



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
 COMMUNITY FOOD AND NUTRITION ASSISTANCE (CFNA)  
 CHILD AND ADULT CARE FOOD PROGRAM (CACFP)  
**APPLICATION FOR PARTICIPATION**

Name of Organization (Check if New, Re-Applying OR Adding) <input type="checkbox"/> NEW <input type="checkbox"/> RE-APPLYING <input type="checkbox"/> ADDING LOCATION		
Mailing Address of Organization		
City, State, Zip Code		
Street Address of Organization (If different from mailing address)		
City, State, Zip Code		
Name of Organization Sponsor / Owner of this Institution (If different than named above)		
Federal Income Tax Number	Secretary of State Charter Number	Pending Sponsor Number (for DHSS use only)
<b>RESPONSIBLE INDIVIDUAL</b>		
Name		Position/Title
E-mail		
Phone / - Ext.:	Fax / -	
Address: <input type="checkbox"/> Mailing Address <input type="checkbox"/> Street Address		
<b>FOOD PROGRAM CONTACT</b>		
Name		Position/Title
E-mail		
Phone / - Ext.:	Fax / -	
Address: <input type="checkbox"/> Mailing Address <input type="checkbox"/> Street Address		
<b>FINANCIAL CONTACT</b>		
Name		Position/Title
E-mail		
Phone / - Ext.:	Fax / -	
Address: <input type="checkbox"/> Mailing Address <input type="checkbox"/> Street Address		
<b>TYPE OF SPONSORING ORGANIZATION (Only one box in this section may be checked.)</b>		
<input type="checkbox"/> PRIVATE NONPROFIT ORGANIZATION [must have tax exempt status with the Internal Revenue Service and be a 501c(3) organization]. Attach a copy of the 501c(3) letter from the IRS. <input type="checkbox"/> PRIVATE FOR-PROFIT ORGANIZATION [for-profit organizations applying as sponsors for the CACFP may only sponsor for-profit centers that fall under the same organizational umbrella as the sponsoring organization]. <input type="checkbox"/> GOVERNMENTAL ENTITY [unit of local, state, or federal government]. <input type="checkbox"/> SCHOOL		
<b>Sponsoring Type</b>		
<input type="checkbox"/> Independent Sponsor (One Center) <input type="checkbox"/> Sponsoring Organization		
<b>If Sponsoring Organization, Check all entity types that are sponsored:</b>		
<input type="checkbox"/> Centers that are legal entities of the Sponsor <input type="checkbox"/> Centers that are not legal entities of the Sponsor <input type="checkbox"/> Homes		
<b>Elects To Receive</b>		
<input type="checkbox"/> Cash In Lieu of Government – Donated Commodities <input type="checkbox"/> Government Donated Commodities		
<b>List the month your fiscal year begins:</b>		<b>List the month your fiscal year ends:</b>
Enter the total amount of Federal Dollars (Including CACFP) that your Organization expended during your last completed fiscal year.		
\$		
What is the total amount of Federal Dollars (Including CACFP) that your Organization expects to spend during the fiscal year you are currently in? (If the amount is over \$500,000 then an A-133 Audit is required.)		
\$		

**INCOME ELIGIBILITY FORM APPROVAL**

Enter the Name and Title of Person responsible for verifying Income Eligibility Forms:  
 Name:  
  
 Title:

**CLAIM REIMBURSEMENT CERTIFICATION**

Enter the Name and Title of person responsible for Certifying the claim for Reimbursement.  
 Name:  
  
 Title:

Describe the controls your organization has in place to backup these persons in the event they are no longer employed by your organization or cannot complete these tasks.

Documentation of meals and supplements served must be made at point of service. (Point of Service is defined as the place and time at which meals are served.) Please describe below how your Sponsoring Organization ensures that meals are documented at point of service.

