

Table of Contents

2017 Missouri SFSP Resources	1
Sponsor Application and Budget	4
Site Information Sheet	10
Medical Food Substitution Record	13
Network User Access Request	14
Policy Statement	15
Vendor Input ACH-EFT Application	17
Documentation of Training	19
Pre-Operational Site Review	20
Daily Meal Count Form	21
Weekly Consolidated Meal Count	23
Site Meal Consolidation Form	24
Self Prep Monitoring Site Review	26
Vended Monitoring Site Review	28
Menu-Meal Requirements	30
Food Chart	31
Four Components	32
Meal Pattern Substitution	33
CN Labels and Product Formulation Statement	35
Production Records	37
Allowable Costs	38
Program Cost Report	39
Updating Changes to CNP Web	40
Requesting Advances for SFSP	41
Corrective Action Plan Process	42
SFSP CAP Form	43
Appeal Procedures	44

Missouri Summer Food Service Program (SFSP) Resources

To get an SFSP application packet, go to <http://www.health.mo.gov/sfsp>, click on “Applications and Forms” to download “the entire SFSP application packet in one file” or call the toll-free number, 888-435-1464, to request via mail, fax or email.

Application Deadlines (for complete applications only)

- By April 1, if you want commodities delivered in May.
- By May 2, if you want commodities delivered in June.
- By May 2, if requesting a June advance.
- The final deadline for a completed application is **NO LATER THEN MAY 15 AND AT LEAST 30 DAYS PRIOR TO THE FIRST DAY OF OPERATION.**
 - For example, if SFSP operations begin June 2, a completed application is due no later than May 1.

Please submit your application to the following address by the deadline date that applies to you. (Dates are listed in the application cover letter). Be sure to keep a copy of the application for your records. Please ensure all questions are complete and all forms have been signed and dated.

Applications missing question responses, signatures, and dates are not considered submitted for SFSP.

Missouri Department of Health and Senior Services
Bureau of Community Food and Nutrition Assistance
930 Wildwood
P.O. Box 570
Jefferson City, MO 65102
or via fax to: 573-526-3679

Use this checklist to ensure all required items are enclosed with your application packet.

- ☐ Form CACFP 1000 Sponsor Application (6 pages)
Ensure that the name on the Sponsor Application is an **exact** match to your business title with the Secretary of State.
<https://bsd.sos.mo.gov/BusinessEntity/BESearch.aspx?SearchType=0>
- ☐ Form CACFP 1001 Site Information Sheet (3 pages) (one for each meal site)
- ☐ Form CACFP 1011 Policy Statement for New Sponsors (2 pages)
- ☐ Form BMA Business Management Analysis
<https://health.mo.gov/atoz/bma/index.php>
The BMA is required to be submitted each January 1, for all sponsors.
- ☐ SFSP Web-Access Form Provides User ID and Password for SFSP database

- | | | |
|--------------------------|---------------|--|
| <input type="checkbox"/> | Form SAMII | Vendor Input/ACH-EFT Application (direct deposit form) |
| <input type="checkbox"/> | FSMC Contract | Required only for Sponsors with Vended/Catered Meals
Contracts under \$150,000 go
to: http://health.mo.gov/living/dnhs_pdfs/R_SFSP_FSMC_less_than.pdf
Contract over
\$150,000: http://health.mo.gov/living/dnhs_pdfs/R_SFSP_FSMC_more_than.pdf |
| <input type="checkbox"/> | IRS Letter | Non-Profit Organizations submit copy of IRS letter |
| <input type="checkbox"/> | Rates | SFSP Rates: http://health.mo.gov/living/dnhs_pdfs/R_SFSP_rates.pdf |

Things to Watch

- Make sure all blanks are completed.
- Submit eligibility documentation for each open site.
- Retain a copy of your SFSP application for your files.
 - If you fax the application, retain the original as your file copy.
 - If you mail the application to DHSS, you should make a copy for your records.

Once approved, submit to DHSS with a signed contract.

- | | | |
|--------------------------|----------|---|
| <input type="checkbox"/> | DUNNS | DUNNS (4 pages) |
| <input type="checkbox"/> | E-Verify | E-Verify: https://www.uscis.gov/e-verify |
-

Use this checklist to ensure sites are ready for operation.

- | <input type="checkbox"/> | <u>Form Name/Number</u> | <u>Description</u> |
|--------------------------|-----------------------------|--|
| <input type="checkbox"/> | Documentation of Training | Required before start of program operations. Kept onsite for DHSS review. |
| <input type="checkbox"/> | Pre-Operational Site Review | Sponsors are required to complete for each new site prior to application submission and kept onsite for DHSS review. |
| <input type="checkbox"/> | And Justice for All Poster | Must be displayed in a prominent location at each site where it can be easily viewed.
http://www.fns.usda.gov/cr/and-justice-all-posters |
| <input type="checkbox"/> | Sponsor/Site Agreement | Before adding a new site, ensure you obtain a sponsor site agreement. |

<input type="checkbox"/>	Daily Meal Count Form	Completed at the point of service for each meal. Must be dated and kept with monthly records.
<input type="checkbox"/>	Medical Food Substitution Form	Have a few copies available for participants with allergies and/or special dietary needs.
<input type="checkbox"/>	1 st & 4 th Week Site Review Form (self-prep and vended sites)	Sponsors are required to conduct reviews during the 1 st and 4 th weeks. There is also space to record your beneficiary data, which is required annually.

Useful Forms and Additional Information

- Menu-Meal Requirements
 - Food Chart
 - Four Components in Menu Planning
 - Meal Pattern Substitution
 - Child Nutrition (CN) Label
 - Food Production Record
 - Allowable SFSP Costs and Needed Documentation
 - Program Cost Report
 - Updating Changes to CNP Web
 - Requesting Advances
-

Monitoring Information

- Corrective Action Plan Instructions and Form (CAP)
- Appeal Flyer



MISSOURI DEPARTMENT OF HEALTH & SENIOR SERVICES
BUREAU OF COMMUNITY FOOD AND NUTRITION
ASSISTANCE SUMMER FOOD SERVICE PROGRAM (SFSP)
SPONSOR APPLICATION AND BUDGET
(Please TYPE or PRINT Clearly)

1. Name of Sponsoring Organization		2. Mailing Address (P.O. Box or Street Address, City, State & Zip Code)	
3. Street Address (if different from 2.) (Street Address, City, State & ZIP Code)		4. County	
5. Responsible Individual Name Position Responsible Individual's Email Address Responsible Individual's Telephone # () - Ext. Responsible Individual's Fax # () - Ext.	6. Food Program Contact's Name Position Food Program Contact's Email Address Food Program Contact's Telephone # () - Ext. Food Program Contact's Fax # () - Ext.	7. Financial Contact's (Optional) Name Position Financial Contact's Email Address Financial Contact's Telephone # () - Ext. Financial Contact's Fax # () - Ext.	
8. Type of Sponsor: <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <input type="checkbox"/> School Food Authority (public or private, non-profit) <input type="checkbox"/> Government Entity (State, Local, Municipal or County) Example: County Health Dept. <input type="checkbox"/> Residential Camp (overnight camp) </div> <div style="width: 48%;"> <input type="checkbox"/> Upward Bound <input type="checkbox"/> National Youth Sports Program (sponsored by a public or private, non-profit college or university) <input type="checkbox"/> Private Non-Profit (PNP) Organization Examples: Boys and Girls Clubs, YMCAs or YWCAs, churches or other faith-based organizations, scouting organizations. </div> </div>			
9. Method of Meal Preparation: <input type="checkbox"/> Self-Preparation OR <input type="checkbox"/> Vended		10. If Method of Meal Preparation is Self Preparation, are meals prepared: <input type="checkbox"/> At each site <input type="checkbox"/> At a central kitchen	
11. If food is prepared at a vendor kitchen (Food Service Management Company or School Food Service Authority) or at a central kitchen (serving more than one site) list the facility name, address and contact information below for each separate facility:			
Facility Type: <u>(Column A)</u> <input type="checkbox"/> Central Kitchen <input type="checkbox"/> FSMC or other vendor Facility Name: Facility Address (street, city, state, ZIP code) County: Contact Person's Name: Telephone Number: () - Ext.	Facility Type: <u>(Column B)</u> <input type="checkbox"/> Central Kitchen <input type="checkbox"/> FSMC or other vendor Facility Name: Facility Address (street, city, state, ZIP code) County: Contact Person's Name: Telephone Number: () - Ext.	Facility Type: <u>(Column C)</u> <input type="checkbox"/> Central Kitchen <input type="checkbox"/> FSMC or other vendor Facility Name: Facility Address (street, city, state, ZIP code) County: Contact Person's Name: Telephone Number: () - Ext.	
If meals are served via a central kitchen, list all sites served by each central kitchen: Use additional sheets if necessary.			
Column A:			
Column B:			
Column C:			

12. Does the sponsor provide an ongoing, year-round service of some type to the community that would be served by the SFSP?
☐ Yes ☐ No

If the sponsor is not a residential camp, please describe the ongoing, year-round service(s) provided:

Note: All sponsors, with the exception of residential camps, must provide an ongoing, year-round service of some type to the community served in order to be eligible for the SFSP. Examples: Schools and colleges provide educational services; private non-profits might provide after-school programming, parent education classes, etc.; churches and faith-based organizations provide religious instruction and other services.

13. Does any other agency other than the sponsor provide site personnel? (If meals are vended, mark yes and enter the information for the FSMC below)
☐ Yes ☐ No
If Yes, provide the name, agency and title of person responsible:

14. I will cover the following **minimum required topics** in my training sessions for administrative and site personnel: ☐ Yes ☐ No
◆Purpose of the Program ◆Meal Pattern Requirements ◆Site Eligibility ◆Site Operations ◆Recordkeeping ◆Duties of a Monitor ◆Civil Rights

15. I understand the following procedures must be used to correct program deficiencies or areas of non-compliance, and will incorporate them into my SFSP operations: ☐ Yes ☐ No

1. Monitor sites and note areas of non-compliance
2. Discuss problems with site supervisor
3. Recommend corrective action
4. Follow-up in one week to assure corrections are made

16. Has the applicant organization ever been terminated or determined to have been seriously deficient in its operation of the SFSP or any other Child Nutrition Program? ☐ Yes ☐ No
If Yes, please submit a written explanation regarding the circumstances to MDHSS—BCFNA.

17. List the names of other Federal agencies providing assistance to the applicant organization.

18. Has the applicant ever been found to be in noncompliance with regard to Civil Rights regulations for any of the agencies listed in question #17, ☐ Yes ☐ No
If yes please explain:

19. List the estimated percentage ethnic make-up of the population of the area to be served (**percentages must total 100%**):

Hispanic or Latino	Not Hispanic or Latino	Total
%	%	100%

20. List the estimated percentage racial make-up of the population of the area to be served (**percentages must total 100%**):

American Indian or Alaskan Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	Total
%	%	%	%	%	100%

21. What efforts will be used to assure that minority populations have equal opportunity to participate? (check all that apply)

☐ Distribution of brochures or Program information at public locations.
☐ Paid or free advertisements in local newspapers.
☐ Personal contact with community groups and/or parents.

☐ Public service announcements in:
☐ Local Newspaper
☐ Radio
☐ Television

22. Do these efforts also reflect methods used to assure minority and grassroots organizations participate in the program as required by program regulations?
☐ Yes ☐ No

22. Has your organization ever been found to be in noncompliance of the Civil Rights Laws by any Federal agency? ☐ Yes ☐ No
If Yes, explain:

23. Is your organization faith-based or affiliated with a church?
☐ Yes ☐ No

23. Advances
Does the applicant organization elect to receive advance payments? ☐ Yes ☐ No
If Yes, for which month(s) is/are advance payment(s) requested? The organization must operate the SFSP 10 or more days in any month(s) selected:

Month	Operating Advance	Requested Amount	Administrative Advance	Requested Amount
June 1 st	<input type="checkbox"/>	\$	<input type="checkbox"/>	\$
July 15 th	<input type="checkbox"/>	\$	<input type="checkbox"/>	\$
August 15 th	<input type="checkbox"/>	\$		

Note: Advances are calculated based on the number of meals you expect to serve this summer, and if you are a returning sponsor, the number of meals you served the previous summer. Your advance will be awarded based on the lesser of this calculation or the requested amount.

SPONSOR BUDGET

1. Administrative Staffing Plan

List administrative positions that will be involved in the SFSP. (Attach additional sheets if necessary.) Include **all** expenses attributable to SFSP administration, regardless of whether SFSP reimbursement will be sufficient to cover them. Administrative labor includes activities such as completing the SFSP application, completing and submitting the claim for reimbursement, monitoring sites, and conducting training. For additional guidance, consult the Operating and Administrative Cost Sheet included with your application packet.

A Title of Position	B. Number of Staff	C. Hours per day on SFSP Admin	D. Salary per hour	E. Number of days	G. Fringe Benefits	H. Total (BxCxDxE)+G	I. Specific Duties
			\$			\$	
			\$			\$	
			\$			\$	
			\$			\$	
			\$			\$	
Total administrative salary/fringe benefits (record this amount in Salary/Fringe Benefits for Administrative Costs in #3 of the Sponsor Budget)						\$	

2. Operational Staffing Plan

List operational positions that will be involved in the SFSP. (Attach additional sheets if necessary.) Include **all** expenses attributable to SFSP operations, regardless of whether SFSP reimbursement will be sufficient to cover them.

A Title of Position	B. Number of Staff	C. Hours per day on SFSP Operations	D. Salary per hour	E. Number of days	G. Fringe Benefits	H. Total (BxCxDxE)+G	I. Specific Duties
			\$			\$	
			\$			\$	
			\$			\$	
			\$			\$	
			\$			\$	
Total operational salary/fringe benefits (record this amount in Food Service Labor/Fringe Benefits for Operational Costs in #3 of the Sponsor Budget)						\$	

3. Monitoring Plan

List monitoring positions that will be involved in the SFSP. (Attach additional sheets if necessary.) Include **all** expenses attributable to SFSP operations, regardless of whether SFSP reimbursement will be sufficient to cover them.

A. Name	B. Number of Sites	C. Hours per day on SFSP Monitoring	D. Salary per hour	E. Number of days	G. Fringe Benefits	H. Total (BxCxDxE)+G
			\$			\$
			\$			\$
			\$			\$
			\$			\$
Total monitoring salary/fringe benefits (record this amount in Food Service Labor/Fringe Benefits for Operational Costs in #3 of the Sponsor Budget)						\$

4. Total SFSP Budget		
BUDGET CATEGORY BY LINE ITEM	ANTICIPATED EXPENDITURES	AMOUNT APPROVED BY DHSS
1. Annual Administrative Salary/Benefits		
a. Total Salaries		
b. Benefits		
1) Health Insurance		
2) Workman's Compensation		
3) Life Insurance		
4) Retirement Plan		
5) FICA		
6) Other (specify)		
2. Travel Expense		
a. Mileage		
b. Per Diem		
c. Leased vehicle		
d. Rental vehicle		
4. Printing		
5. Postage		
6. Annual Contracted Services		
a. Audit A-133 (required by 7 CFR 226)		
b. Professional (specify)		
8. Telephone		
a. Office Telephone Service		
b. Cellular Service		
c. Internet Service Provider		
BUDGET CATEGORY BY LINE ITEM (Cont.)	AMOUNT REQUESTED	AMOUNT APPROVED BY DHSS

9. Office Rent/Use Allowance			
a. Rent/Lease			
b. Use Allowance or Depreciation (circle one)			
c. Insurance (cover loss of Federal property)			
d. Maintenance			
e. Janitorial			
10. Utilities			
a. Gas/Electric			
b. Water/Sewer			
c. Trash Removal			
d. Other (specify)			
Total of Direct Expenses:			
11. Annual Indirect Costs (Submit C.A.P.)			
Include all expenses attributable to SFSP operations, regardless of whether SFSP reimbursement will be sufficient to cover them. Please consult the Operating and Administrative Cost Sheet included with your application packet to help determine whether expenses are administrative or operational.			
Administrative Costs	Proposed Administrative Budget	MDHSS USE ONLY Approved Administrative Budget	Operational Costs
Salaries/Fringe Benefits (Total from #1 on p. 3)	\$	\$	Food Service Labor/ Fringe Benefits (Total from #2 on p. 3)
Rent for Office Space	\$	\$	Food
Office Supplies	\$	\$	Supplies
Administrative Mileage	\$	\$	Transportation of Food
Audit Fees	\$	\$	Utilities
Telephone	\$	\$	Equipment Rent
Postage	\$	\$	Other (please specify)
Printing/Copying	\$	\$	
Advertising	\$	\$	
Other (please specify)	\$	\$	
Total Administrative Costs	\$	Total Approved Administrative Budget	Total Operational Costs
			Grand Total
Administrative Meals x Rates	\$	\$	Operational Meals x Rates

MULTI-STATE OPERATIONS

Does the organization operate in more than one State? ☐ Yes ☐ No Please list the states _____

Does the local affiliate send money from the non-profit food service account or money from the SFSP to the parent organization? ☐ Yes ☐ No

APPLICATION COMPLETION

Before your application will be considered complete, you must submit the following items:

One Site Information Sheet for each meal service site, with required attachments as described on the Site Information Sheet
Vendor Input/ACH-EFT Form (all new sponsors; previous sponsors with address, contact, or telephone number changes) Copy of entire, current Food Service Management Company (FSMC) or School Food Service contract (vended sponsors only) Completed and signed Policy Statement (new sponsors only)

SIGNATURE

Signature by the superintendent/board president/director and/or authorized representative below certifies that:

1. The information on this form is true and correct to the best of my knowledge.
2. 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.
3. The program must be made available to all children regardless of race, color, national origin, sex, age, or disability. (Not all prohibited bases apply to all programs.)
4. The program is directly operated by the applicant organization (sponsor) at all sites.
5. Reimbursement will be claimed only for meals served to eligible children.
6. Each site will maintain a daily point-of-service meal count for each meal or snack service, which will be collected at least weekly by the sponsor.
7. The superintendent/board president/director and authorized representative(s) accept final administrative and financial responsibility for all SFSP operations at the applicant organization's (sponsor's) site(s).

NAME, TITLE, AND SIGNATURE OF THE FINANCIALLY AND/OR ADMINISTRATIVELY RESPONSIBLE PARTY

SIGNATURE OF SUPERINTENDENT/BOARD PRESIDENT/DIRECTOR

► ☐

SIGNATURE OF AUTHORIZED REPRESENTATIVE

► ☐

TITLE

DATE

TITLE

DATE

DHSS USE ONLY BELOW THIS LINE

APPROVED BY DHSS—CFNA REPRESENTATIVE

► ☐

TITLE

DATE



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
SUMMER FOOD SERVICE PROGRAM (SFSP)
SITE INFORMATION SHEET (Please TYPE or PRINT clearly)

1. Name of Sponsor:		2. Name of Site:	
3. Street Address of Site (where children are fed). Include street, city, state & ZIP code:			4. County:
5. Site Supervisor's Name:		6. Site Supervisor's Position:	
7. Site Supervisor's E mail address:			
8. Site Supervisor's Telephone Number: () - Ext.		9. Site Supervisor's Fax Number: () - Ext.	
10. a. Site Location: <input type="checkbox"/> Rural <input type="checkbox"/> Urban <small>Areas considered urban include Kansas City, St. Louis, Columbia, Jefferson City, Joplin, Springfield and St. Joseph. All others are considered rural.</small>		10. b. Urban sites and sponsors with more than one site: Describe the geographical boundaries served and attach a map with the boundaries marked. If boundaries overlap, include a brief statement indicating the necessity for each site.	
11. Site Type (choose only one): <input type="checkbox"/> Open Site Using School Data Percentage of Students Eligible for Free or Reduced Price Meals: _____ % School Name _____ District Name _____ <input type="checkbox"/> Open Site Using Census Tract Data (Contact MDHSS—BCFNA for assistance 888-435-1464) <input type="checkbox"/> Migrant Site Using Migrant Organization Information (Mail in documentation to MDHSS—BCFNA) <input type="checkbox"/> Enrolled Site (Income Eligibility Forms must be collected) Projected # Enrolled in SFSP: _____ Projected # Eligible for Free or Reduced-price Meals _____ <input type="checkbox"/> Camp—(Income Eligibility Forms are Required) <input type="checkbox"/> National Youth Sports Program that meets income eligibility guidelines of the U.S. Dept. of Health and Human Services (DHHS)			
12. Is there regularly scheduled, organized activity at the site? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes a list of the activities is required. Please list below or attach a schedule of daily activities.</i>			
13. Is this site a Child Care Center, Group Home, or Family Home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is it <input type="checkbox"/> Licensed or <input type="checkbox"/> Licensed Exempt			
14. Does the system used to serve meals to children at the site ensure that each child receives a complete meal, and that meals are counted at the point of service? <input type="checkbox"/> Yes <input type="checkbox"/> No			
15. Does the site have the necessary staff and facilities so that the meal service is organized and properly supervised? <input type="checkbox"/> Yes <input type="checkbox"/> No			
16. Leftover meals are handled by: <input type="checkbox"/> Discarding <input type="checkbox"/> Storing <input type="checkbox"/> Returning to central kitchen			

17. What method is used at the facilities for holding meals at proper temperatures? <input type="checkbox"/> Delivered within one hour of meal service <input type="checkbox"/> Prepared onsite and held at proper temperature <input type="checkbox"/> Stored properly and at the proper temperature																																																																																																																																																																													
18. Sites can adjust meal deliveries by: <input type="checkbox"/> Calling a request into the sponsor <input type="checkbox"/> Writing a request to the sponsor <input type="checkbox"/> Faxing a request into the sponsor <input type="checkbox"/> E-mailing a request to the sponsor <input type="checkbox"/> All methods are used																																																																																																																																																																													
19. Is Offer vs Serve requested for this site? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																																																																																																													
20. Program regulations require that the sponsor conduct a pre-approval visit to the site, before the Missouri Department of Health and Senior Services will approve the site for participation. Has the sponsor conducted a pre-approval visit to this site? (The application will not be processed until a site visit is completed) <input type="checkbox"/> Yes <input type="checkbox"/> No Date of site visit: _____																																																																																																																																																																													
21. Operating Dates Begin Date (First date SFSP meals to be served at site): ____ / ____ / ____ End Date (Last date SFSP meals to be served at site): ____ / ____ / ____																																																																																																																																																																													
20. Total number of operating days each month: <i>Exclude weekends and holidays if you will not serve meals on those days.</i>			May		June		July		August		September		TOTAL																																																																																																																																																																
21. Meal Service Information: Note: You may choose a combination of two meals or one meal and one snack per day, with the exception of lunch and supper on the same day. Meals should be served within the normal timeframes.																																																																																																																																																																													
<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th rowspan="2">Meal Type</th> <th rowspan="2">Preparation Method</th> <th rowspan="2">Begin Time</th> <th rowspan="2">End Time</th> <th colspan="7">Days Meals Served</th> <th rowspan="2">Estimated Number to be served (ADP)</th> <th rowspan="2">Estimated Number Eligible (Camps Only)</th> <th rowspan="2">CAP (MDHSS use only)</th> </tr> <tr> <th>M</th> <th>T</th> <th>W</th> <th>T</th> <th>F</th> <th>S</th> <th>S</th> </tr> </thead> <tbody> <tr> <td rowspan="3">Breakfast</td> <td><input type="checkbox"/> Self-Prep</td> <td rowspan="3"></td> <td rowspan="3"></td> <td>M</td><td>T</td><td>W</td><td>T</td><td>F</td><td>S</td><td>S</td> <td rowspan="3"></td> <td rowspan="3"></td> <td rowspan="3"></td> </tr> <tr> <td><input type="checkbox"/> Vended</td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Central Kitchen</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td rowspan="3">AM Snack</td> <td><input type="checkbox"/> Self-Prep</td> <td rowspan="3"></td> <td rowspan="3"></td> <td>M</td><td>T</td><td>W</td><td>T</td><td>F</td><td>S</td><td>S</td> <td rowspan="3"></td> <td rowspan="3"></td> <td rowspan="3"></td> </tr> <tr> <td><input type="checkbox"/> Vended</td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Central Kitchen</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td rowspan="3">Lunch</td> <td><input type="checkbox"/> Self-Prep</td> <td rowspan="3"></td> <td rowspan="3"></td> <td>M</td><td>T</td><td>W</td><td>T</td><td>F</td><td>S</td><td>S</td> <td rowspan="3"></td> <td rowspan="3"></td> <td rowspan="3"></td> </tr> <tr> <td><input type="checkbox"/> Vended</td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Central Kitchen</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td rowspan="3">PM Snack</td> <td><input type="checkbox"/> Self-Prep</td> <td rowspan="3"></td> <td rowspan="3"></td> <td>M</td><td>T</td><td>W</td><td>T</td><td>F</td><td>S</td><td>S</td> <td rowspan="3"></td> <td rowspan="3"></td> <td rowspan="3"></td> </tr> <tr> <td><input type="checkbox"/> Vended</td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Central Kitchen</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td rowspan="3">Supper</td> <td><input type="checkbox"/> Self-Prep</td> <td rowspan="3"></td> <td rowspan="3"></td> <td>M</td><td>T</td><td>W</td><td>T</td><td>F</td><td>S</td><td>S</td> <td rowspan="3"></td> <td rowspan="3"></td> <td rowspan="3"></td> </tr> <tr> <td><input type="checkbox"/> Vended</td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Central Kitchen</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> </tbody> </table>													Meal Type	Preparation Method	Begin Time	End Time	Days Meals Served							Estimated Number to be served (ADP)	Estimated Number Eligible (Camps Only)	CAP (MDHSS use only)	M	T	W	T	F	S	S	Breakfast	<input type="checkbox"/> Self-Prep			M	T	W	T	F	S	S				<input type="checkbox"/> Vended	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Central Kitchen							AM Snack	<input type="checkbox"/> Self-Prep			M	T	W	T	F	S	S				<input type="checkbox"/> Vended	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Central Kitchen							Lunch	<input type="checkbox"/> Self-Prep			M	T	W	T	F	S	S				<input type="checkbox"/> Vended	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Central Kitchen							PM Snack	<input type="checkbox"/> Self-Prep			M	T	W	T	F	S	S				<input type="checkbox"/> Vended	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Central Kitchen							Supper	<input type="checkbox"/> Self-Prep			M	T	W	T	F	S	S				<input type="checkbox"/> Vended	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Central Kitchen						
Meal Type	Preparation Method	Begin Time	End Time	Days Meals Served							Estimated Number to be served (ADP)	Estimated Number Eligible (Camps Only)					CAP (MDHSS use only)																																																																																																																																																												
				M	T	W	T	F	S	S																																																																																																																																																																			
Breakfast	<input type="checkbox"/> Self-Prep			M	T	W	T	F	S	S																																																																																																																																																																			
	<input type="checkbox"/> Vended			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
	<input type="checkbox"/> Central Kitchen																																																																																																																																																																												
AM Snack	<input type="checkbox"/> Self-Prep			M	T	W	T	F	S	S																																																																																																																																																																			
	<input type="checkbox"/> Vended			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
	<input type="checkbox"/> Central Kitchen																																																																																																																																																																												
Lunch	<input type="checkbox"/> Self-Prep			M	T	W	T	F	S	S																																																																																																																																																																			
	<input type="checkbox"/> Vended			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
	<input type="checkbox"/> Central Kitchen																																																																																																																																																																												
PM Snack	<input type="checkbox"/> Self-Prep			M	T	W	T	F	S	S																																																																																																																																																																			
	<input type="checkbox"/> Vended			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
	<input type="checkbox"/> Central Kitchen																																																																																																																																																																												
Supper	<input type="checkbox"/> Self-Prep			M	T	W	T	F	S	S																																																																																																																																																																			
	<input type="checkbox"/> Vended			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
	<input type="checkbox"/> Central Kitchen																																																																																																																																																																												
22. If Central Kitchen Meal Type was chosen, list the name of the Central Kitchen preparing the food.																																																																																																																																																																													
23. <input type="checkbox"/> Meal Time Waiver is requested. Select this option if you are not a residential camp and you will be serving more than two meal types throughout the duration of your operating dates but will not be serving more than two meals on any given day. (Example: Weeks 1-3 will site will serve breakfast and lunch. Weeks 4-6 will serve lunch and snack)																																																																																																																																																																													
24. How many children can eat at this site at one time? _____																																																																																																																																																																													
25. How many staff members supervise the meal service? _____																																																																																																																																																																													

26. Please list any holidays the site will not be serving or any specific dates during the dates of operation when the site will not be in operation. (i.e., July 4 or Every other Friday beginning mm/dd/yyyy.)

27. If this is an outdoor site, where will meals be served during inclement weather?
Please provide the address and procedures for alternate meal service.

28. For Residential and Day Camps Only (use additional sheets if necessary)

Session	Begin Date	End Date
1		
2		
3		
4		
5		

29. For Field Trips and Off Site Meals Only (use additional sheets if necessary)

Field Trip	Date	Meal (Breakfast, Lunch, AM or PM Snack)
1		
2		
3		
4		
5		

30. Comments

☐ Yes ☐ No This site operated last year and is in good standing with the sponsor. I request waiver for the first week monitoring. I certify this site will be monitored within the first four weeks.

☐ I certify that this site has the capabilities and facilities to provide the meal service planned for the number of participants to be served, and that the information on this form is true and correct to the best of my knowledge. I understand that this information is being given in connection with the receipt of Federal funds, and that withholding information or deliberate misrepresentation may subject me to prosecution under applicable state and federal criminal statutes.

Signature of Authorized Sponsor Representative	Title	Date
--	-------	------

MDHSS USE ONLY BELOW THIS LINE

Approval Signature of MDHSS—BCFNA Representative	Title	Date
--	-------	------



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE
SUMMER FOOD SERVICE PROGRAM
MEDICAL FOOD SUBSTITUTION RECORD

Authorization by a recognized medical authority is required for food substitutions to the Summer Food Service Program meal pattern. A recognized medical authority includes a physician, physician assistant, or nurse practitioner. The recognized medical authority must specify, in writing, the food to be omitted from the patient's diet and the food or choice of foods that may be substituted.

PATIENT'S NAME:

MEDICAL DIAGNOSIS / REASON:

SPECIAL ASSISTANCE/EQUIPMENT REQUIRED:

FOOD SUBSTITUTION LIST:

Fluid Milk	Allowed Substitutes	Texture (e.g., cut up, ground mince, puree, liquidity)
Meat & Meat Alternative (e.g., eggs, cheese peanut butter, dry bean, yogurt, etc.)	Allowed Substitutes	Texture (e.g., cut up, ground mince, puree, liquidity)
Bread, Cereal or Whole Grain Products	Allowed Substitutes	Texture (e.g., cut up, ground mince, puree, liquidity)
Fruit & Vegetables or Juice	Allowed Substitutes	Texture (e.g., cut up, ground mince, puree, liquidity)

Additional Dietary Concerns and/or Required Equipment or Assistance Needed:

I (medical authority) certify that the above patient must be provided a special diet or requires special accommodations as indicated above.

SIGNATURE

TITLE

DATE



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
P.O. Box 570, Jefferson City, MO 65102-0570

MDHSS-BCFNA USE ONLY

**NETWORK USER ACCESS REQUEST
(SFSP)**

SOCIAL SECURITY NUMBER	OFFICE TELEPHONE
NAME (Last Name, First Name, MI)	ORGANIZATION NAME (Must Match SFSP Application)
DIVISION	AUTHORIZED REPRESENTATIVE (Must Match SFSP Application)
DCPH/BCFNA – Summer Food Service Program (SFSP) 888-435-1464	
ADDRESS (PO Box/Street, City, State, ZIP)	COUNTY
	EMAIL ADDRESS OF REQUESTOR

SOFTWARE ACTION REQUESTED

ACTION REQUESTED: ☒ ADD ACCESS ☐ DELETE ACCESS

☒ SFSP web-based system for application updates and claim submission.

COMMENTS

NOTES

Keep a copy of the signed form for your records.

*Submit a separate form for each individual needing access. (Copies can be made if needed.)
Access is limited to two users per sponsor.*

Submit the completed, signed form by fax to 573-526-3679 OR by mail to SFSP, PO Box 570, Jefferson City, MO 65102.

I, the undersigned, understand that individual user IDs and passwords may not be transferred to others or shared. The individual user or the authorized representative must contact the Missouri Department of Health and Senior Services-Bureau of Community Food and Nutrition Assistance (MDHSS-BCFNA) in writing if the user is leaving employment or changing job duties so that access may be revoked immediately. I understand that state and federal statutes require confidentiality of information and provide penalties for unauthorized access, use and/or disclosure of information. In addition, I agree not to divulge or share my passwords with anyone. I understand that misuse of another individual's user ID and password will not be tolerated. Access will be revoked immediately, and may only be restored by submitting a corrective action plan to MDHSS-BCFNA detailing how individual passwords will be protected and not shared. Claims for reimbursement submitted through misuse of another individual's user ID and password will be considered invalid, and must be repaid in full to the MDHSS-BCFNA.

