



# Child and Adult Care Food Program Application

Provider Number: \_\_\_\_\_

Fiscal Year 2012 (October 1, 2011- September 30, 2012)

Application type:  New  Renewal  Name Change  Relocation - Date of Move:

Name or Names as appear on license:		TIN (e.g. Social Security No.)	Phone (area code)
Address of licensed site (city, state, zip code):			County:
Mailing address if different from above (city, state, zip code):			E-Mail Address:
Days of Care: M Tu W Th F Sa Su	Hours of Care:	License Number:	

### List Provider's, Co-Provider's, or Residential Children (ages birth through age 12).

Child's name	Birth date	Age	Child's name	Birth date	Age

Do you have a helper? Y or N      Is helper 18 years or older? Y or N

Days and hours helper is present:

### Meal Services and Time Check the meals you plan to serve and list serving times. We can only reimburse you for meals checked.

√ Meal	From	To	√ Meal	From	To
Breakfast			Supper		
Morning Snack			Evening Snack		
Lunch			Midnight Snack		
Afternoon Snack					

### Voluntary Civil Rights Information Check the box(es) which best describes your race and ethnicity. This information is voluntary.

Ethnicity (check one)      Race (check one or more)       I do not wish to give this information.

Hispanic or Latino       American Indian or Alaskan Native       Noted by advisor.\*

Not Hispanic or Latino       Asian

Black or African American

Native Hawaiian or Pacific Islander

White

\*Note if you choose not to give this information  
Your advisor must choose the categories for you.  
Information is gathered for statistical purposes  
and does not determine eligibility.

This institution is an equal opportunity provider.

I certify that to the best of my belief and knowledge, the information provided on this Child and Adult Care Food Program Application is correct in all respects. I understand this application will be verified and that deliberate misrepresentation may subject me to prosecution under applicable State and Federal civil and criminal statutes. I have not applied to another CACFP sponsor for Fiscal Year 2012.

Provider's Signature	Co-Provider's Signature	Date:      /      /
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For Office Use Only

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Date Received:	Orientation Date:	Orientation By:	Latitude:
			Longitude: