Home Information Form (HIF)

a. Provider Information

Provider Name: _____

Provider Date of Birth *(required):* _____

Day Care Home Name *(if applicable)*: _____

Phone Number: _____ Email Address: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____ Ward: _____

b. Provider's USDA Program Participation

Has the provider previously participated in CACFP under another sponsor? Yes: _____ No: _____

If yes, please provide the following information and submit a provider transfer request or proof of termination of the agreement with the previous sponsor.

Name of Previous Sponsoring Organization: _____

Address of Previous Sponsoring Organization: _____

City: _____ State: _____ ZIP Code: _____

Dates of participation: _____

Does the provider currently participate in any other USDA program (ex. SNAP)? Yes: _____ No: _____

If yes, please list the program(s): _____

c. Day Care Home Enrollment

Number of children currently enrolled for day care services: _____

Of these, how many are the providers own children? _____

Do the provider's own children (ages 12 or under) receive meals or snacks while other enrolled children are present? Yes: _____ No: _____

If yes, the provider must complete an Income Eligibility Statement (IES) and the sponsor must determine that the children are eligible for free or reduced-price meals before the provider may claim meals served to her own children while other enrolled children are present.

d. Day Care Home Operation

Day care services are provided:

Monday: ___ Tuesday: ___ Wednesday: ___ Thursday: ___ Friday: ___ Saturday: ___ Sunday: ___

Hours of Operation: _____ AM / PM to _____ AM / PM

Note: Do not include times when only the provider's own children are in care.

List all dates and times during which the provider will NOT offer day care services (i.e. vacations, holidays, etc.):

_____

Provider's Name: _____

e. Tier Information

This home has been classified as: Tier I: _____ Tier II: _____

If Tier II, has the provider opted to be single rate or mixed? Single Rate: _____ Mixed: _____

If Tier I, provide the information used to make this determination:

_____ School Data Date of Determination: _____

Name of School: _____

Percentage Eligible for Free or Reduced-Price Meals: _____

_____ Census Data Date of Determination: _____

Percentage of Children from Households Income-Eligible for Free or Reduced-Price Meals: _____

_____ Provider income Date of Determination: _____

f. Meal Service Information

Meal Type	Est. Number of Meals to be Served	Time Meal Service Begins	Time Meal Service Ends
Breakfast			
AM Snack			
Lunch			
PM Snack			
Supper			

Are children served meals at different times or in shifts? Yes: _____ No: _____

Second Shift Meal Service Information *(if applicable)*

Meal Type	Est. Number of Meals to be Served	Time Meal Service Begins	Time Meal Service Ends
Breakfast			
AM Snack			
Lunch			
PM Snack			
Supper			

g. Verification and Signatures

I certify that I have understood this application to participate in the Child and Adult Care Food Program in the District of Columbia, and that the information provided in this application is true and correct to the best of my knowledge.

_____ _____

Signature of Provider **Date**

_____

Printed Name of Provider

_____ _____

Signature of Sponsoring Organization Authorized Representative (or Official Designee) **Date**

_____

Printed Name of Sponsoring Organization Authorized Representative (or Official Designee)