Child and Adult Care Food Program Application

Fiscal Year 20_____ (October 1–September 30)

Provider Number:

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 your for meals checked.

✓	Meal	To	From	✓	Meal	To	From
	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)

☐ Hispanic or Latino

☐ Not Hispanic or Latino

Race (check one or more)

☐ American Indian or Alaskan Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or Pacific Islander

☐ White

☐ I do not wish to give this information.

☐ Noted by advisor*

*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 sponsorship for this fiscal year.

Provider's Signature	Co-Provider's Signature	Date:

For Office Use Only 4040 3/15

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