MDHSS BCFNA USE ONLY

DATE RECEIVED:

USER SIGNATURE (Required) ➤	DATE
AUTHORIZED REPRESENTATIVE SIGNATURE (Must match SFSP application) (Required) ➤	DATE
MDHSS-BCFNA APPROVAL SIGNATURE ➤	DATE



MISSOURI DEPARTMENT OF HEALTH & SENIOR SERVICES
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
SUMMER FOOD SERVICE PROGRAM (SFSP)
POLICY STATEMENT FOR NEW SPONSORS

FOR ALL SPONSORS:

_____ has agreed to participate in the Summer Food Service Program
(Name of Sponsoring Organization)
and accepts responsibility for providing program benefits to eligible children in the site(s) under its jurisdiction. The Sponsor assures the Missouri Department of Health and Senior Services (DHSS) that although there is no separate charge established for meals, it will uniformly implement the following policy. In fulfilling its responsibilities, the Sponsor:

- A. Agrees that in operation of the Program, no child shall be discriminated against because of race, color, national origin, gender, religion, age, disability, or political beliefs. (Not all prohibited bases apply to this program.)
- B. Agrees to establish a procedure to account for meals claimed.

FOR SPONSORS OF CAMPS AND ENROLLED SITES ONLY, in addition to A and B, the Sponsor:

- C. Agrees that no meals will be claimed unless there is adequate documentation on file to support the claim. Adequate documentation (for each child's family) includes household income received by each household member, identified by source of income; names of all household members; social security number of either the head of household/primary wage earner or the adult signing the application; and the signature of an adult member of the household. Adequate documentation for a child who is a member of a food stamp or Temporary Assistance (TA) unit includes the name(s) and appropriate food stamp or Temporary Assistance case number(s) for the child(ren) and the signature of an adult member of the household.
- D. Agrees to maintain on file for three years all documentation to support claims.
- E. Agrees that there will be no physical segregation of, or other discrimination against any child. The names of the children for which meals may be claimed shall not be published, posted, or announced in any manner, and there shall be no overt identification of any such children by any means. Further assurance is given that all children shall be served the same meals.

Shall describe below the method used for collecting payments from children who pay the full price of the meal while preventing the overt identification of children receiving a free meal:

- F. Shall attach a sample of the Income Eligibility Application, parent letter, and public release to be used. If the DHSS prototype forms will be used, indicate in the space below and do not attach the forms.
Shall describe below the method for accepting Income Eligibility Applications:

- G. Agrees to designate _____ to make determinations of
(Name and Title)
eligibility for purpose of claiming meals. The official will use the USDA eligibility criteria to make eligibility determinations conforming to the family size and income standards for reduced price school meals determined by the Secretary of Agriculture.
- H. Agrees that the application and parent letter and/or any other descriptive material distributed to parents or guardians shall contain only the family size and income levels for reduced price school eligibility. It shall also include an explanation that households with income less than or equal to these values would be eligible for free meals. The application and parent letter shall not contain the income standards for free meals. It shall contain a statement that if a child is a member of a food stamp or Temporary Assistance unit, the child is automatically eligible to receive free program meals, subject to completion of an application as described in C of this policy statement. Finally, a statement shall also be included to the effect that "In certain cases, foster children are eligible for free meals regardless of household income. If such children are living with you and you wish to apply for such meals, please contact us."
- I. Will establish a hearing procedure for families wishing to appeal a denial of an application for free meals. The Sponsor assures that if a family requests a hearing, the child shall continue to receive free meals until a decision is rendered.

FOR SPONSORS OF OPEN SITES ONLY, in addition to A and B, the Sponsor:

- J. Agrees that no meals will be claimed unless there is adequate documentation on file to support the eligibility as an open site. Adequate documentation includes, but is not limited to census data and/or school data verifying 50 percent or more of the children meet the 185 percent poverty guidelines.
- K. Agrees to maintain on file for three years all documentation to support claims for reimbursement.
- L. Assures that all children shall be served the same meals.

SIGNATURE OF SUPERINTENDENT/BOARD PRESIDENT/DIRECTOR		SIGNATURE OF AUTHORIZED SPONSOR REPRESENTATIVE	
TITLE	DATE	TITLE	DATE



STATE OF MISSOURI
OFFICE OF ADMINISTRATION
VENDOR INPUT/ACH-EFT APPLICATION

***REQUIRED FIELDS**

*NAME/ADDRESS AS SHOWN ON FEDERAL TAX RETURN		*FEDERAL TAX ID NUMBER OR SOCIAL SECURITY NUMBER	
 		*TYPE OF ENTITY <input type="checkbox"/> Corporation <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Individual <input type="checkbox"/> State Employee <input type="checkbox"/> Other _____	
		DATE OF CHANGE	
REMIT TO NAME/ADDRESS IF DIFFERENT THAN ABOVE		PREVIOUS FEDERAL TAX ID NUMBER OR SOCIAL SECURITY NUMBER	
 		PREVIOUS NAME	
		PREVIOUS ADDRESS	
PURCHASE ORDER NAME/ADDRESS IF DIFFERENT THAN ABOVE		COMMENTS	
TO BE COMPLETED BY FINANCIAL INSTITUTION		<input type="checkbox"/> I (We) hereby authorize the State of Missouri, to initiate credit entries to my (our) account at the depository financial institution named and to credit the same such account. I (We) acknowledge that the origination of ACH transactions to my (our) account must comply with the provision of U.S. law.	
NAME/ADDRESS OF FINANCIAL INSTITUTION		This authorization is to remain in full force and effect until the State of Missouri, Office of Administration, has received written notification from me (us) of its termination in such time and in such manner as to afford the State of Missouri and the financial institution a reasonable opportunity to act on it.	
 		<input type="checkbox"/> I (We) hereby cancel my (our) ACH/EFT authorization.	
DEPOSITOR ROUTING NUMBER		*VENDOR SIGNATURE	
DEPOSITOR ACCOUNT NUMBER		X	
NAME ON ACCOUNT		*PRINT NAME	
TYPE OF ACCOUNT <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS		*TITLE	
SIGNATURE OF REPRESENTATIVE OF FINANCIAL INSTITUTION		EMAIL ADDRESS	
PRINT NAME		*TELEPHONE	
TITLE		*DATE	
TELEPHONE NUMBER	DATE		
CERTIFICATION FOR INTERNAL REVENUE SERVICE (IRS)			
<input type="checkbox"/> Exempt from Backup Withholding			
Under penalties of perjury, I certify that: I. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and II. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and III. I am a U.S. person (including a U.S. resident alien). Certification instructions. You must cross out item II above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For all real estate transactions, item II does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See W-9 Instructions on irs.gov website for more information.) The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.			
SIGNATURE			

VENDOR INPUT FORM INSTRUCTIONS

The purpose of this form is to add a vendor record or to make changes to a vendor record. A vendor is a person or business being paid by the State of Missouri.

THESE FIELDS ARE REQUIRED TO BE COMPLETED FOR ALL CIRCUMSTANCES. (SHADED FIELDS)

Enter NAME/ADDRESS AS SHOWN ON FEDERAL TAX RETURN.

Enter the FEDERAL TAX ID NUMBER OR SOCIAL SECURITY NUMBER that is used for income taxes for the name entered.

Check the correct TYPE OF ENTITY.

Signature is required at VENDOR SIGNATURE along with PRINT NAME, TITLE, TELEPHONE, and DATE.

CONDITIONAL FIELDS

If payments are to be sent to a different address, enter a REMIT TO NAME/ADDRESS.

If purchase orders are to be sent to a different address, enter a PURCHASE ORDER NAME/ADDRESS.

If you are making a change to your vendor record, fill out these additional fields:

DATE OF CHANGE is the effective date of the change in business structure/activity

PREVIOUS FEDERAL TAX ID NUMBER OR SOCIAL SECURITY NUMBER

PREVIOUS NAME

PREVIOUS ADDRESS

COMMENTS are for additional information that may be helpful including reason for the change.

TO SET UP OR TO CHANGE DIRECT DEPOSIT INFORMATION, FILL IN THE FOLLOWING, INCLUDING THE REQUIRED FIELDS FROM ABOVE.

NAME/ADDRESS OF FINANCIAL INSTITUTION where you want the money to be deposited. A representative from the financial institution must complete and sign this section.

Check appropriate box for electronic deposits.

If changing bank account information, fill in DATE OF CHANGE.

CERTIFICATION FOR INTERNAL REVENUE SERVICE (IRS)

This certifies that the Taxpayer Identification Number (TIN) on this form is the correct number and whether backup withholding applies.

Fax to (573) 526-9813 or mail to Office of Administration/Accounting, PO Box 809, Jefferson City, MO 65102.



MISSOURI DEPARTMENT OF HEALTH & SENIOR SERVICES
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
SUMMER FOOD SERVICE PROGRAM (SFSP)

Documentation of Training to Program Personnel

Name and Address of Sponsor	Date of Training
------------------------------------	-------------------------

Name of Trainer(s)	Location of Training
---------------------------	-----------------------------

Training Topics:
Check the topics covered and list any additional. Topics listed below are the minimum required.

☐ Purpose of the Program
 ☐ Site Eligibility
 ☐ Record-Keeping
 ☐ Civil Rights
☐ Meal Pattern Requirements
 ☐ Site Operations
 ☐ Duties of a Monitor
 ☐ Other _____

Attach additional pages if necessary or attach copy of training program outline.

Training Participant (print name)	Participant's Signature	Title	Name of Participant's Site



MISSOURI DEPARTMENT OF HEALTH AND SENIOR
SERVICES COMMUNITY FOOD AND NUTRITION
ASSISTANCE
SUMMER FOOD SERVICE PROGRAM

Pre-Operational Site Review

Site Selection Worksheet

Sponsor Name and Address				
Site Address				
Site Phone Number		Person to contact for use of site		
Type of Site <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 30%;"> <input type="checkbox"/> Open <input type="checkbox"/> Recreation Center <input type="checkbox"/> Playground <input type="checkbox"/> Residential Camp </div> <div style="width: 30%;"> <input type="checkbox"/> School <input type="checkbox"/> Settlement House <input type="checkbox"/> Play-street </div> <div style="width: 30%;"> <input type="checkbox"/> Enrolled <input type="checkbox"/> Church <input type="checkbox"/> Park <input type="checkbox"/> Other </div> </div>				
Estimated number of participants the site could serve				
Estimated number of supervisory personnel needed to adequately control food service				
Does the site have:	Yes	No	NA	Comments
A shelter or alternate site for inclement weather?				
Hand washing facilities for the food handlers and participants?				
Adequate refrigeration for storage of meals?				
Adequate cooking facilities for preparation of meals, if applicable?				
A place to store prepared or delivered food to maintain appropriate food temperatures?				
Is another site needed in the area?				
Are present facilities adequate for an organized meal service?				
If no, explain				
What types of organized activities are planned at this site?				
Signature of Authorized Representative				Date



Missouri Department of Health & Senior Services SUMMER FOOD SERVICE PROGRAM

Daily Meal Count Form

Name of Site:					Date:				
Meal: (circle one) Breakfast A.M. Snack Lunch P.M. Snack Supper					Site Supervisor:				
Delivery Time:		Total Meals Delivered/Prepared:		Delivery Temperature:		Meal Service Time: Begin: End:			

First Meals Served to Children:

