South Carolina Department of Social Services
Child and Adult Care Food Program

APPLICATION FOR PARTICIPATION FOR CHILD CARE HOMES

Facility Name ____ Agreement Number __________________

Facility Info

Facility Name _________________________________ **Agreement Number** ______________________
Operation Start Date ________________________ **Operation End Date** __________________________
Physical Address # # – # ____
U # # – #
Responsible Person _____________________________________ **Title:** ___________________________
License Type ________________ **License Number** _______________ **-** _________________

General Info

Does this facility now participate, or has it previously participated in a program(s) funded by the Food and Nutrition Service (or any other Federally Funded Program) within the past seven (7) years?
Yes_____ No_____
If yes, provide name of program(s) and operation dates. ____

Participants

Residents:

Number of Provider's own children eligible to be claimed for reimbursement: ________
Number of Provider's foster children: ________
Disabled (must be over 12 years old): ________

Non-Residents:
Non-Resident: _______
Migrant (must be over 12 years old): _______
Disabled (must be over 12 years old): _______

Accept Drop-In Participants?: ____Yes ____No License Capacity: _______
Age of participants accepted in facility: (Enter infants under 1 year as 0)
From: __________ To: __________ years old

Ethnic/Racial Category Make-up
Actual enrollment data by ethnic/racial category for each facility must be collected by the institution each year. Visual identification may be used by institutions to determine a participant’s ethnic/racial category or the family may be asked to identify the ethnic/racial group of the participant. For data collecting purposes, a beneficiary may be included in the group to which he or she appears to belong, identifies with, or is regarded in the community as belonging. Parents/guardian of participants may be asked to identify the ethnic/racial group of the participant only after it has been explained and they understand that the collection of this information is strictly for statistical reporting requirements.

This **Facility's actual enrollment data** by ethnic/racial category make-up **must be reported in whole numbers only.**

Ethnic Break-down (actual enrollment)
Hispanic: __________ Non-Hispanic: __________

Racial Breakdown (actual enrollment)
American Indian or Alaska/Native: _________ Asian: _________ Black or African: _________
Hawaiian or Pacific Islander: _________ White: _________

Operations

Operations Data
Responsible individual: First Name ____________________Last Name: ________________ Title:__________

Does Facility operate 24 hours: _____ yes _____ no
Enter the number of operating days per week and check the operating days:
Number of operating days per week: _________
Monday____ Tuesday____ Wednesday____ Thursday____ Friday____ Saturday____ Sunday____

Operating Months: (Check all months in which the CACFP will operate)
October ___ November___ December___ January ___ February ___ March ___
April ___ May ___ June ___ July ___ August ___ September ___

Does the facility provide care in shifts: yes____ no ____

Hours of Operation
Does the facility provide overnight care? _______ Yes _______ No

Day of Week	**Start time**	**End time**	**Check if open 24 hours**
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

First Service Period (Shift One)
Check all that apply:
Monday____ Tuesday____ Wednesday____ Thursday____ Friday____ Saturday____ Sunday____

Enter start time and end time of your first service period (shift):
Service Period (Shift) Start Time: _________ Service Period (Shift) End Time: _________

Meals

Note: service type is the location meals are prepared for the facility, such as self prep at the facility (sp), central kitchen (ck), local school system (school) or food service management co. (fsmc).

Meal Type: _Breakfast_ Service Type: ________________________ Number of Meals per Day: ______
Service Periods: _________________ Meal Time: _____________
Meal Type: _AM Snack_ Service Type: ________________________ Number of Meals per Day: ______
Service Periods: _________________ Meal Time: _____________
Meal Type: _Lunch_ Service Type: ___________________________ Number of Meals per Day: ______
Service Periods: _________________ Meal Time: _____________
Meal Type: _PM Snack_ Service Type: ________________________ Number of Meals per Day: ______
Service Periods: _________________ Meal Time: _____________
Meal Type: _Supper/Dinner Service_ Type: ___________________ Number of Meals per Day: ______
Service Periods: _________________ Meal Time: _____________
Meal Type: _Evening Snack_ Service Type: _____________________ Number of Meals per Day: ______ Service Periods: _________________ Meal Time: _____________