Has this Institution or any of its Principals, Sponsoring Organizations, or Key Staff of Sponsored Organizations ever been terminated in any state for being seriously deficient in operating any United States Department of Agriculture (USDA) Child Nutrition Program and placed on the National Disqualified List?

Yes  No

During the last seven years, has this Institution or any of this Institution's Principals been declared ineligible for any other publicly funded program by reason of violating that program's requirements?

Yes  No

During the last seven years has this Institution or any of its Principals been convicted of any activity that indicated a lack of business integrity (fraud, antitrust violations, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, obstruction of justice, or any other activity indicating a lack of business integrity)?

Yes  No (If yes, give details on name of person)

List the Federal, State or Locally Funded Programs in which this Institution and its Principals have participated in the past seven years.

**EXECUTIVE DIRECTOR**

<b>Name</b>	<b>Birthdate</b> / /
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**Home Address**

**City, State, Zip Code**

**CHAIRMAN OF THE BOARD OR OWNER**

<b>Name</b>	<b>Birthdate</b> / /
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**Home Address**

**City, State, Zip Code**

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

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

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

**SIGNATURE**

SIGNATURE BY THE AUTHORIZED REPRESENTATIVES BELOW CERTIFIES THAT:

- I certify that the information on the application is true and accurate to the best of my knowledge; that I will accept final administrative and financial responsibility for the total CACFP operations at all institutions under my sponsorship; that reimbursement will be claimed only for meals served to enrolled children, that a provider must be eligible for free-reduced price meals in order to claim own children; that the CACFP will be eligible to all children without regard to race, color, sex, national origin, age, or disability at the approved food service institutions; and that these institutions have the capability for the meal service planned for the number of children anticipated. 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.
- Yes  No Have you ever been found to be in noncompliance of the Civil Rights Law by any federal agency?
- Yes  No Is this business minority owned and operated?
- Yes  No Is this business a registered woman owned and operated business?
- Yes  No Does the organization operate the CACFP in any other state?  
If Yes, list states \_\_\_\_\_
- Yes  No Does your organization have a governing board?  
If Yes, attach on a separate sheet, a list including name of member, title/position, mailing address, and date of birth.
- Yes  No Has your organization been disqualified from participation in any publicly funded program for violating requirements within the last seven years? (publicly funded means any program or grant funded by federal, state or local government)
- Yes  No Have any of your organization's board members, owners, directors, or other principals of the organization been disqualified from participation in any publicly funded program for violating that programs requirements within the last seven years?
- Yes  No Is the organization, the board president, or any other members of the board, the owner, director, or any other persons responsible for the management of the CACFP on the National Disqualification List?
- Yes  No Have any of the organization's board members, owners, directors, or other principals of the organization been convicted of any business related crime during the past seven years?
- Yes  No The information on the application is true and accurate to the best of my knowledge.
- Yes  No The authorized representatives, owners, partners, and the corporation accept final administrative and financial responsibility for the total CACFP operation at the sponsored institutions.
- Yes  No Reimbursement will be claimed only for the meals served to enrolled and qualified participants, and meet all CACFP meal pattern requirements.
- Yes  No Department officials may verify information.
- Yes  No The authorization representatives understand that information is being given in connection with the receipt of federal funds, and that deliberate misrepresentation may subject the authorized representatives to prosecution under applicable state and federal criminal statutes.
- Yes  No The institutions under the sponsor's administration assure that all participants enrolled in the institutions are served the same meals regardless of race, color, national origin, age sex, or disability and there is no discrimination in the course of the meal service.
- Yes  No All materials related to the program will contain the following nondiscrimination statement and complaint procedures.
  - In accordance with Federal law and USDA policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability.
  - To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Ave SW, Washington, DC 20250-9410 or call (866) 632-9992 USDA is an equal opportunity provider and employer.
- Yes  No If the sponsoring organization is a for-profit organization, the centers under its sponsorship share the same legal entity as the sponsoring organization.
- Yes  No Only for-profit centers meeting the 25% standard will submit a claim for reimbursement, or will be included in the sponsoring organization's claim for reimbursement. The institution or the sponsoring organization will indicate on the monthly claim the total number of participants that are Title XX and/or Title XIX beneficiaries or eligible for free or reduced-price meal classification.
- Yes  No For pricing institutions, meals will be available to all enrolled participants. A separate charge will be made for the meals. For non-pricing institutions, meals will be made available to all enrolled participants at no separate charge.

