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

Name of Organization (Check if New or Re-Applying) ☐ NEW INSTITUTION ☐ RE-APPLYING INSTITUTION	FOR PARTICIPATING INSTITUTIONS ONLY: Current Contract Number	FOR DHSS USE ONLY: New Contract Number

Mailing Address of Organization (If different from street address)	**Street Address of Organization**

City	State	Zip Code	City	State	Zip Code

Secretary of State Charter Number	Name of Organization Sponsor / Owner of this Institution (If different than named above)

Responsible Individual

Name: _____Position/Title_____

E-mail:_____

Phone: _____Extension:_____Fax: _____

Address: ☐ Mailing Address or ☐ Street Address

Food Program Contact

Name: _____Position/Title_____

E-mail:_____

Phone: _____Extension:_____Fax: _____

Address: ☐ Mailing Address or ☐ Street Address

Financial Contact

Name: _____Position/Title_____

E-mail:_____

Phone: _____Extension:_____Fax: _____

Address: ☐ Mailing Address or ☐ Street Address

TYPE OF SPONSORING ORGANIZATION (Only one box in this section may be checked.)

☐ **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.

☐ **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].

☐ **GOVERNMENTAL ENTITY** [unit of local, state, or federal government].

☐ **SCHOOL**

Sponsoring Type

☐ Independent Sponsor (One Center) ☐ Sponsoring Organization (must complete pages 4 and 5)

If Sponsoring Organization, Check all entity types that are sponsored:

☐ Homes ☐ Centers that are legal entities of the Sponsor ☐ Centers that are not legal entities of the Sponsor

Elects To Receive

☐ Cash In Lieu of Government – Donated Commodities

☐ Government Donated Commodities

List the month your fiscal year Begins:	**List the month your fiscal year Ends:**

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 and an A-133 Audit is required.)
$

INCOME ELIGIBILITY FORM APPROVAL	**CLAIM REIMBURSEMENT CERTIFICATION**
Enter the Name and Title of Person Responsible for verifying Income Eligibility Forms: Name: Title:	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

Name: _____

Birthdate: _____

Mailing Address: _____

_____

_____

Chairman of the Board or owner

Name: _____

Birthdate: _____

Mailing Address: _____

_____

_____

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:

For Sponsor of Family Day Care Homes

☐ I certify that the information submitted to the State Agency on the information sheet, the management plan and the budget and its attachments is true and accurate to the best of my knowledge; that I will accept the final administrative and financial responsibility for the total CACFP operations at all facilities under my sponsorship; that the reimbursement will be claimed only for meals served to enrolled children; that the CACFP will be available to all eligible enrolled children without regard to race, color, sex, national origin, age, or disability at the approved food service institutions; and that these food service institutions have capability for the meal service planned for the number of children anticipated. I understand that this information is being given in connection with receipt of Federal funds and that deliberate misrepresentation may subject me to prosecution under applicable State and Federal criminal statutes.

For Sponsor Centers

☐ 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.

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

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES USE ONLY

APPROVED BY:	TITLE	DATE	EFFECTIVE DATE

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

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.

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? ☐ Yes ☐ No	Are at least two monitoring visits per year unannounced? ☐ Yes ☐ No

DOES THE MONITORING REVIEW INCLUDE A REVIEW OR OBSERVATION OF THE FOLLOWING REVIEW KEY ELEMENTS?

Menus ☐ Yes ☐ No	Attendance In Required Training ☐ Yes ☐ No
Meal Records ☐ Yes ☐ No	Enrollment Forms and Annual Update ☐ Yes ☐ No
Meal Pattern Compliance ☐ Yes ☐ No	Five Day Reconciliation of Meals ☐ Yes ☐ No
Meal Counting Procedures/Point of Service Meal Counts ☐ Yes ☐ No	Actions Taken To Correct Previous Problems ☐ Yes ☐ No
License Status and Expiration ☐ Yes ☐ No	Sanitation of Institutions ☐ Yes ☐ 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? ☐ Yes ☐ No	Does the sponsor assure that the outside employment does not interfere or conflict with the performance of CACFP duties? ☐ Yes ☐ No

TRAINING

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

Is training offered at least annually? ☐ Yes ☐ No	Is the training documented, including the name of the trainer, date of the training, topics provided, and the participants in attendance? ☐ Yes ☐ No

Does the training include, at a minimum, the following topics in accordance with CACFP Policy 6.3? ☐ Yes ☐ No

CACFP Meal Pattern Requirements ☐ Yes ☐ No	Reimbursement Process ☐ Yes ☐ No
Infant Meal Pattern Requirements ☐ Yes ☐ No	Meal Counting Procedures ☐ Yes ☐ No
Creditable Foods ☐ Yes ☐ No	Claim Consolidation and Submission ☐ Yes ☐ No
Requirements for Documenting Child and Infant Meals ☐ Yes ☐ No	Food Safety and Sanitation ☐ Yes ☐ No
CACFP Recordkeeping Requirements ☐ Yes ☐ No	Nutrition ☐ Yes ☐ No

PERSONAL INFORMATION

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

Name: _____

Address_____

Phone: _____Extension:_____

Date of Birth: _____

Signature: _____

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