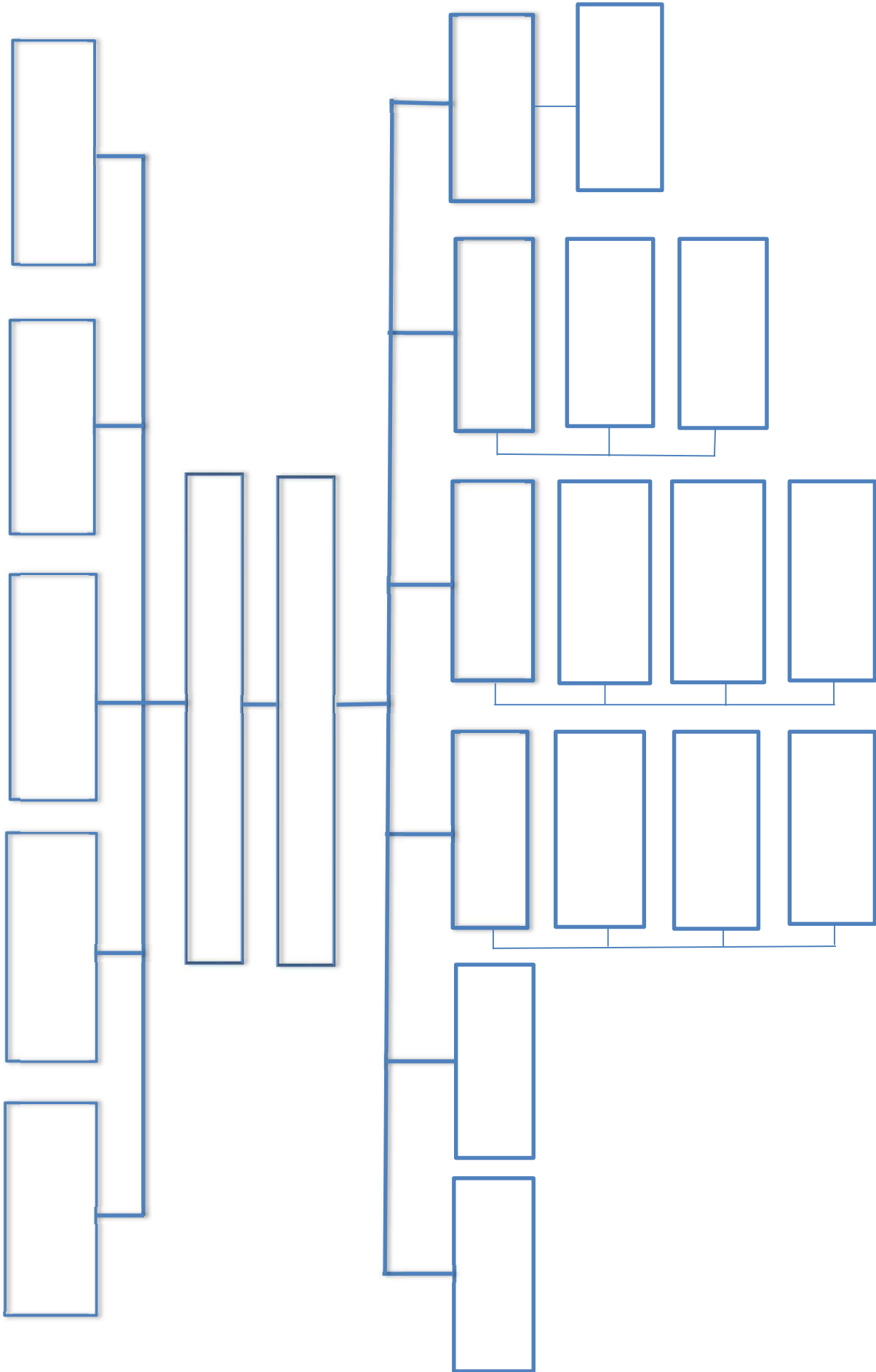


# CENTER ORIGINALS

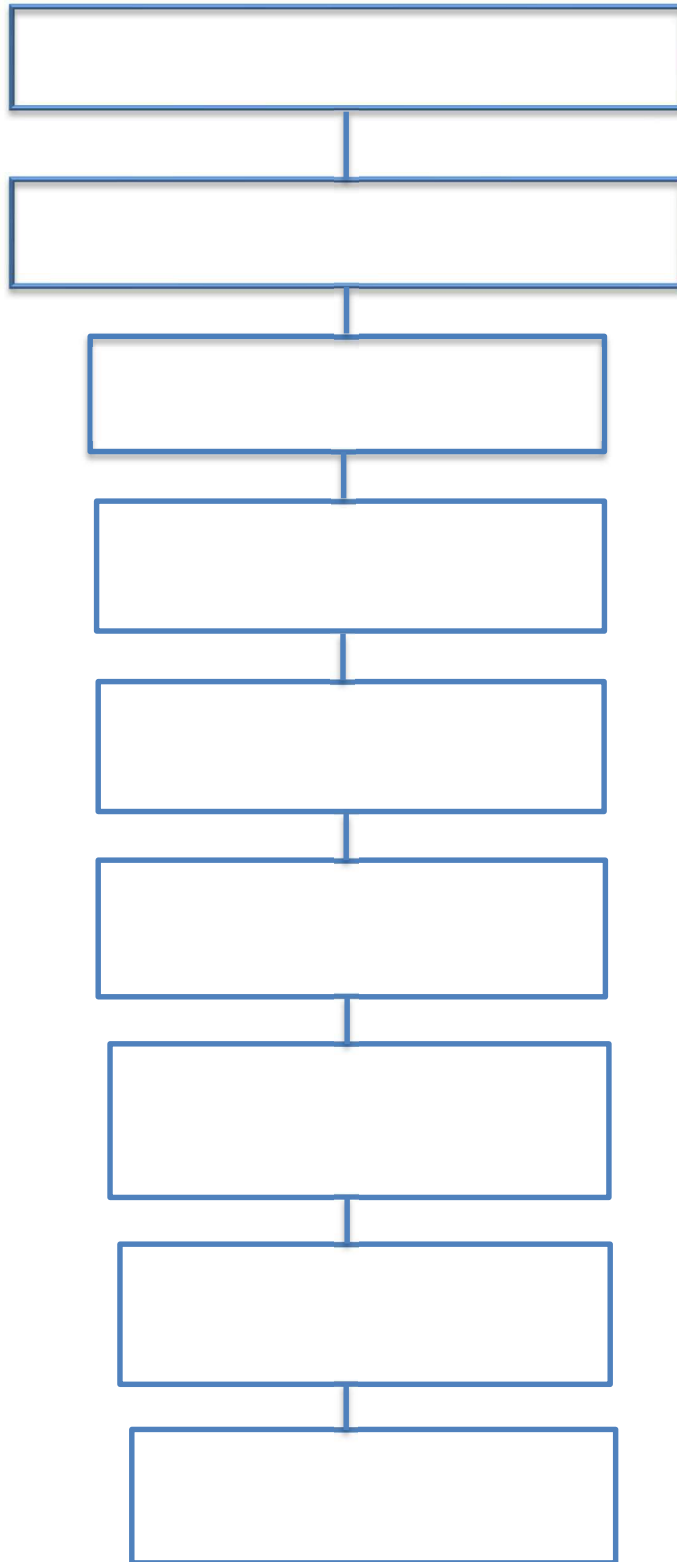
# Organizational Chart

Name of Institution



# Organizational Chart

Name of Institution \_\_\_\_\_





# EXPENDITURE/REIMBURSEMENT WORKSHEET

## INDEPENDENT CENTERS OR SITES UNDER A SPONSOR

Month: \_\_\_\_\_ Year: \_\_\_\_\_

Date	ITEM/ENTRY (Vendor or Personnel, Etc.)	Check #	OPERATING AND ADMINISTRATIVE COSTS (\$)								Misc.	INCOME (Other Than CACFP Reimbursement)
			CACFP Admin. Labor	CACFP Admin. Expenses	Food Service Salaries/Benefits	Food Service Rent/Utilities/Janitorial	Food Service Equipment	Food Purchases (Food and Milk)	Nonfood Purchases (Food-Related Supplies)			
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	
			\$	\$	\$	\$	\$	\$	\$	\$	\$	
(13)	<b>Grand Totals</b>											

(14) Net Costs (Total of Columns 4 through 11 Minus Column 12) \$ \_\_\_\_\_

(15) Reimbursement Received plus total of Column 12 \$ \_\_\_\_\_

(16) Operating Balance (Item 14 Minus Item 15—See Instructions) \$ \_\_\_\_\_

NOTE: Each cost category must be as approved on your CACFP application and/or amendments.

**Form completed by:** \_\_\_\_\_

# END OF YEAR REPORT

Institution Name: \_\_\_\_\_ Year: \_\_\_\_\_ Fiscal Months: \_\_\_\_\_

OPERATING AND ADMINISTRATIVE COSTS (\$)									
Expenditure for EACH Month (start with the first month of fiscal year) <sup>(1)</sup>	CACFP Admin. Labor <sup>(2)</sup>	CACFP Admin. Expenses <sup>(3)</sup>	Food Service Salaries/Benefits <sup>(4)</sup>	Food Service Rent/Utilities/Janitorial <sup>(5)</sup>	Food Service Equipment <sup>(6)</sup>	Food Purchases (Food & Milk) <sup>(7)</sup>	Nonfood Purchases (Food-Related Supplies) <sup>(8)</sup>	Misc. <sup>(9)</sup>	CACFP Reimbursement for each month <sup>(10)</sup>
	\$	\$	\$	\$	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$	\$	\$	\$	\$
<b>Grand Totals</b>	\$	\$	\$	\$	\$	\$	\$	\$	\$

(11) Total CACFP Expenditures (Total of Columns 2 through 9) \$ \_\_\_\_\_

(12) Total Reimbursement Received (Total of Column 10) \$ \_\_\_\_\_ Form completed by: \_\_\_\_\_

(13) Operating Balance (Item 11 Minus Item 12—See Instructions) \$ \_\_\_\_\_ Contact Info: \_\_\_\_\_

**NOTE:** attach all expenditure/reimbursement worksheets listed on this form to validate.

# MEDICAL STATEMENT

<b>Part I</b> (to be filled out by <i>institution or parent/guardian</i> )	
Name of Student:	Age:
Name of Parent/Guardian:	Telephone Number:
Name of Institution:	

<b>Part II</b> (to be filled out by a <i>medical authority</i> )
Diagnosis (include description of the patient's medical or other special dietary needs that restrict the patient's diet):
List food(s) to be omitted from diet:
List food(s) that may be substituted (diet plan):
Additional information:

This child has a disability as defined by the American Disability Act:      Yes       No

Date	Signature of State-Recognized Medical Authority
	Telephone Number

# MILK SUBSTITUTION REQUEST

Child's Name:	Age:
---------------	------

My child cannot consume milk for the following reason(s):

Signature of Parent/Guardian:	Date:
-------------------------------	-------

INSTITUTION APPROVAL:	
Signature:	Date:

## Nondairy Beverages

In the case of children who cannot consume fluid milk due to medical or other special dietary needs other than a disability, nondairy beverages may be served in lieu of fluid milk. Nondairy beverages must be nutritionally equivalent to milk and meet the Nutrient Standards found in cow's milk. Nondairy beverage nutrient requirements per cup include each of the following:

- Calcium 276 mg
- Protein 8 g
- Vitamin A 500 IU
- Vitamin D 100 IU
- Magnesium 24 mg
- Potassium 349 mg
- Phosphorus 222 mg
- Riboflavin 0.44 mg
- Vitamin B-12 1.1 mcg

Parents or guardians may now request in writing nondairy milk substitutions, as described above, without providing a medical statement. As an example, if a parent has a child who follows a vegan diet, the parent can submit a written request of the child's caretaker asking that a milk substitution be served in lieu of cow's milk. The written request must identify the medical or other special dietary need that restricts the diet of the child. ***Such substitutions are at the option and the expense of the facility.*** The requirements related to milk or food substitutions for a participant who has a medical disability and who submits a medical statement signed by a state-recognized medical authority remain unchanged.



## LETTER TO THE HOUSEHOLD

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. **(Name of Center)** \_\_\_\_\_ offers healthy meals to all enrolled children as part of our participation in the United States Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached CACFP Family-Size and Income Application (FSIA). In addition, by filling out this application, we will be able to determine if your children qualify for free or reduced-price meals.

1. **Do I need to fill out an FSIA for each of my children in day care?** You may complete and submit one FSIA for all children enrolled in child care in your household *ONLY* if the children in child care are enrolled in the same center. We cannot approve an FSIA that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed FSIA to:** *(Name of Center)* \_\_\_\_\_, *(Address)* \_\_\_\_\_, *(Phone Number)* \_\_\_\_\_.
2. **Who can get free meals without providing income information?** Children in households getting Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) can get free meals. Foster children and children enrolled in Head Start are also eligible for free meals. Children in households participating in Women, Infants, and Children (WIC) *MAY* be eligible for free meals.
3. **Who can get reduced-price meals?** Your children can get low-cost meals if your household income is within the reduced-price limits on the Income-Eligibility Guidelines, shown on the application. Children in households participating in WIC *MAY* be eligible for reduced-price meals.
4. **May I fill out an FSIA if someone in my household is not a United States (U.S.) citizen?** Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.
5. **Who should I include as members of my household?** You must include all people in your household (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children who live with you. You also must include foster children who live with you.
6. **How do I report income information and changes in employment status?** The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income-Eligibility Guidelines, the center will receive a higher level of reimbursement. Once properly approved for free or reduced-price benefits, whether through income or by providing a current SNAP, TANF, or FDPIR case number, you will remain eligible for those benefits for the current fiscal year. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.
7. **What if my income is not always the same?** List the amount that you normally get. For example, if you normally get \$1000 each month but you missed some work last month and only got \$900, put down that you get \$1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.
8. **What if I have foster children?** Foster children who are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the FSIA but are not required to include payments received for the foster child as income.
9. **We are in the military; do we include our housing and supplemental allowance as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

This institution is an equal opportunity provider.

If you have other questions or need help, call *(Phone Number)* \_\_\_\_\_.

Sincerely,

*(Signature)* \_\_\_\_\_

## INSTRUCTIONS FOR COMPLETING THE CACFP FAMILY-SIZE AND INCOME APPLICATION

IF YOUR HOUSEHOLD RECEIVES BENEFITS FROM *SNAP*, *TANF*, OR *FDPIR*, FOLLOW THESE INSTRUCTIONS:

- Top Section:** List all enrolled children, include his/her birth date.  
Circle the meals the child normally eats.  
Insert the normal hours the child is in care.  
List the case number for any household member (including adults) receiving *SNAP*, *TANF*, or *FDPIR* benefits.  
Check normal days the child is in care.
- Part 1:** Answer this question if you choose.
- Part 2:** Skip this part.
- Part 3:** Sign the form. The last four digits of a social security number are **NOT** necessary.

IF YOU ARE APPLYING FOR A FOSTER CHILD, FOLLOW THESE INSTRUCTIONS:

- Top Section:** List all enrolled children, include his/her birth date.  
Circle the meals the child normally eats.  
Insert the normal hours the child is in care.  
Check any child enrolled that is a foster child (a child awarded to the State)  
Check normal days the child is in care
- Part 1:** Answer this question if you choose.
- Part 2:** Skip this part.
- Part 3:** Sign the form. The last four digits of a social security number are **NOT** necessary.
- **If any child in the household is a foster child, mark the foster box in the top section for each foster child in the household.**

IF YOU ARE APPLYING BASED ON INCOME, FOLLOW THESE INSTRUCTIONS:

- Top Section:** List all enrolled children, include his/her birth date.  
Circle the meals the child normally eats.  
Insert the normal hours the child is in care.  
Check any child enrolled that is a foster child (a child awarded to the state)  
Check normal days the child is in care.
- Part 1:** Answer this question if you choose
- Part 2:** Follow these instructions to report total CURRENT household income .
- **Column A—Name:** List only the first and last names of **EACH** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you), with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.
  - **Column B—Gross Income:** For each household member receiving income, list each income received and the interval the household member is paid.  
In Box 1, list the **gross income**, not the take-home pay. Gross income is the amount earned **BEFORE** taxes and other deductions. You should be able to find it on your pay stub, or your boss can tell you.
  - If any member of the household does not receive income, the zero income box should be marked as no reportable income or \$0 can be listed in the income box.
- Part 3:** Sign and date the form. The last four digits of a social security number **IS** necessary, or if the parent or guardian does not have a social security number, the box indicating this must be checked.