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

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

APPROVED BY:	TITLE	DATE	EFFECTIVE DATE
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**Submit the completed, signed form by fax to 573-526-3679 OR by e-mail to [CACFP@health.mo.gov](mailto:CACFP@health.mo.gov)  
Missouri Department of Health and Senior Services  
Community Food and Nutrition Assistance  
PO Box 570  
Jefferson City, MO 65102**

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:** U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410; or
2. **fax:** (833) 256-1665 or (202) 690-7442; or
3. **email:** [program.intake@usda.gov](mailto:program.intake@usda.gov)

This institution is an equal opportunity provider.

**TO BE COMPLETED BY SPONSORING ORGANIZATIONS ONLY (A SPONSORING ORGANIZATION IS AN ORGANIZATION THAT OWNS, OPERATES, OR SPONSORS MORE THAN ONE INSTITUTION) STAFFING PLAN**

- Yes  No Does your organization have a governing board?
- Yes  No Do any board members own sponsor used property?
- Yes  No Do any board members have interest in any organization doing business with the sponsor?

How often does you board meet?  Annually  Quarterly  Monthly  
 Date of last board meeting: / /

Provide the address where all CACFP records will be stored for review by DHSS. Out of state sponsors must provide an in-state location for storage of records:

List the Sponsoring Organizations normal business hours of operation:

- Sunday  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday

OPEN TIME:  A.M.  P.M. CLOSE TIME:  A.M.  P.M.

**HOW DO YOU ASSURE THAT EACH SPONSORED INSTITUTION IS LICENSED OR LICENSE-EXEMPT DURING THE TIME PERIOD OF THE AGREEMENT?** (It is the responsibility of the sponsoring organization to assure that each institution under its sponsorship is currently licensed or license-exempt and inspected. DHSS will not track this information for the sponsor. Institutions that are not licensed or license-exempt for the entire claim period are not eligible for CACFP reimbursement during periods when not licensed.)

**IF YOU ARE A SPONSOR OF FOR-PROFIT INSTITUTIONS, HOW WILL YOU ASSURE THAT EACH INSTITUTION RECEIVES FUNDS UNDER TITLE XX OR TITLE XIX (FOR ADULT DAY CARE INSTITUTIONS) OF THE SOCIAL SECURITY ACT FOR AT LEAST 25 PERCENT OF ITS ENROLLMENT (OR FOR CHILD CARE INSTITUTIONS, ENROLLMENT OR LICENSED CAPACITY, WHICHEVER IS LESS), DURING THE MONTH PRECEDING APPLICATION TO THE CACFP AS WELL AS DURING EACH MONTH CLAIMED FOR REIMBURSEMENT?** (At a minimum, the sponsor must collect and review FSD invoices against the center's enrollment to assure that 25% of enrolled participants are Title XX and/or Title XIX recipients.)

**DOES THE SPONSOR OR ANY OF THE INSTITUTIONS UNDER THE SPONSOR, CONTRACT WITH A FOOD SERVICE MANAGEMENT COMPANY (CATERER) FOR MEALS?**

- Yes  No  
 If yes, attach copies of the contract and the procedures used to select the food service management company.

Federal regulations require that organizations obtain catered services in a competitive manner if the annual contract for such services will exceed \$100,000. The instructions on the competitive bid process and a copy of a bid prototype for contracts above \$100,000 can be found at [www.health.mo.gov/cacafp](http://www.health.mo.gov/cacafp).