1	16	31	46	61	76	91	106	121	136	151	166	181	196	211	226	241	256	271	286	301	316	331	346	361	376	391	406	421	436
2	17	32	47	62	77	92	107	122	137	152	167	182	197	212	227	242	257	272	287	302	317	332	347	362	377	392	407	422	437
3	18	33	48	63	78	93	108	123	138	153	168	183	198	213	228	243	258	273	288	303	318	333	348	363	378	393	408	423	438
4	19	34	49	64	79	94	109	124	139	154	169	184	199	214	229	244	259	274	289	304	319	334	349	364	379	394	409	424	439
5	20	35	50	65	80	95	110	125	140	155	170	185	200	215	230	245	260	275	290	305	320	335	350	365	380	395	410	425	440
6	21	36	51	66	81	96	111	126	141	156	171	186	201	216	231	246	261	276	291	306	321	336	351	366	381	396	411	426	441
7	22	37	52	67	82	97	112	127	142	157	172	187	202	217	232	247	262	277	292	307	322	337	352	367	382	397	412	427	442
8	23	38	53	68	83	98	113	128	143	158	173	188	203	218	233	248	263	278	293	308	323	338	353	368	383	398	413	428	443
9	24	39	54	69	84	99	114	129	144	159	174	189	204	219	234	249	264	279	294	309	324	339	354	369	384	399	414	429	444
10	25	40	55	70	85	100	115	130	145	160	175	190	205	220	235	250	265	280	295	310	325	340	355	370	385	400	415	430	445
11	26	41	56	71	86	101	116	131	146	161	176	191	206	221	236	251	266	281	296	311	326	341	356	371	386	401	416	431	446
12	27	42	57	72	87	102	117	132	147	162	177	192	207	222	237	252	267	282	297	312	327	342	357	372	387	402	417	432	447
13	28	43	58	73	88	103	118	133	148	163	178	193	208	223	238	253	268	283	298	313	328	343	358	373	388	403	418	433	448
14	29	44	59	74	89	104	119	134	149	164	179	194	209	224	239	254	269	284	299	314	329	344	359	374	389	404	419	434	449
15	30	45	60	75	90	105	120	135	150	165	180	195	210	225	240	255	270	285	300	315	330	345	360	375	390	405	420	435	450

(Continue counting on back of form if needed.)

Total First Meals Served to Children _____

Complete Second Meals Served to Children:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
---	---	---	---	---	---	---	---	---	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

Total Second Meals Served to Children _____

Meals Served to Program Adults:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
---	---	---	---	---	---	---	---	---	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

Total Meals Served to Program Adults _____

Meals Served to Non-Program Adults:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
---	---	---	---	---	---	---	---	---	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

Total Meals Served to Non-Program Adults _____

Total Meals Served _____
Total Damaged Meals _____

Total Leftover Meals _____
Income from Adult Meals _____

Site Supervisor's Signature:	Date:
------------------------------	-------

First Meals Served to Children, continued:

451	456	461	466	471	476	481	486	491	496	501	506	511	516	521	526	531	536	541	546	551	556	561	566	571	576	581	586	591	596
452	457	462	467	472	477	482	487	492	497	502	507	512	517	522	527	532	537	542	547	552	557	562	567	572	577	582	587	592	597
453	458	463	468	473	478	483	488	493	498	503	508	513	518	523	528	533	538	543	548	553	558	563	568	573	578	583	588	593	598
454	459	464	469	474	479	484	489	494	499	504	509	514	519	524	529	534	539	544	549	554	559	564	569	574	579	584	589	594	599
455	460	465	470	475	480	485	490	495	500	505	510	515	520	525	530	535	540	545	550	555	560	565	570	575	580	585	590	595	600

Instructions for Completing the Daily Meal Count Form

- ⇒ **Name of Site:** Enter the name of the approved SFSP site.
- ⇒ **Date:** Enter the complete date (mm/dd/yy) for which the meal count is being completed.
- ⇒ **Meal:** Circle the meal for which the count is being completed.
- ⇒ **Site Supervisor:** *Print* or *type* the site supervisor's first and last name.
- ⇒ **Delivery Time:** If meals are delivered to the site, enter the time the meals arrived at the site.
- ⇒ **Total Meals Delivered/Prepared:** Enter the number of meals that were delivered or prepared.
- ⇒ **Delivery Temperature:** If meals are delivered to the site, take the meal and milk temperatures and record the temperatures in the space provided.
- ⇒ **Meal Service Time:** Enter the time the meal service begins and ends.
- ⇒ **First Meals Served to Children:** As meals are served to children (i.e., at the point of service), put a slash mark through each consecutive number. Only count *complete* meals (containing all required components) served to children.
- ⇒ **Second Meals Served to Children:** After all children have been served a first meal, put a slash mark through each consecutive number for any second meals served to children. Only count second meals that are *complete* (contain all required components).
- ⇒ **Total Reimbursable Meals Served:** Add Total First Meals Served to Children, Total Second Meals Served to Children, and enter the total here.
- ⇒ **Meals Served to Program Adults:** After all children have been served a first meal, put slash marks, as meals are served, through the number of *complete* program adult meals served (these meals must meet all SFSP meal pattern requirements). Program adults are those adults who are involved in cooking and serving the meal and/or supervising children during the meal service.
- ⇒ **Meals Served to Non-Program Adults:** After all children have been served a first meal, put slash marks, as meals are served, through the number of non-program adults meals served. Non-program adults are those adults, paying or not, who are not directly involved in the meal service. This includes, but is not limited to, teachers or other school faculty or staff seated at a separate table from children, parents and other guests.
- ⇒ **Total Damaged Meals:** Enter the number of meals that were damaged and therefore not served (generally applies only to sites that have meals delivered or to sites serving packaged or unitized meals).
- ⇒ **Total Leftover Meals:** Enter the number of meals leftover after the meal service. Total Meals Served + Total Damaged Meals + Total Leftover Meals should be equal to Total Meals Delivered (or prepared).
- ⇒ **Income from Adult Meals:** Record the amount of money received from paying adults, if applicable.
- ⇒ **Site Supervisor's Signature:** Once the form is complete, the site supervisor must sign and date the form. The site supervisor is responsible for verifying that the meal counts have been recorded accurately. The meal count form will not be considered valid without the site supervisor's signature and date.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
SUMMER FOOD SERVICE PROGRAM

WEEKLY CONSOLIDATED MEAL COUNT

Site Name and Address:													Week of:						
	Monday			Tuesday			Wednesday			Thursday			Friday			Weekly Totals			
	Brfst	Lunch	Snack	Brfst	Lunch	Snack	Brfst	Lunch	Snack	Brfst	Lunch	Snack	Brfst	Lunch	Snack	Brfst	Lunch	Snack	
Number of Meals Ordered																			
Meals Received or Prepared																			
Meals Leftover from Previous Day																			
First Meals Served to Children																			
Second Meals Served to Children																			
Total Meals Served																			
Meals Served to Program Adults																			
Meals Served to Non-Program Adults																			
Total Damaged/Incomplete Meals																			
Total Meals Leftover																			
Income from Adult Meals																			
Comments																			



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
SUMMER FOOD SERVICE PROGRAM

Completed by:

☐ Sponsor

☐ MDHSS Reviewer

SITE MEAL COUNT CONSOLIDATION FORM

Sponsor Name:

Site Name:

Month/Year:

	Breakfast		Lunch		Supper		Snack	
Date	Child 1st Meals	Child 2nd Meals	Child 1st Meals	Child 2nd Meals	Child 1st Meals	Child 2nd Meals	Child 1st Meals	Child 2nd Meals
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
Site Totals	0	0	0	0	0	0	0	0

Instructions for Completing the Site Meal Count Consolidation Form

This is an optional form. It should be used to consolidate the meal counts for each site, one form per site. The totals from each site's worksheet should be added to get the sponsor's monthly claim totals. If the sponsor has only one site, this form may be used in lieu of the Monthly Consolidation Form.

This form is available as an Excel spreadsheet at: <http://www.dhss.mo.gov/sfsp/Forms.html>.
Or call 888-435-1464 or email sfsp@dhss.mo.gov to request an email with the form attached..

Sponsor Name: Enter the sponsoring organization's name.

Site Name: Enter the name of the site for which meal counts are being recorded

Month/Year: Enter the name of the month and year for which meal counts are being recorded.

Date: For each calendar date, enter the number of breakfasts, lunches, suppers and/or snacks served as firstmeals to children and second mealss to children. Do not enter meals on dates the site wasn't open (such as Saturdays, Sundays and holidays), and do not enter numbers for meals that weren't approved and served (e.g., if the site is approved to serve breakfasts and lunches, do not record meals under suppers and snacks).

Site Totals: Enter the totals for each column. (If using the Excel spreadsheet, totals will calculate.)

Multiple Site Totals: When one form is complete for each site, use the space below to add the Site Total for Child 1st Meals for Breakfast from each site's form, to get the total breakfast first meals served to children for the month. Add each additional column in the same manner for each site, to get all other totals for the monthly consolidation form and claim for reimbursement.

Sponsor Name:					Month/Year:			
	Breakfast		Lunch		Supper		Snack	
Site Name or Number	Child 1st Meals	Child 2nd Meals	Child 1st Meals	Child 2nd Meals	Child 1st Meals	Child 2nd Meals	Child 1st Meals	Child 2nd Meals
Total meals	0	0	0	0	0	0	0	0



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
SUMMER FOOD SERVICE PROGRAM

Monitor Site Review Form (For Self-Preparation Sites)

(Circle One) 1st Week Review 4th Week Review

Name of Sponsor			Name of Site		
Date of Review	Time of Arrival	Time of Departure	Site Supervisor		
Dates of Site Operation		Beginning Date	Ending Date		
Type of Site <input type="radio"/> Open <input type="radio"/> Enrolled <input type="radio"/> Camp <input type="radio"/> Migrant <input type="radio"/> Other					
Meal Service Reviewed <input type="radio"/> Breakfast <input type="radio"/> Lunch <input type="radio"/> Supper <input type="radio"/> Snack					
Approved Average Daily Participation					
Breakfast	Snack	Lunch	Snack	Supper	
Day of Visit	Breakfast	Lunch/Supper	Snack	Comments	
Number of Meals Prepared					
Number of First Meals Served					
Number of Second Meals Served					
Number of Meals To Program Adults					
Number of Meals to Non-Program Adults					
Number of Meals Leftover					
Food Items Served	Quantity Prepared	Servings Per Unit	Total Amount Available	Amount Needed	Comments
		Yes	No	NA	Comments
Does the meal served meet meal pattern requirements?					
Production records are maintained that show the amount of food prepared? Vended only					
Foods Served are creditable?					
Food is prepared, handled and served in a sanitary manner?					
Food preparer(s) maintain good personal hygiene and wash hands prior to the meal service?					
Facilities are clean and free from rodents and insects?					
Are meals served as a unit?					
Are meals consumed by participants on-site?					