ALL OTHER HOUSEHOLDS, INCLUDING WIC HOUSEHOLDS, FOLLOW THESE INSTRUCTIONS:

**Top Section:** List all enrolled children, include his/her birth date.

Circle the meals the child normally eats.

Insert the normal hours the child is in care.

Check normal days the child is in care.

**Part 1:** Answer this question if you choose

**Part 2:** Follow these instructions to report total current household income.

- **Column A—Name:** List only the first and last names of *EACH* person living in your household, related or not (such as grandparents, other relatives, or friends who live with you), with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.
- **Column B—Gross Income:** For each household member receiving income, list each income received for the month.

In Box 1, list the *gross income*, not the take-home pay. Gross income is the amount earned *BEFORE* taxes and other deductions. You should be able to find it on your pay stub, or your boss can tell you.

If any member of the household does not receive income, the zero income box should be marked or \$0 can be listed in the income box.

**Part 3:** Sign and date the form. The last four digits of a social security number *IS* necessary, or if the parent or guardian does not have a social security number, the box indicating this must be checked.

**NONDISCRIMINATION STATEMENT:** This explains what to do if you believe you have been treated unfairly.

**CHILD AND ADULT CARE FOOD PROGRAM (CACFP)  
FAMILY-SIZE & INCOME APPLICATION AND ENROLLMENT FORM FOR YEAR 2023-24**

**Participation Information: (To be completed by Parent/Guardian)**

*If a child is receiving SNAP, TANF, FDPIR or is a Foster child, also complete the last two columns of this section and skip to Part 3*

Participant's Last Name	Participant's First Name	Birth Date	Meals Normally Eaten (Circle all that apply)	Normal Times in Care	Foster	SNAP, TANF, or FDPIR # (List CASE #)
			B AM L PM S LPM		<input type="checkbox"/>	
			B AM L PM S LPM		<input type="checkbox"/>	
			B AM L PM S LPM		<input type="checkbox"/>	
			B AM L PM S LPM		<input type="checkbox"/>	
			B AM L PM S LPM		<input type="checkbox"/>	
			B AM L PM S LPM		<input type="checkbox"/>	

**Normal Days In Care :** Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday

**PART 1: PARTICIPANT'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)**

<i>Mark one ethnic identity:</i>	<i>Mark one or more racial identities:</i>		
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	

**PART 2. INCOME APPLICATION, HOUSEHOLD MEMBERS, AND INCOME**

A. NAME OF OTHER HOUSEHOLD MEMBERS Including Children not listed above	B. GROSS INCOME AND HOW OFTEN PAID				Zero Income
	Earnings From Work (Before Deductions)	Welfare, Child Support, Alimony	Pensions, Retirement, Social Security, SSI, VA Benefits	All Other Income or SNAP, TANF, FDPIR #	
1.	\$	\$	\$	\$	<input type="checkbox"/>
2.	\$	\$	\$	\$	<input type="checkbox"/>
3.	\$	\$	\$	\$	<input type="checkbox"/>
4.	\$	\$	\$	\$	<input type="checkbox"/>

**PART 3. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER**

*I certify that all information on this form is true and that all income is reported. I understand that the center will get federal funds based on the information that I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, this participant receiving meals may lose the meal benefits and I may be prosecuted.*

Signature of Adult Household Member \_\_\_\_\_

Home/Cell Phone Number \_\_\_\_\_

Date \_\_\_\_\_

Last four digits of social security number: \*\*\*\* - \*\* - \_\_\_\_\_  I do not have a social security number

**FOR INSTITUTION USE ONLY:**

*Annual Income Conversion: Weekly x 52 Every 2 Weeks x 26 Twice a Month x 24 Monthly x 12*

**Application Approved For:**

- Free
- Reduced
- Not Eligible

- SNAP/TANF/FDPIR
- Foster
- Income: Total Income : \$ \_\_\_\_\_

Signature of Determining Official \_\_\_\_\_

Date \_\_\_\_\_

How often Paid? (circle one): Weekly Every 2 weeks Twice a month Monthly Annually

Household Size \_\_\_\_\_

**7 CFR 226.15(e)(2)**

"The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The last four digits of the Social Security Number are not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program rules.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or fax: (833) 256-1665 or (202) 690-7442; or email: [program.intake@usda.gov](mailto:program.intake@usda.gov) This institution is an equal opportunity provider

**INCOME-ELIGIBILITY GUIDELINES FOR YEAR 2023-2024  
FOR FREE AND REDUCED-PRICE MEALS**

This is the income scale used by \_\_\_\_\_  
to determine eligibility for free meals. (Sponsor/Center)