**FOR ANY INSTITUTION OPERATING A PRICING PROGRAM, HOW DO YOU ENSURE THAT THE INSTITUTION'S COLLECT PAYMENT FOR MEALS IN ACCORDANCE WITH THE APPROVED POLICY STATEMENT?** (Pricing program means an institution in which a separate identifiable charge is made for meals served to participants.)

**IN THE CHART BELOW, LIST THE STAFF MEMBER WITH PRIMARY RESPONSIBILITY FOR THE ACTIVITIES LISTED. INDICATE THE NUMBER OF HOURS PER MONTH SPENT COMPLETING THESE ACTIVITIES.**

ACTIVITY	NAME OF STAFF MEMBER	HOURS PER MONTH
APPROVE INCOME ELIGIBILITY FORMS (IEFs)		
OBTAIN ENROLLMENT FORMS AND UPDATE ANNUALLY		
PROVIDE TRAINING TO KEY STAFF		
CONDUCT CACFP ORIENTATION FOR NEW STAFF		
PLAN MENUS		
DOCUMENT FOOD AND LABOR COSTS		
COMPILE THE CLAIM FOR REIMBURSEMENT		
SUBMIT THE CLAIM ON-LINE		
OBTAIN AND UPDATE INFANT FEEDING PREFERENCE FORMS FOR ALL INFANT MEALS		
MONITOR CENTERS		

**MONITORING AND REVIEWS**

**THE SPONSOR IS REQUIRED TO MONITOR EACH INSTITUTION UNDER ITS SPONSORSHIP AT LEAST THREE TIMES PER YEAR, IN ACCORDANCE WITH CACFP POLICY 6.3.**

Are monitoring visits documented? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are at least two monitoring visits per year unannounced? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**DOES THE MONITORING REVIEW INCLUDE A REVIEW OR OBSERVATION OF THE FOLLOWING REVIEW KEY ELEMENTS?**

Menus <input type="checkbox"/> Yes <input type="checkbox"/> No	Attendance In Required Training <input type="checkbox"/> Yes <input type="checkbox"/> No
Meal Records <input type="checkbox"/> Yes <input type="checkbox"/> No	Enrollment Forms and Annual Update <input type="checkbox"/> Yes <input type="checkbox"/> No
Meal Pattern Compliance <input type="checkbox"/> Yes <input type="checkbox"/> No	Five Day Reconciliation of Meals <input type="checkbox"/> Yes <input type="checkbox"/> No
Meal Counting Procedures/Point of Service Meal Counts <input type="checkbox"/> Yes <input type="checkbox"/> No	Actions Taken To Correct Previous Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
License Status and Expiration <input type="checkbox"/> Yes <input type="checkbox"/> No	Sanitation of Institutions <input type="checkbox"/> Yes <input type="checkbox"/> No

**THE SPONSOR IS REQUIRED TO HAVE A POLICY REGARDING OUTSIDE EMPLOYMENT OF STAFF WORKING FOR THE SPONSOR AT ANY OF ITS INSTITUTIONS.**

Is the policy available for review by the Missouri Department of Health and Senior Services? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does the sponsor assure that the outside employment does not interfere or conflict with the performance of CACFP duties? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**TRAINING**

**THE SPONSOR IS REQUIRED TO TRAIN KEY ADMINISTRATIVE AND OPERATIONAL STAFF ON CACFP RELATED ISSUES.**

Is training offered at least annually? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the training documented, including the name of the trainer, date of the training, topics provided, and the participants in attendance? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Does the training include, at a minimum, the following topics in accordance with CACFP Policy 6.3?**

