in a nonresidential setting].

HAVE YOU EVER BEEN FOUND TO BE IN NONCOMPLIANCE OF THE CIVIL RIGHTS LAWS BY ANY FEDERAL AGENCY?

☐ YES ☐ NO

| IS THIS FACILITY MINORITY OWNED AND OPERATED? | IS THIS FACILITY A REGISTERED WOMAN OWNED AND OPERATED FACILITY? |
|---|---|
| ☐ YES ☐ NO | ☐ YES ☐ NO |

DOES THE FACILITY WISH TO RECEIVE ADDITIONAL (CHECK ONE)

☐ CASH REIMBURSEMENT OR ☐ USDA COMMODITIES

**CIVIL RIGHTS REVIEW (MUST BE COMPLETED BY FIRST TIME APPLICANTS)**

Collection of racial/ethnic data is for statistical reporting and in no way affects program participation. For information on the racial/ethnic make-up of your area, check with the local Chamber of Commerce, the public library, or the public school system in your area. For racial/ethnic make-up of the participants in the facility, use visual identification or parental report to determine the racial/ethnic category.

| | PERCENT RACIAL/ETHNIC MAKE-UP OF THE POPULATION OF THE AREA TO BE SERVED. | ACTUAL NUMBER OF PARTICIPANTS ENROLLED IN THE CENTER BY RACIAL/ETHNIC CATEGORY. |
|---|---|---|
| AMERICAN INDIAN OR ALASKAN NATIVE | % | |
| ASIAN | % | |
| BLACK OR AFRICAN AMERICAN | % | |
| NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER | % | |
| WHITE | % | |
| | | |
| WITHIN EACH CATEGORY ABOVE, INDICATE HOW MANY ARE OF HISPANIC OR LATINO ETHNICITY | | |

**BOARD MEMBERS, OWNERS, DIRECTORS, AND OTHER ORGANIZATION PRINCIPALS**

IN THE TABLE BELOW, LIST ALL BOARD MEMBERS, OWNERS, EXECUTIVE DIRECTORS, DIRECTORS AND OTHER PRINCIPALS OF THE ORGANIZATION, WHO ARE RESPONSIBLE FOR THE FINANCIAL VIABILITY AND ACCOUNTABILITY OF THE ORGANIZATION. ATTACH ADDITIONAL SHEETS IF NECESSARY.

| NAME OF INDIVIDUAL | TITLE/POSITION | ADDRESS | DATE OF BIRTH (required) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**AT-RISK AFTER SCHOOL PROGRAMS:**

| NAME OF THE SCHOOL DISTRICT WHERE AFTER SCHOOL PROGRAM IS LOCATED: | NAME OF ELEMENTARY SCHOOL CLOSEST TO PROGRAM LOCATION: |
|---|---|
| | |

ARE EDUCATIONAL AND/OR ENRICHMENT ACTIVITIES PROVIDED AS PART OF THIS AFTER SCHOOL PROGRAM? ☐ YES ☐ NO

**SIGNATURE**

SIGNATURE BY THE AUTHORIZED REPRESENTATIVE (S) BELOW CERTIFIES THAT:

A. The information on the application is true and correct to the best of my knowledge.

B. The authorized representative(s) accept final administrative and financial responsibility for the total CACFP operation at the facility, if not under a sponsoring organization.

C. Reimbursement will be claimed only for meals and snacks served to enrolled participants.

D. Department officials may verify information.

E. The authorized representative(s) understand that information is being given in connection with the receipt of federal funds, and that deliberate misrepresentation may subject the authorized representative(s) to prosecution under applicable state and federal criminal statutes.

F. The above named facility assures that all participants enrolled in the facilities described on the application form are served the same meals regardless of race, color, national origin, age, sex, or disability, and there is no discrimination in the course of the meal service.

G. For pricing facilities, meals will be available to all enrolled participants. A separate charge will be made for the meals. For non-pricing facilities, meals will be made available to all enrolled participants at no separate charge.

H. All materials related to the program will contain the following nondiscrimination statement and complaint procedures:

- *In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.*
- *To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.*

I. The above named center or facility, and any of its directors, owners, board members, or other principals of the organization, have not been disqualified from participation in any publicly funded program for violating that program's requirements during the past seven years.

J. During the past seven years, the board members, owners, directors, or other principals of the organization have not been convicted of any crime indicating a lack of business integrity, such as fraud, antitrust violations, theft, forgery, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, obstruction of justice or any other activity indicating a lack of business integrity as determined by the state agency .

K. If the sponsoring organization is a for-profit organization, the centers under its sponsorship share the same legal entity as the sponsoring organization.

L. Only for-profit centers meeting the 25% standard will submit a claim for reimbursement, or will be included in the sponsoring organization's claim for reimbursement. The institution or the sponsoring organization will indicate on the monthly claim the total number of participants which are Title XX and/or Title XIX beneficiaries.

| SIGNATURE OF OWNER OR BOARD PRESIDENT | | SIGNATURE OF CENTER DIRECTOR OR OTHER AUTHORIZED REPRESENTATIVE (person authorized to sign CACFP claims for reimbursement) | |
|---|---|---|---|
| TITLE/POSITION | DATE | TITLE/POSITION | DATE |
| PRINT OR TYPE NAME OF OWNER OR BOARD PRESIDENT | | PRINT OR TYPE NAME OF CENTER DIRECTOR OR OTHER AUTHORIZED REPRESENTATIVE | |
| SOCIAL SECURITY NUMBER (OPTIONAL) | DATE OF BIRTH (REQUIRED) | SOCIAL SECURITY NUMBER (OPTIONAL) | DATE OF BIRTH (REQUIRED) |

**MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES USE ONLY**

| APPROVED BY: | TITLE | DATE | EFFECTIVE DATE |
|---|---|---|---|
| | | | |