*(The Free Scale Should Not Be Distributed to Families)*

<b>ELIGIBILITY SCALE FOR FREE MEALS 130 Percent of Poverty Level</b>					
<b>Household Size</b>	<b>Income</b>				
	<b>Annual</b>	<b>Monthly</b>	<b>Twice Per Month</b>	<b>Every Two Weeks</b>	<b>Weekly</b>
<b>1</b>	18,954	1,580	790	729	365
<b>2</b>	25,636	2,137	1,069	986	493
<b>3</b>	32,318	2,694	1,347	1,243	622
<b>4</b>	39,000	3,250	1,625	1,500	750
<b>5</b>	45,682	3,807	1,904	1,757	879
<b>6</b>	52,364	4,364	2,182	2,014	1,007
<b>7</b>	59,046	4,921	2,461	2,271	1,136
<b>8</b>	65,728	5,478	2,739	2,528	1,264
For each additional family member, add:	6,682	557	279	257	129

<b>ELIGIBILITY SCALE FOR REDUCED-PRICE MEALS 185 Percent of Poverty Level</b>					
<b>Household Size</b>	<b>Income</b>				
	<b>Annual</b>	<b>Monthly</b>	<b>Twice Per Month</b>	<b>Every Two Weeks</b>	<b>Weekly</b>
<b>1</b>	26,973	2,248	1,124	1,038	519
<b>2</b>	36,482	3,041	1,521	1,404	702
<b>3</b>	45,991	3,833	1,917	1,769	885
<b>4</b>	55,500	4,625	2,313	2,135	1,068
<b>5</b>	65,009	5,418	2,709	2,501	1,251
<b>6</b>	74,518	6,210	3,105	2,867	1,434
<b>7</b>	84,027	7,003	3,502	3,232	1,616
<b>8</b>	93,536	7,795	3,898	3,598	1,799
For each additional family member, add:	9,509	793	397	366	183

# CHILD AND ADULT CARE FOOD PROGRAM (CACFP) ENROLLMENT FORM

<b>CHILDREN'S INFORMATION</b>							
1. Child's Name:					Date of Birth:		
2. Normal Days in Attendance:	<input type="checkbox"/> Sunday	<input type="checkbox"/> Monday	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Thursday	<input type="checkbox"/> Friday	<input type="checkbox"/> Saturday
3. Normal Hours of Attendance:	a.m./p.m. <b>to</b>				a.m./p.m.		
4. Normal Meals Eaten:	Breakfast <input type="checkbox"/>	A.M. Snack <input type="checkbox"/>	Lunch <input type="checkbox"/>	P.M. Snack <input type="checkbox"/>	Supper <input type="checkbox"/>	Late P.M. Snack <input type="checkbox"/>	
5. Race (Optional): <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Black or African <input type="checkbox"/> Hawaiian or Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White				6. Ethnicity (Optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic			
1. Child's Name:					Date of Birth:		
2. Normal Days in Attendance:	<input type="checkbox"/> Sunday	<input type="checkbox"/> Monday	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Thursday	<input type="checkbox"/> Friday	<input type="checkbox"/> Saturday
3. Normal Hours of Attendance:	a.m./p.m. <b>to</b>				a.m./p.m.		
4. Normal Meals Eaten:	Breakfast <input type="checkbox"/>	A.M. Snack <input type="checkbox"/>	Lunch <input type="checkbox"/>	P.M. Snack <input type="checkbox"/>	Supper <input type="checkbox"/>	Late P.M. Snack <input type="checkbox"/>	
5. Race (Optional): <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Black or African <input type="checkbox"/> Hawaiian or Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White				6. Ethnicity (Optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic			
1. Child's Name:					Date of Birth:		
2. Normal Days in Attendance:	<input type="checkbox"/> Sunday	<input type="checkbox"/> Monday	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Thursday	<input type="checkbox"/> Friday	<input type="checkbox"/> Saturday
3. Normal Hours of Attendance:	a.m./p.m. <b>to</b>				a.m./p.m.		
4. Normal Meals Eaten:	Breakfast <input type="checkbox"/>	A.M. Snack <input type="checkbox"/>	Lunch <input type="checkbox"/>	P.M. Snack <input type="checkbox"/>	Supper <input type="checkbox"/>	Late P.M. Snack <input type="checkbox"/>	
5. Race (Optional): <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Black or African <input type="checkbox"/> Hawaiian or Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White				6. Ethnicity (Optional): <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic			
<b>PARENT'S INFORMATION</b>							
Name of Parent/Guardian:							
Address:				City:			Zip:
Home Telephone Number:							
Signature:					Date:		

**OKLAHOMA STATE DEPARTMENT OF EDUCATION  
 HEAD START *FEDERALLY FUNDED ENROLLMENT INFORMATION*  
 CHILD NUTRITION PROGRAMS  
 Fiscal Year \_\_\_\_\_**

Name of Institution: \_\_\_\_\_ Facility: \_\_\_\_\_

<b>NAME OF CHILD</b> (List each child in the facility enrolled in Head Start)	<b>AGE</b>	<b>ENTRY DATE</b>	<b>DROP DATE</b>	<b>EARLY HEAD START</b>	<b>HEAD START</b>

I certify that the children listed above are currently enrolled as participants in the Head Start Program.