<input type="checkbox"/> Yes <input type="checkbox"/> No	
CACFP Meal Pattern Requirements <input type="checkbox"/> Yes <input type="checkbox"/> No	Reimbursement Process <input type="checkbox"/> Yes <input type="checkbox"/> No
Infant Meal Pattern Requirements <input type="checkbox"/> Yes <input type="checkbox"/> No	Meal Counting Procedures <input type="checkbox"/> Yes <input type="checkbox"/> No
Creditable Foods <input type="checkbox"/> Yes <input type="checkbox"/> No	Claim Consolidation and Submission <input type="checkbox"/> Yes <input type="checkbox"/> No
Requirements for Documenting Child and Infant Meals <input type="checkbox"/> Yes <input type="checkbox"/> No	Food Safety and Sanitation <input type="checkbox"/> Yes <input type="checkbox"/> No
CACFP Recordkeeping Requirements <input type="checkbox"/> Yes <input type="checkbox"/> No	Nutrition <input type="checkbox"/> Yes <input type="checkbox"/> No

**PERSONAL INFORMATION**

**Please enter the name, address, phone number, date of birth of the person completing this application and sign below.**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip Code:** \_\_\_\_\_

**Phone:**    /    -    Ext.: \_\_\_\_\_

**Birthdate:**    /    /    \_\_\_\_\_

**Signature:** \_\_\_\_\_

**INSTRUCTIONS: PLEASE MAKE A COPY FOR YOUR FILES BEFORE MAILING**

**Missouri Department of Health and Senior Services  
Community Food and Nutrition Assistance  
PO Box 570  
Jefferson City, MO 65102  
Fax: 573-526-3679**

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

- mail:** U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410; or
- fax:** (833) 256-1665 or (202) 690-7442; or
- email:** program.intake@usda.gov

This institution is an equal opportunity provider.

## CACFP Application Process Check List

Below is a list of items needed to complete the application process:

- [Application and Management Plan, 5 pages \(CACFP-1\)](#)
- [Application/Center Information, 4 pages \(CACFP-2\)](#)
- [Application Budget](#)
- Copy of 501(c) (3) approval letter from IRS, if applicable
  - Application for [501\(c\) \(3\)](#) - if needed
- Unlicensed institutions must:
  - Have a Fire Inspection
  - Have a Sanitation Inspection
  - Complete a [Program Evaluation Questionnaire](#) (MO500-3297) and fax to licensing at 573-526-5345; after receiving a letter from licensing a copy must be sent to us by either fax or email. **Your application cannot be approved without this letter from licensing.**
- Copy of [Overlap Request](#) Approval (MO500-3307) – if applicable
- [Network User Access Request](#)
- [Vendor Input/ACH-EFT do not return per instructions on bottom of form, return as directed at the bottom of this check list](#)
- Copy of Enrollment Roster [pdf](#) or [doc](#)
- 2 Weeks of Menus (choice of menu templates listed below)
  - 3 Meal Menu Template (5 day) [pdf](#) or [fillable doc](#)
  - USDA Requirements (5 day) [pdf](#) or [fillable doc](#)
  - USDA Requirements (7 day) [pdf](#) or [fillable doc](#)
  - 5 Meal Menu Template (5 day) [pdf](#) or [fillable doc](#)
  - 5 Meal Menu Template (7 day) [pdf](#) or [fillable doc](#)
  - At-Risk Snack & Supper Menu Template (7 day) [pdf](#) or [fillable doc](#)
- Copy of Food Service Management Company or School Food Authority Contract, if vended
- Vendor No Tax Due letter from Mo Department of Revenue
- Annual Subrecipient Information Form – <https://health.mo.gov/information/asif/index.php>
- E-Verify - <https://www.uscis.gov/e-verify>
- Orientation Class Certificate –If you have attended Orientation please provide a copy of your certificate that was provided the day of training. If you have not taken the training within the last 6 months please go to: [www.health.mo.gov/cacfp](http://www.health.mo.gov/cacfp) to enroll in the mandatory orientation class. One on one training will be scheduled for Adult Day Care Centers, At Risk, Afterschool and Emergency/Homeless Shelters.

You may either fax or scan and email the needed items to me at:

Fax - 573-526-3679

Email – [cacfp@health.mo.gov](mailto:cacfp@health.mo.gov)