Second Service Period (Shift Two)

Check all that apply:
Monday____ Tuesday____ Wednesday____ Thursday____ Friday____ Saturday____ Sunday____

Enter start time and end time of your second service period (shift):
Service Period (Shift) Start Time: ________ Service Period (Shift) End Time: ________

Meals

Meal Type: _Breakfast_ Service Type: ________________________ Number of Meals per Day: ______
Service Periods: _________________ Meal Time: _____________
Meal Type: _AM Snack_ Service Type: ________________________ Number of Meals per Day: ______
Service Periods: _________________ Meal Time: _____________
Meal Type: _Lunch_ Service Type: ___________________________ Number of Meals per Day: ______
Service Periods: _________________ Meal Time: _____________
Meal Type: _PM Snack_ Service Type: ________________________ Number of Meals per Day: ______
Service Periods: _________________ Meal Time: _____________
Meal Type: _Supper/Dinner Service_ Type: ___________________ Number of Meals per Day: ______
Service Periods: _________________ Meal Time: _____________
Meal Type: _Evening Snack_ Service Type: _____________________ Number of Meals per Day: ______
Service Periods: _________________ Meal Time: _____________

Third Service Period (Shift Three)

Check all that apply:
Monday____ Tuesday____ Wednesday____ Thursday____ Friday____ Saturday____ Sunday____

Enter start time and end time of your third service period (shift):
Service Period (Shift) Start Time: ________ Service Period (Shift) End Time: ________

Meals

Meal Type: _Breakfast_ Service Type: _______________________ Number of Meals per Day: ______
Service Periods: _________________ Meal Time: _____________
Meal Type: _AM Snack_ Service Type: _______________________ Number of Meals per Day: ______
Service Periods: _________________ Meal Time: _____________
Meal Type: _Lunch_ Service Type: __________________________ Number of Meals per Day: ______
Service Periods: _________________ Meal Time: _____________
Meal Type: _PM Snack_Service Type: _______________________ Number of Meals per Day: ______
Service Periods: _________________ Meal Time: _____________
Meal Type: _Supper/Dinner Service_ Type: ___________________ Number of Meals per Day: ______
Service Periods: _________________ Meal Time: _____________
Meal Type: _Evening Snack_ Service Type: ____________________ Number of Meals per Day: ______
Service Periods: _________________ Meal Time: _____________

Meals

Meal Service Info
Is the Facility Requesting more than two meals and one snack or two snacks and one meal?
Yes____ No____

Menu Variations

Does this facility require approval of meal variation for religious reasons? _____ Yes _____ No
Does this facility require approval of meal variation due to unavailability of fluid milk? _____ Yes _____ No;
if yes, identify the time period fluid milk will not be available: __________________
Does this facility require approval of meal variation due to another reason? ____ Yes ____ No If yes, specify the reason: ____

Meal Providers (Identify how meals are provided for this facility. Note: Complete this section if meals are not prepared at the facility.)

Central Kitchen (CK): ____
Local School System(s) (LSS): ____
Food Service Management Co. (s) (FSMC): ____

Closures

(Holidays or days the facility will be closed)

Holiday or reason for closure	Start Date (MMDDYYYY)	End Date (MMDDYYYY)

Certification Tab

I HEREBY CERITFY that to the best of my knowledge, this home is not participating in the Child and Adult Food Care Program under any other sponsoring organization. I further **CERTIFY** that all of the above information is true and correct. I understand that this information is being given in connection with the receipt of federal funds; that Department officials may, for cause, verify information; and that deliberate misrepresentation may subject me to prosecution or civil action under applicable state and criminal statutes. This institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, disability, or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

By submitting this information, the sponsor is verifying that it has a signed application/agreement for this provider on file at its organization's office.

Provider Signature: ____ Date: ________________

Institution's Representative's Signature: ______________________________ Date: ________________