\_\_\_\_\_  
Signature of Person Authorized to Provide Certification on Behalf of Head Start

\_\_\_\_\_  
Date

# FREE CACFP ROSTER

Center: \_\_\_\_\_ Fiscal Year: \_\_\_\_\_

Form completed by: \_\_\_\_\_

NAME	EF*	DATE APPROVED	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	DROP DATE
1.															
2.															
3.															
4.															
5.															
6.															
7.															
8.															
9.															
10.															
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26.															
27.															
28.															
29.															
30.															
31.															
32.															
33.															
34.															
35.															
<b>TOTAL</b>															

\*EF = Enrollment Form obtained



# REDUCED-PRICE CACFP ROSTER

Center: \_\_\_\_\_ Fiscal Year: \_\_\_\_\_

Form completed by: \_\_\_\_\_

NAME	EF*	DATE APPROVED	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	DROP DATE
1.															
2.															
3.															
4.															
5.															
6.															
7.															
8.															
9.															
10.															
11.															
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28.															
29.															
30.															
31.															
32.															
33.															
34.															
35.															
<b>TOTAL</b>															

\*EF = Enrollment Form obtained

# NOT ELIGIBLE CACFP ROSTER

Center: \_\_\_\_\_ Fiscal Year: \_\_\_\_\_

Form completed by: \_\_\_\_\_

NAME	EF*	DATE APPROVED	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	DROP DATE
1.															
2.															
3.															
4.															
5.															
6.															
7.															
8.															
9.															
10.															
11.															
12.															
13.															
14.															
15.															
16.															
17.															
18.															
19.															
20.															
21.															
22.															
23.															
24.															
25.															
26.															
27.															
28.															
29.															
30.															
31.															
32.															
33.															
34.															
35.															
<b>TOTAL</b>															

\*EF = Enrollment Form obtained

# DAILY ATTENDANCE RECORD

- Regular Meals
- At-Risk Meals

Name of Day Care Center: \_\_\_\_\_ Month: \_\_\_\_\_ Year: \_\_\_\_\_

Form Completed By: \_\_\_\_\_

Name	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		

# DAILY ATTENDANCE RECORD ARRIVAL AND DEPARTURE TIMES

- Regular Meals  
 At-Risk Meals

Name of Day Care Center: \_\_\_\_\_ Month: \_\_\_\_\_ Year: \_\_\_\_\_

Form Completed By:

NAME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

# DAILY RECORD OF MEALS SERVED

Month and Year:

Regular Meals

At-Risk Meals

Total Reimbursable Meals

Children	Meal	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	B	AM	L	PM	S	L	PM							
1.	B*																																													
	AM*																																													
	L*																																													
	PM*																																													
	S*																																													
2.	LPM*																																													
	B																																													
	AM																																													
	L																																													
	PM																																													
3.	S																																													
	LPM																																													
	B																																													
	AM																																													
	L																																													
4.	PM																																													
	S																																													
	LPM																																													
	B																																													
	AM																																													
5.	L																																													
	PM																																													
	S																																													
	LPM																																													
	B																																													

\*B = Breakfast; AM = AM Snack; L = Lunch; PM = PM Snack; S = Supper; LPM = Late PM Snack  
 You may not claim more than two main meals and one snack or two snacks and one main meal per child daily.

Totals  
Grand Totals From All Pages

# CHILD AND ADULT CARE FOOD PROGRAM (CACFP) MEAL COUNT WORKSHEET

- Regular Meals
- At-Risk Meals

Agreement Number: DC- \_\_\_\_\_ Month: \_\_\_\_\_ Year: \_\_\_\_\_

Form completed by: \_\_\_\_\_

	MEALS SERVED TO PROGRAM CHILDREN Ages 1 Through 12 Years								NUMBER NONCLAIMABLE MEALS SERVED*				
				AM-1	AM-2	PM-1	PM-2	LT PM-1	LT PM-2				
DATE	Breakfast	Lunch	Supper	Snack						Breakfast	Lunch	Supper	Snack
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
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19													
20													
21													
22													
23													
24													
25													
26													
27													
28													
29													
30													
31													
<b>TOTAL</b>													

\* Any nonclaimable or nonprogram meals must have income reported on the Expenditure/Reimbursement Worksheet and/or the center's summary of allowable costs.

To be maintained at institution with CACFP records

# CHILD AND ADULT CARE FOOD PROGRAM (CACFP) INFANT MEAL COUNT WORKSHEET

Agreement Number: DC- \_\_\_\_\_ Month: \_\_\_\_\_ Year: \_\_\_\_\_

**Form completed by:** \_\_\_\_\_

	MEALS SERVED TO PROGRAM INFANTS AgeS 0 Through 12 Months								NUMBER NONCLAIMABLE MEALS SERVED*				
				AM-1	AM-2	PM-1	PM-2	LT PM-1	LT PM-2				
DATE	Breakfast	Lunch	Supper	Snack						Breakfast	Lunch	Supper	Snack
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
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21													
22													
23													
24													
25													
26													
27													
28													
29													
30													
31													
<b>TOTAL</b>													

\* Any nonclaimable or nonprogram meals must have income reported on the Expenditure/Reimbursement Worksheet and/or the center's summary of allowable costs.

To be maintained at institution with CACFP records

# Building for the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a federal program that provides healthy meals and snacks to children receiving day care.