	Yes	No	NA	Comments
Are meals planned and prepared with one meal per participant in mind?				
Are more meals served as seconds than the 2% limit?				
Are accurate counts taken of meals served?				
Is required health department certification available for inspection?				
Is an inventory record being kept?				
Are receiving reports and purchase invoices kept?				
Does staffing pattern correspond to that listed on approved application?				
Has the site supervisor attended training?				
Are records of adult meals kept?				
Is there documentation of participants eligible for free or reduced-price meals available if applicable?				
Are the "And Justice for All" & "Federal Relay Service" posters provided by the sponsor, on display in a prominent place?				
Are meals served to all attending participants regardless of race, color, national origin, age, sex, or disability?				
Beneficiary Data				
Indicate the number of participants in attendance who are of Hispanic, Latino or Spanish origin:				
Indicate the number (not percent) of participants in attendance in each racial category (count individuals in one or more categories).				
American Indian or Alaskan Native	Asian	Black or African	Native Hawaiian or other Pacific Islander	White
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> Corrective Action Plan:				
<input type="checkbox"/> No Findings <input type="checkbox"/> Findings (listed below)		<u>Follow-up</u> o N/A o Follow-up Plan/Corrective Action Taken (listed below) o Corrective Action Taken by Sponsor following Sanitation Inspection (listed below):		
The monitor conducted an Announced Site Review ____ Unannounced Site Review _____. List the reason for the type of review.				
Signature of Sponsor Monitor				Date
Site Supervisor Signature				Date



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

Monitor Site Review Form (For Vended Sites)

(Circle One)

1st Week Review

4th Week Review

Name of Sponsor		Name of Site		
Date of Review	Time of Arrival	Time of Departure	Site Supervisor	
Dates of Site Operation		Beginning Date	Ending Date	
Type of Site	<input type="checkbox"/> Open	<input type="checkbox"/> Enrolled	<input type="checkbox"/> Camp	<input type="checkbox"/> Migrant <input type="checkbox"/> Other
Meal Service Reviewed	<input type="checkbox"/> Breakfast	<input type="checkbox"/> Lunch	<input type="checkbox"/> Supper	<input type="checkbox"/> Snack
Approved Average Daily Participation				
Breakfast	Snack	Lunch	Snack	Supper
Day of Visit	Breakfast	Lunch/Supper	Snack	Comments
Number of Meals Delivered				
Time Meals Delivered				
Number of First Meals Served				
Number of Second Meals Served				
Number of Meals To Program Adults				
Number of Meals to Non-Program Adults				
Number of Meals Leftover				
Number of Incomplete/Damaged Meals				
	Yes	No	NA	Comments
Meals are served within the approved time frame?				
Does the meal served meet meal pattern requirements?				
Are adequate quantities of all food components served?				
Foods served are creditable?				
Food is prepared, handled and served in a sanitary manner?				
Do food handlers maintain good personal hygiene and wash hands prior to the meal service?				
Facilities are clean and free from rodents and insects?				
Are the meals counted before signing the delivery				
Are food temperatures taken when meals are delivered?				
Are meals checked for quality and completeness?				
Is there proper sanitation/storage available for delivered				
Are meals stored at safe temperatures?				
Are there provisions for storing or returning excess meals?				
Is the meal delivery schedule followed?				
Is the site supervisor following procedures established to make Meal or Order adjustments?				

	Yes	No	NA	Comments
meal order adjustments?				
Are meals served as a unit?				
Are meals consumed by participants on-site?				
Are meals ordered with one meal per participant in mind?				
Are more meals served as seconds than the 2% limit?				
Are accurate counts taken of meals served?				
Does the site staffing pattern correspond to that listed on				
Has the site supervisor attended training?				
Are records of adult meals kept?				
Is there documentation of participants eligible for free or				
Are the "And Justice for All" & "Federal Relay Service" posters provided by the sponsor, on display in a prominent place?				
Are meals served to all attending participants regardless				
Beneficiary Data				
Indicate the number of participants in attendance who are of Hispanic, Latino or Spanish origin:				
Indicate the number (not percent) of participants in attendance in each racial category (count individuals in one or more categories).				
American Indian or Alaskan Native	Asian	Black or African American	Native Hawaiian or other Pacific Islander	White
_____	_____	_____	_____	_____
Corrective Action Plan:				
<input type="checkbox"/> No Findings <input type="checkbox"/> Findings (listed below)		Follow-up <input type="checkbox"/> N/A <input type="checkbox"/> Follow-up Plan/Corrective Action Taken (listed below) <input type="checkbox"/> Corrective Action Taken by Sponsor following Sanitation Inspection (listed below):		
The monitor conducted an Announced Site Review ____ Unannounced Site Review _____. List the reason for the type of review chosen.				
Signature of Sponsor Monitor				Date
Site Supervisor Signature				Date



Missouri Department of Health and Senior Services
SUMMER FOOD SERVICE PROGRAM

Menu – Meal Requirements

Name of Sponsor					
Name of Site				Week of	
Year					
Breakfast	Monday	Tuesday	Wednesday	Thursday	Friday
Fluid Milk					
Juice, Fruit or Vegetable					
Grain/Bread					
Meat/Meat Alternate					
Other Foods					
Snack <i>Serve 2 of 4 components</i>					
Fluid Milk					
Juice; Fruit and/or Vegetable					
Grain/Bread					
Meat / Meat Alternate					
Other foods					
Lunch					
Fluid Milk					
Juice, Fruit and/or Vegetable 2 servings					
Grain/Bread					
Meat/ Meat Alternate					
Other Foods					

Food Chart – Summer Food Service Program

Breakfast	Fluid Milk	1 cup (8 fluid ounces) ¹
	Juice or Fruit or Vegetable	½ cup
	Bread, or	1 slice
	Cold Dry Cereal, or	¾ cup or 1 ounce ²
	Cornbread, Biscuits, Rolls, Muffins, etc., or	1 serving
	Cooked Cereal or Cereal Grains	½ cup
	Pasta, Cooked Noodles	½ cup
Lunch or Supper	Fluid Milk	1 cup (8 fluid ounces) ³
	Meat, Poultry, Fish, Cheese, or	2 ounces
	Egg, or	1 large egg
	Cooked Dry Beans, Peas, or	½ cup
	Peanut Butter or other Nut Butters,	4 tablespoons ⁴
	Peanuts, Soy nuts, Tree Nuts or	1 ounce = 50% ⁵
	Yogurt, plain or sweetened, flavored	1 cup
	Vegetables and/or Fruits (must serve at least two different varieties)	¾ cup total ⁶
	Grains/Breads	1 serving
Snack ⁷	Fluid Milk	1 cup (8 fluid ounces) ¹
	Juice or Fruit or Vegetable	¾ cup
	Meat or Meat Alternate	1 ounces
Serve 2 of 4 components	Grains/Bread	1 serving

1. Serve as a beverage, or on cereal, or use part of it for each purpose.
2. Either volume (cup) or weight (ounces), whichever is less.
3. Must be served as a beverage.
4. At lunch or supper, must serve an additional meat/meat alternate with peanut butter.
5. No more than 50% of the requirement can be met with nuts or seeds. Nuts or seeds must be combined with another meat/meat alternate to fulfill the requirement.
6. Serve two or more kinds. Full-strength juice may be counted to meet not more than one-half of this requirement.
7. Serve two food items. Each food item must be from a different food component. Juice may not be served when milk is served as the only other component.

Note: All grain/bread items must be enriched or whole-grain, made from enriched or whole-grain meal or flour, or if it is a cereal, the product must be whole grain, enriched, or fortified. Bran and germ are credited the same as enriched or whole-grain meal or flour.

Four Components in Menu Planning

SFSP nutritional guidelines help assure that children are provided with healthy foods that meet their growing needs. The four components below are used to plan meals and snacks. Additional foods may be served to provide additional calories and nutrients. Specific food information resources can be found in The Food Buying Guide and Creditable Food Guide.

***Breakfast must contain milk, grains/breads and vegetable/fruit components.**

***Lunch and Dinner meals must contain all four components, including two different servings of vegetable/fruit.**

***Snacks must contain at least two different food components.**

<p style="text-align: center;">Meat/Meat Alternates</p> <p>Lean meat, poultry, fish, cheese, egg, cooked dry beans or peas, nuts and seeds, nut and seed butters, alternate protein products, yogurt (creditable at lunch, supper and snack only)</p> <p>Specifics</p> <ul style="list-style-type: none"> • Required at Lunch and Supper as main dish • Minimum creditable amount is ¼ oz. • Nuts/seeds/butters can meet only ½ of meat requirement at meals; meets full requirement at snacks • No more than 2 different meat items creditable at 1 meal • Peanut butter may not be used to meet the entire meat/meat alternate requirement at lunch or supper because of the large amount needed. An additional meat/meat alternate must be served with peanut butter at lunch or supper. • Lunch meat/Cold cuts; including but not limited to hot dogs, polish sausage, little smokies, and sausage <i>no more than 1 time per week</i> 	<p style="text-align: center;">Milk</p> <p>Pasteurized fluid milk, flavored or unflavored</p> <p>Specifics</p> <ul style="list-style-type: none"> • Fluid milk is required for breakfast, lunch and supper. Fluid milk may be served as one of two choices at snack. • Milk must be served as a beverage at lunch and supper. • Milk may be served as a beverage, served on cereal, or used for some of both at breakfast and snack.
<p style="text-align: center;">Vegetable/Fruit/Juice</p> <p>Fruits and vegetables 100% full strength fruit or vegetable juice</p> <p>Specifics</p> <ul style="list-style-type: none"> • 1 serving required at Breakfast • 2 different kinds required at Lunch & Supper • Minimum creditable amount - 1/8 cup • Dried beans and peas cannot count as both fruit and vegetable and meat at 1 meal • Juice cannot be served with milk for snacks • Only one vegetable/fruit creditable for snacks <p>(Example – Not orange juice and apple wedges)</p>	<p style="text-align: center;">Grains/Breads</p> <p>Whole grain or enriched bread, grains, cereal, crackers, pasta</p> <p>Specifics</p> <ul style="list-style-type: none"> • Required at Breakfast, Lunch, and Supper • Minimum creditable amount is ¼ serving • Ready — to—eat cereal at breakfast and snack only • Grain-based chips creditable only 2 times a week and only at lunch, snack and supper • Sweet type breads and grains including but not limited to: Coffee cake, doughnuts, sweet rolls, muffins, cereal/granola bars, and pop-tarts are creditable for breakfast and snack only; <i>No more than 1 time per week at breakfast and no more than 2 times per week at snack.</i>

Meal Pattern Substitution

In order to claim a meal for reimbursement, all required food components must be served in at least the minimum serving size per age group(s). Exceptions to this requirement occur under the following circumstances:

Substitution for a Documented “Disability” (42 U.S. Code Sec. 12102)

Meal pattern substitutions (accommodation[s]) **must** be made when a condition recognized as a “disability” is documented by a recognized medical authority. **A participant with a “disability” is any person who has a physical or mental impairment, which substantially limits one or more “major life activities”, has a record of such impairment, or is regarded as having such impairment.** The list of “major life activities”, for purposes of identifying individuals with disabilities, added a new category called **“major bodily functions.”**

Feeding sites participating in the SFSP are required to make substitutions or modifications to the meal pattern for a participant with a disability that restricts his/her diet. Substitutions must be made on a case by case basis only when supported by a written statement signed by a recognized medical authority (licensed physician, physician’s assistant or nurse practitioner) which explains the need for substitutions and includes recommended alternate foods. The medical statement kept on file must identify:

- The participant’s disability and an explanation of why the disability restricts the participant’s diet;
- The major life activity affected by the disability; and
- The food or foods to be omitted from the participant’s diet and the food or foods that must be substituted.

NOTE: Reimbursement for meals served with documented food substitutions are claimed at the same reimbursement rate as meals which meet the meal pattern. The site may not charge for the substituted food item – substitutions that exceed program reimbursement are at the site’s expense.

Substitution for Medical or Special Dietary Reasons – *Not a Disability*

Substitutions *may* be made on a case by case basis (at the discretion of the center) for a participant who is unable to consume a **food item** because of a medical or other special dietary need but who is *not* disabled. Meal pattern substitutions or modifications for foods (other than milk) may be honored only when written statement signed by a recognized medical authority (licensed physician, physician’s assistant or nurse practitioner) is available.

Fluid Milk (Non-Dairy Beverage) Substitutions – *Not a Disability*

At the discretion of the sponsor, a non-dairy beverage *may* be served in lieu of fluid milk in the case of a child who cannot consume fluid milk due to medical or other special dietary needs, other than a disability. Sites *may* serve a fluid milk substitute to a child without a disability and count it as the milk component if the substitute is nutritionally equivalent to cow’s milk.

A written request for a fluid milk substitute must be made by a medical authority, parent or guardian. *The written request must identify the medical or other special dietary need that restricts the diet of a child.* Prior to this rule, SFSP sponsors were only able to accept a substitution statement signed by a recognized medical authority.

Acceptable fluid milk substitutes must contain the following nutrients in the quantities specified in order to be considered nutritionally equivalent to fluid cow's milk:

Fluid Milk Substitute - Minimum Nutrient Requirements

Nutrient	Per one (1) cup (8 ounces)
Calcium	276 mg.
Protein	8 gm.
Vitamin A	500 IU.
Vitamin D	100 IU.
Magnesium	24 mg.
Phosphorus	222 mg.
Potassium	349 mg.
Riboflavin	0.44 mg.
Vitamin B-12	1.1 mcg.

Non-Dairy Beverages meeting USDA Substitution criteria per 8 fluid ounces include:

8th Continent - Original Soymilk and Light Chocolate Soymilk;

Pacific Natural - 2 varieties of Ultra Soymilk: Plain and Vanilla;

Kikkomon - 2 varieties of Pearl Organic Soymilk: Creamy Vanilla and Chocolate;

Great Value (WalMart) – Original soymilk; and

Sunrich Naturals – 2 varieties: Original and Vanilla

Silk - Original Soymilk

NOTE: The availability of the above nutritionally equivalent non-dairy beverage products may not be available in all Missouri locations.

Any reasonable parent or guardian written request for a non-dairy milk substitution could be accepted at the discretion of the sponsor, as described above, without providing a medical statement. As an example, if a parent has a child who follows a vegan diet, the parent can submit a written request to the sponsor asking that soy milk be served in lieu of cow's milk. The written request must identify the medical or other special dietary need that restricts the diet of the child. Non-dairy milk substitutions are at the option and expense of the sponsor.

Other examples that may be considered a reasonable written request would be for religious, cultural or ethical reasons. However, a request which only states that a child “does not like milk” would *not* be a reasonable request for a fluid milk substitute.

Processed Food Documentation

CN Labels –What to Look For:

USDA released two Policy Memos on March 11, 2015 [CACFP 08-2015 and CACFP 09-2015], listed two types of acceptable documentation approved to verify meal pattern compliance: Child Nutrition (CN) label or manufacturer's product formulation statement (PFS).

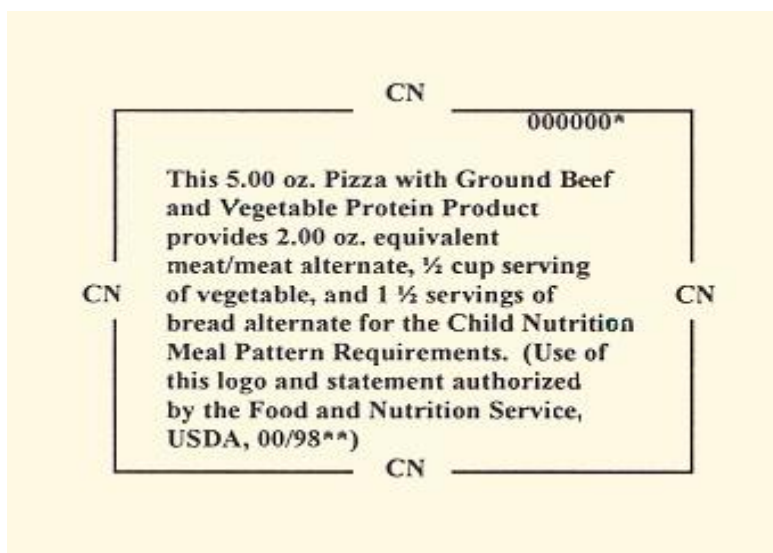
Per Policy Memos CACFP 08-2015 and CACFP 09-2015, acceptable and valid documentation for the CN Label includes:

1. The **original CN Label removed** from the product carton; or
2. A **photocopy of the CN Label** shown attached to the original product carton; or
3. A **photograph of the CN Label** shown attached to the original product carton. (CN Labels that are photocopied or photographed must be visible and legible.)

NOTE: If none of the required documentation is available, Program operators may provide the Bill of Lading (invoice) containing the product name **and:** a **hard (or electronic) copy of the CN Label with a watermark** displaying the product name and CN number provided by the vendor. A CN label with a watermark is used when the CN logo and contribution statement are used on product information other than the actual product carton and is presented as a separate document. Manufacturers may provide schools (not common for CACFP providers) with a CN label with a watermark during the bidding process. (Original CN labels on product cartons will not have a watermark.)

How do I identify a CN label?

- In addition to required labeling features, a CN label will always contain the following:
- The CN logo (which is a distinct border) The meal pattern contribution statement
- A 6-digit product identification number
- USDA/FNS authorization statement
- The month and year of approval.



Sample label statement:

The six-digit CN identification number in the upper-right corner is assigned by the AMS-CN Labeling Program Operations Office.

The date found at the end of this statement reflects the month/year of final approval.

Product Formulation Statement what to look for:

BURRITO FACTORY

Effective Date: November1,1988 Product No.: 9999

Total weight of precooked product: 4.00

Total of raw meat: 0.650oz.

Percent of fat of raw meat: Nottoexceed30%

Weight of dry VPP: 0.094oz.

Weight of liquid used to hydrate VPP: 0.176oz.

Percent of Protein in dry VPP: 52%

Weight of raw meat and hydrated VPP: 0.920

Type of VPP used: XX Flour: _____ Isolate: _____

Weight of other ingredients: 1.005oz.

Weight of pinto beans: 0.325oz.FactoredWt.0.503

Weight of cheese: none

Weight of cooked meat with VPP: 0.644oz.

Total weight of filling: 2.25oz.

Total weight of enriched flour tortilla: 1.75oz.1.59serv.

I certify the above information is true and correct and that the product (ready for serving) contributes **1.14 ounces of equivalent meat/meat alternative** toward the meal pattern when prepared according to direction. I understand that the above named product will be used as a meal component for which Federal reimbursement will be claimed, and that records are available to support the information indicated above. The VPP used conforms to Food and Nutrition Service regulations. This product analysis will supersede all previously issued sheets.

SUGGESTED BID SPECIFICATIONS: _____ cases – Red Chili Beef, Bean and Chicken Burrito, 4.00 ounces Each, un-fried, packed 3/24 count. Must meet 1.00 ounces of meat/meat alternate and 1.50 bread servings.

James Smith Title

DirectorofManufacturing

XYZBurritoFactory

November1,1988

A product formulation statement (formerly known as product analysis sheet) is a detailed information sheet from the product manufacturer. It identifies the weight of the food components in the product and the product's contribution to the Child Nutrition Meal Pattern Requirements.

Key components of the product analysis sheet include:

- The product name; may include a description of the product and/or a product code.
- The food components in the product that contribute to the meal pattern requirement.
- The raw and/or cooked weights of the components that contribute to the meal pattern requirement.
- The product's total contribution towards the meal pattern requirement.
- A statement that any VPP (vegetable protein product) contained in the product has been rehydrated in accordance with Appendix A of the code of Federal Regulations issued January 7, 1983 relating to vegetable protein products used in the national School Lunch Program.
- The original signature of a company official.
- The date.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
SUMMER FOOD SERVICE PROGRAM

Food Production Record

Sponsor:

Site Name:

Date:

Breakfast

A	B	C	D	E	x	F	=	G	H
Food Components	Food Items Used	Serving Size	Purchase Units (lb, Can size, etc.)	Servings Per Purch. Unit		Number of Purchase Units Used		Total Servings Prepared	Number of Meals Served
Milk									
Meat/ Alternate									
Fruit/Vegetable									
Grain/Bread									
Optional Foods									

Lunch/Supper

A	B	C	D	E	x	F	=	G	H
Food Components	Food Items Used	Serving Size	Purchase Units (lb, Can size, etc.)	Servings Per Purch. Unit		Number of Purchase Units Used		Total Servings Prepared	Number of Meals Served
Milk									
Meat/Alternate									
Fruit/Vegetable									
Fruit/Vegetable									
Grain/Bread									
Optional Foods									

Snack (Serve at least Two of the Four Components)

A	B	C	D	E	x	F	=	G	H
Food Components	Food Items Used	Serving Size	Purchase Units (lb, Can size, etc.)	Servings Per Purch. Unit		Number of Purchase Units Used		Total Servings Prepared	Number of Meals Served
Milk									
Meat/Alternate									
Fruit/Vegetable									
Grain/Bread									
Optional Foods									

At a minimum, columns B, D, F, and H must be completed.

ALLOWABLE SFSP COSTS AND NEEDED DOCUMENTATION

Sponsors are no longer required to differentiate between operating and administrative costs. However, sponsors must continue to document all costs attributable to the SFSP in order to demonstrate a non-profit food service. Costs are grouped by administrative and operational categories in this chart to assist in the discussion of different types of costs.

ADMINISTRATIVE COSTS	
COST	DOCUMENTATION
LABOR Completing the sponsor application Attending sponsor training Conducting pre-operational and first week visits Conducting site reviews Reviewing family size and income forms or school applications (enrolled sites and camps) Consolidating meal counts for more than one site Paying food program bills Payroll activity of summer food staff Clerical activity Completing claims for reimbursement Your time working with USDA when they conduct a review and time spent responding to the review	LABOR Time sheets showing name of person, activity and amount of time spent
OFFICE COSTS Telephone Postage Printing Rent (if special Summer Office is needed and special space is rented) Utilities used for administrative staff	OFFICE COSTS Bills Receipts Canceled checks Documented method of proration if cost needs to be shared with other programs Rental Agreement
TRANSPORTATION COSTS Going to training Monitoring of sites	TRANSPORTATION COSTS Mileage records Gas receipts Basis for mileage charges

OPERATING COSTS	
COST	DOCUMENTATION
FOOD Purchases Costs associated with getting food Storing charges	FOOD Invoices Grocery tapes Delivery receipts Canceled checks Receiving reports Refunds and discounts Starting and ending inventories
LABOR Preparing Menus Purchasing/ordering food Delivering food Completing the meal production records Taking the meal count during the meal service Supervising/assisting children during the meal service Clean up after the meal service Supervising food service operations at the site or kitchen level, including the direct supervision of food service staff Processing, transporting, storing and handling food and supplies and transporting equipment, food and supplies	LABOR Time and attendance documents Payroll records including benefits
OTHER COSTS Non-food items (e.g. napkins, kitchen cleaning supplies, etc.) Utilities for food service Rental of facilities, equipment vehicles Transporting children (rural sites only) Transporting food Repairs of kitchen equipment	OTHER COSTS Invoices Grocery tapes Delivery receipts Canceled checks Documented method of proration if cost needs to be shared with other programs Mileage records Gas receipts Basis for mileage charges



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 SUMMER FOOD SERVICE PROGRAM
 PROGRAM COST REPORT

Name of Sponsor									
Program Costs for Period Beginning (mm/dd/yyyy)						Ending (mm/dd/yyyy)			
Position	Salary per Hour	Number of Hours Worked Per Day		Number of Days Worked		Fringe Benefits		Total	
		X		X		+		=	0
		X		X		+		=	0
		X		X		+		=	0
		X		X		+		=	0
		X		X		+		=	0
		X		X		+		=	0
		X		X		+		=	0
		X		X		+		=	0
		X		X		+		=	0
		X		X		+		=	0
		X		X		+		=	0
		X		X		+		=	0
		X		X		+		=	0
		X		X		+		=	0
		X		X		+		=	0

1. Total Labor Costs for Period.....	0
2. Food Purchased for Period.....	
3. Food Service Supplies.....	
4. Transportation.....	
5. Communication.....	
6. Rental of Office Space (non public or sponsor owned).....	
7. Office Supplies.....	
8. Utilities.....	
9. Use allowance on fixtures and furniture (non public or sponsor owned).....	
10. Audit Fees.....	
11. Legal fees.....	
12. Other (specify).....	
Total Monthly Administrative Costs (sum of lines 1 through 12)	0

Updating Changes to CNP Web

Sponsors are required to contact DHSS-CFNA to report any site changes. Site changes can be entered on-line at: <https://dhssweb04.dhss.mo.gov/cnp/>. Submit into Pending Approval status.