Each day millions of children participate in CACFP at day care homes and centers across the country. Providers are reimbursed for serving nutritious meals which meet United States Department of Agriculture (USDA) requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

## Meals

CACFP homes and centers follow meal patterns established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the Five Groups)
Milk, 1% Fruit Vegetable Grains	Milk, 1% Meat or Meat Alternate Grains Fruit Vegetable	Milk, 1% Meat or Meat Alternate Grains Fruit Vegetable

## Participating Facilities

Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child care centers**—Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- **Family day care homes**—Licensed or approved private homes.
- **At-Risk Programs**—Centers in low-income areas provide free snacks to school-age children and youth.
- **Homeless shelters**—Emergency shelters provide food services to homeless children.

## Eligibility

State agencies reimburse facilities that offer nonresidential day care to the following children:

- Children aged 12 and under
- Migrant children aged 15 and younger
- Youths through the age of 18 in At-Risk Programs in needy areas

## Contact Information

If you have questions about CACFP, please contact one of the following:

Sponsoring Organization/Center

State Department of Education  
Child Nutrition Programs  
2500 North Lincoln Boulevard  
Oklahoma City, Oklahoma 73105-4599  
405-521-3327

This institution is an equal opportunity provider



## CACFP Claim Revision

Agreement #: \_\_\_\_\_

Institution/Site Name: \_\_\_\_\_

Please provide the revised counts

Claim Month/Year: \_\_\_\_\_

Number of days in operations: \_\_\_\_\_

Total enrollment: \_\_\_\_\_

At-Risk number of days in operation, if applicable: \_\_\_\_\_

At-Risk total enrollment, if applicable: \_\_\_\_\_

### **Participation Data:**

Title XX/XIX, if applicable: \_\_\_\_\_

Number free eligible: \_\_\_\_\_

Number reduced eligible: \_\_\_\_\_

Number not eligible: \_\_\_\_\_

	Child Care	At-Risk	Adult Care
Number of Breakfasts			
Number of Lunches			
Numbers of Suppers			
Number of Snacks			

Reason for revision: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## CACFP Notification of Meal Service Change

Agreement Number: \_\_\_\_\_ Institution/Site Name: \_\_\_\_\_

**This form must be submitted if any of the following information has changed from the original application. Please complete and submit to our office for approval prior to meal service change.**

**For recordkeeping purposes, please list the days and times of meal service that you are currently approved for. Please list currently approved mealtimes here:**

Breakfast		AM Snack		Lunch		PM Snack		Supper		Late PM Snack	
1 <sup>st</sup> shift		1 <sup>st</sup> shift		1 <sup>st</sup> shift		1 <sup>st</sup> shift		1 <sup>st</sup> shift		1 <sup>st</sup> shift	
Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending
2 <sup>nd</sup> shift		2 <sup>nd</sup> shift		2 <sup>nd</sup> shift		2 <sup>nd</sup> shift		2 <sup>nd</sup> shift		2 <sup>nd</sup> shift	
Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending

Please list currently approved maximum number of meals:

Breakfast		AM Snack		Lunch		PM Snack		Supper		Late PM Snack	
1 <sup>st</sup>	2 <sup>nd</sup>	1 <sup>st</sup>	2 <sup>nd</sup>	1 <sup>st</sup>	2 <sup>nd</sup>	1 <sup>st</sup>	2 <sup>nd</sup>	1 <sup>st</sup>	2 <sup>nd</sup>	1 <sup>st</sup>	2 <sup>nd</sup>

Please check the box for each day currently approved to serve meals and current hours of operation:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Open	Close

**Please enter the new information you wish to change and submit for approval below.**

If applicable, list NEW mealtimes here:

No change to mealtimes

Breakfast		AM Snack		Lunch		PM Snack		Supper		Late PM Snack	
1 <sup>st</sup> shift		1 <sup>st</sup> shift		1 <sup>st</sup> shift		1 <sup>st</sup> shift		1 <sup>st</sup> shift		1 <sup>st</sup> shift	
Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending
2 <sup>nd</sup> shift		2 <sup>nd</sup> shift		2 <sup>nd</sup> shift		2 <sup>nd</sup> shift		2 <sup>nd</sup> shift		2 <sup>nd</sup> shift	
Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending

Please list NEW maximum number of meals:

No change to max number

Breakfast		AM Snack		Lunch		PM Snack		Supper		Late PM Snack	
1 <sup>st</sup>	2 <sup>nd</sup>	1 <sup>st</sup>	2 <sup>nd</sup>	1 <sup>st</sup>	2 <sup>nd</sup>	1 <sup>st</sup>	2 <sup>nd</sup>	1 <sup>st</sup>	2 <sup>nd</sup>	1 <sup>st</sup>	2 <sup>nd</sup>

If serving shift or weekend meals, please provide justification:

If applicable, check the box for each day you wish to serve meals:

No change to days of the week

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

If applicable, list your NEW hours of operation:

Open	Close

No change to hours of operation

I further certify that all the 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 under applicable state and criminal statutes. The program must be made available to all eligible children regardless of race, color, national origin, disability, age, reprisal, and retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Authorized Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

SDE Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Budget Revision Justification Form

Date: \_\_\_\_\_

Institution Name: \_\_\_\_\_

Agreement Number: \_\_\_\_\_

Budget Amendment Justification Month and Year: \_\_\_\_\_

**NOTE:** Budget amendments can only be effective beginning the first of the month in which the amendment is received. Example: A budget amendment received on October 25 can be effective on October 1.