Prior to starting operation check all information on the site forms and correct if there are any changes.

The Sponsor must notify DHSS-CFNA if any of the following occur:

- Changes in meal service times
- Changes in meal types
- Increases in estimated attendance (i.e., number of children to be served at each meal or snack service)
- Changes in operations—site closed (temporarily), field trips, etc.
- Start/Stop date change
- Extending site operations
- Permanent site closings
- Sites that were approved for operation, but never opened
- Changes in personnel—report changes of administrative personnel who serve as contacts to DHSS-CFNA. Site supervisory personnel changes must also be reported to DHSS-CFNA.

This information must be updated on-line and submitted into Pending Approval status. Failure to update this information could cause a claim for reimbursement to be rejected by the claims payment system and result in delayed and/or reduced payment.

The Sponsor must notify DHSS-CFNA by 2:00 p.m. the day before the anticipated change is to take place. Failure to meet this deadline will result in disallowed meals. If a change is to occur on a Monday, the sponsor is required to notify DHSS-CFNA by 2:00 p.m. on the preceding Friday.

In emergency situations, such as fire, flood, or transportation breakdowns, contact DHSS-CFNA at 888-435-1464 as soon as possible, once the situation has been assessed.

The following changes CAN ONLY be done using the CACFP 1001 form.

New site openings – Sponsors must submit the paper form Site Information Sheet (CACFP-1001) along with site eligibility documentation (school data or census data). **New sites may not operate until approved by the DHSS-CFNA.**

If the site location changes – The sponsor must submit a new paper form Site Information Sheet (CACFP-1001) prior to operating at the new location. Meals served at the new location may not be claimed for reimbursement until the new site has been approved by DHSS-CFNA.

Requesting Advances for your SFSP

Request advances that are reasonable and accurately reflect estimated site attendance and meal reimbursements in accordance with 7 CFR 225.6(3). First advances shall not be paid until the sponsor has a fully executed contract with the Department.

Advances are payments that may be received before the program begins to pay for administrative and operating costs that are incurred before the program starts. When determining the amount of the advance payment, the State agency will make the best possible estimate based on the sponsor's request and any other available data. These payments are advances on the reimbursement that sponsors will receive for a month of operations and will be deducted from future reimbursement payments.

Sponsor requesting an advance for SFSP:

- Must sign and return a fully executed contract with DHSS to operate as a SFSP sponsor prior to receiving any advance funds
- Must be in good standing with Missouri Food and Nutrition Programs
- Cannot miss a payment for Missouri Food and Nutrition Programs debt deadline from a previous SFSP operational year

If a second or third advance is requested, the sponsor must provide accurate attendance information to the Department by June 20 for the second advance and by July 21 for the third advance, in accordance with 7 CFR Section 225.9.

Debt Repayment

In the event that overpayments are identified and pursuant to 7 CFR 225.12, the sponsor must agree to an overpayment payment schedule and that such overpayments shall be deducted from future claim payments except in the event that no future claim payments are due. For such an event, the Contractor shall remit the full amount of the overpayment pursuant to 7 CFR 225.12, within 30 days of receipt of the notice of the overpayment.

Any and all representatives of the contractor that signs this agreement on behalf of the contractor is aware of his/her personal responsibility for repayment in the case of an overpayment and acknowledges that he/she is personally liable for repayment of any overpayment. In addition, all principals of the contractor are aware of his/her personal responsibility for repayment in the case of an overpayment and acknowledge that he/she is personally liable for repayment of any overpayment.

Corrective Action Plan Process (CAP)

The Summer Food Service Program Sponsor has the responsibility of responding to both site and sponsor review findings (instances of non-compliance) if they occur. There are two different types of reviews, Site reviews and Sponsor reviews. Each has different requirements as well as different lengths of time allotted to complete a Corrective Action Plan.

The CAP Process for Site Reviews:

Following a review by the SFSP Nutritionist, a letter detailing the events of the review, along with a report indicating if each requirement was in compliance, will be mailed to the Sponsor. If findings (instances of non-compliance) occurred during the review, a Corrective Action Plan will be requested.

A copy of the report will be included with the letter and report, for completion by the sponsor. On this form, the Sponsor will address each finding indicated on the report, explaining how each finding will be corrected, who will be responsible for correcting the finding, and a date by which the finding will be corrected.

Each Corrective Action Plan will have a due date. The Sponsor will have three weeks from the date of the letter to respond to the findings. Failure to respond to the report could affect the site and Sponsor's ability to participate in the SFSP. After the Nutritionist has approved the Corrective Action Plan, a closeout letter will be sent to the sponsor.

The CAP Process for Sponsor Reviews:

After the Nutritionist has conducted the sponsor review, a letter will be sent to the sponsor indicating that a review has been conducted and a report detailing compliance/non-compliance will be attached. If findings (instances of non-compliance) occurred during the review, a Corrective Action Plan will be requested.

A Corrective Action Plan form will be included with the letter and report, for completion by the sponsor. On this form, the sponsor will address each finding indicated on the report, explaining how each finding will be corrected, who will be responsible for correcting the finding, and a date by which the finding will be corrected.

The sponsor will have **60** days from the date of the letter to respond to the findings. Failure to respond to the report could affect the Sponsor's ability to participate in the SFSP, and may result in the Sponsor being classified as Seriously Deficient. After the Nutritionist has approved the Corrective Action Plan, a closeout letter will be sent to the Sponsor.

Complete this form and fax (573-526-3679) or mail to:

Missouri Department of Health and Senior Services, Bureau of Community Food & Nutrition Assistance,
P.O. Box 570 Jefferson City, Mo 65102

FINDING (as noted in the letter or on the report)	ACTIONS TO FULLY AND PERMANENTLY CORRECT THE FINDING:	WHO IS RESPONSIBLE	CHECK IF THERE IS A WRITTEN POLICY	DATE OF EXPECTED COMPLETION	DATE STAFF WILL BE TRAINED ON PROCEDURE

SFSP-CAP (form CACFP-230)

Please copy form if additional space is needed

06/2014

Appeal Flyer
Summer Food Service Program (SFSP) – 7 CFR § 225.13
Missouri Department of Health and Senior Services (DHSS)

Appeals of DHSS actions are conducted before an independent administrative hearing officer at the Missouri Department of Social Services' Division of Legal Services (DLS). DLS' main office can be reached at (573) 751-3229 (phone) and (573) 526-1484 (fax).

What can be appealed?

A sponsor may appeal any of the following actions DHSS takes relating to its participation in SFSP or claims for reimbursement [7 CFR § 225.13(a)]:

- A denial of an application for participation;
- A denial of a sponsor's request for an advance payment;
- A denial of a sponsor's claim for reimbursement (except when submitted after the deadline [See 7 CFR § 225.9(d)(6)]);
- A state agency's refusal to forward to USDA's Food and Nutrition Service (FNS) the sponsor's requested exception for payment of a late claim or a request for an upward adjustment to a claim;
- A claim against a sponsor for remittance of a payment;
- The termination of a sponsor or a site;
- A denial of a sponsor's application for a site;
- A denial of a food service management company's application for registration, if applicable; or
- The revocation of a food service management company's registration, if applicable.

A sponsor cannot appeal decisions FNS makes relating to late claims for reimbursement or upward adjustments under 7 CFR § 225.9(d)(6).

How can a sponsor appeal?

- Appeal requests must be in writing.
- A sponsor can either:
 - Fax the appeal request to 573-526-3679; or
 - Mail the appeal request to:
Missouri Department of Health and Senior Services
Bureau of Community Food and Nutrition Assistance
ATTN: SFSP Appeals
PO Box 570
Jefferson City, MO 65102-0570
- DHSS must receive the appeal request no more than 14 calendar days after the sponsor receives the notice of DHSS' action.

What must a sponsor include in its appeal request?

- The sponsor's name, telephone number, and mailing address.
- The name and title (printed or typed) of the sponsor's contact person/authorized representative.
- The DHSS action(s) that the sponsor is appealing, the reason(s) the sponsor is appealing, and the action(s) the sponsor wants DHSS to take instead (i.e., the remedy the sponsor is seeking).
- Whether the sponsor is requesting an abbreviated review or an administrative hearing:
 - Abbreviated administrative review: a review of written documentation only.
 - In an abbreviated review, both the sponsor and DHSS submit written documentation for the hearing officer to consider when deciding the appeal.
 - A sponsor requesting a written review may choose to have an abbreviated administrative review even if it is entitled to a full, in-person hearing.
 - To be considered by the hearing officer, the sponsor must submit all written documentation in support of its appeal to the hearing officer within 7 calendar days of the date it submits its appeal request [7 CFR § 225.13(b)(4)].
 - A sponsor cannot request an in-person administrative hearing after the abbreviated administrative review has taken place.
 - Administrative hearing: an in-person hearing at which the sponsor and DHSS submit verbal testimony and evidence.
 - The DLS hearing officer can hold a hearing in addition to, or instead of, an abbreviated administrative review only if the sponsor requests a hearing in its appeal request.
- A copy of the notice from DHSS that outlines the actions the sponsor is appealing.

Additional information:

- The DLS hearing officer will send the sponsor a letter giving the date, time, and location of the administrative hearing.
- Under Missouri law, corporations and LLCs must be represented by an attorney. A non-attorney cannot file motions or briefs, make legal arguments, or examine witnesses.
- DHSS will have legal counsel representation for both in-person hearings and abbreviated administrative (written) reviews.
- The DLS hearing officer must make a decision within 5 days of either holding an administrative hearing or receiving the written documentation from the sponsor and DHSS.

Remember these deadlines:

- DHSS must receive the sponsor's appeal request within 14 calendar days of the sponsor receiving notice of DHSS' actions;
- The sponsor must submit any written documentation to the hearing officer within 7 calendar days of submitting the appeal request.

For more information: Call DHSS at 888-435-1464.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER. Services provided on a nondiscriminatory basis.