Budget Line-Item Number/Type of Expense: \_\_\_\_\_

Original projected amount: \_\_\_\_\_

Adjusted projected amount: \_\_\_\_\_

Justification Explanation:

Budget Line-Item Number/Type of Expense: \_\_\_\_\_

Original projected amount: \_\_\_\_\_

Adjusted projected amount: \_\_\_\_\_

Justification Explanation:

Budget Line-Item Number/Type of Expense: \_\_\_\_\_

Original projected amount: \_\_\_\_\_

Adjusted projected amount: \_\_\_\_\_

Justification Explanation:

# MONTHLY RECORD-KEEPING CHECKLIST

Month: \_\_\_\_\_ Year: \_\_\_\_\_

This form should be maintained on the outside or inside of each monthly folder. A check mark should be placed beside those items that are included in the monthly folder or by tasks that were completed. Some documents may not be immediately available and will be *checked off* as they are added to the folder.

- Meal Count Worksheet
- Expenditure/Reimbursement Worksheet (Summary of All Allowable Operating and Administrative Costs)
- Financial Documentation - Any bank and credit card statement(s) where CACFP funds were deposited, spent, or transferred to or from, Year to date report, Profit/Loss statement, canceled checks, etc.
- Food-Purchasing Forms/Itemized Receipts
- End of the Month Inventory for Food and Milk
- Title XX Documentation
- Canceled Checks (Documentation of CACFP Expenditures)
- Daily Attendance Records
- Daily Attendance Records—Arrival and Departure Times, if applicable
- Daily Record of Meals Served, if applicable

## ADDITIONAL TASKS THAT MUST BE COMPLETED PRIOR TO SUBMISSION OF A CLAIM FOR REIMBURSEMENT:

- Obtain enrollment forms and FSIA's on new participants and maintain with all other FSIA's/enrollment forms.
- Add new participants in attendance to the CACFP Roster for updated monthly count of *free*, *reduced-price*, and *not eligible*.
- Menus as Served forms and CN labels and Product Formulation Statements, if applicable, were maintained daily documenting meals being claimed for reimbursement or ***Contract Meal Delivery Receipt for contract meal sites only***. Infant Feeding Record, if applicable.

KEEP ALL CORRESPONDENCE RECEIVED FROM THE STATE AGENCY IN A MONTHLY FOLDER OR IN A GENERAL CORRESPONDENCE FOLDER.

## ***ANNUAL REQUIRED DOCUMENTATION***

- Procurement Documentation
- Training Records

# END OF THE MONTH INVENTORY FOR UNOPENED PRODUCTS

(Additional forms may be needed to ensure all items are inventoried)

Center Name: \_\_\_\_\_

Inventory Month/Year: \_\_\_\_\_

Date Conducted: \_\_\_\_\_

Form Completed by: \_\_\_\_\_

Meat/Meat Alternate	Purchase Unit	# of Units	Grain/Bread	Purchase Unit	# of Units
Fruit	Purchase Unit	# of Units	Vegetable	Purchase Unit	# of Units



# WEEKLY MENU PLANNER

BREAKFAST	AM SNACK	LUNCH

This institution is an equal opportunity provider.

# WEEKLY MENU PLANNER

PM SNACK	SUPPER	LATE PM SNACK

This institution is an equal opportunity provider.



# BREAKFAST

## HOW TO CALCULATE NUMBER OF SERVINGS NEEDED

Children Present: \_\_\_\_\_ (Aged 1 through 2)  
 \_\_\_\_\_ (Aged 3 through 5)  
 \_\_\_\_\_ (Aged 6 through 12)

Number of Children/Adults Served					
MILK (Only Approved Types Allowed)					
Aged 1 through 2		X	4 fluid oz (1/2 cup)	=	
Aged 3 through 5		X	6 fluid oz (3/4 cup)	=	
Aged 6 through 12		X	8 fluid oz (1 cup)	=	
Program Adults*		X	8 fluid oz (1 cup)	=	
					<b>Total Number of Fluid Ounces Needed</b>
There are 128 ounces of milk in one gallon.					

FRUIT/VEGETABLE					
Aged 1 through 2		X	1 (1/4 cup)	=	
Aged 3 through 5		X	2 (1/4 cup)	=	
Aged 6 through 12		X	2 (1/4 cup)	=	
Program Adults*		X	2 (1/4 cup)	=	
					<b>Total Number of 1/4 Cups</b>

MEAT/MEAT ALTERNATE (Optional)					
Aged 1 through 2		X	.5 oz	=	
Aged 3 through 5		X	.5 oz	=	
Aged 6 through 12		X	1.0 oz	=	
Program Adults*		X	1.0 oz	=	
					<b>Total Ounces Needed</b>

GRAINS					
Aged 1 through 2		X	0.5 (1/2 oz eq)	=	
Aged 3 through 5		X	0.5 (1/2 oz eq)	=	
Aged 6 through 12		X	1 (1 oz eq)	=	
Program Adults*		X	1 (1 oz eq)	=	
					<b>Total Oz Eq Needed</b>

•Adult meals on this form are calculated using the 6- through 12-year-old serving size.

# LUNCH AND SUPPER

## HOW TO CALCULATE NUMBER OF SERVINGS NEEDED

Children Present: \_\_\_\_\_ (Aged 1 - 2)      \_\_\_\_\_ (Aged 3 - 5)      \_\_\_\_\_ (Aged 6 - 12)

Number of Children/Adults Served					
MILK (Only Approved Types Allowed)					
Aged 1 through 2		X	4 fluid oz (1/2 cup)	=	
Aged 3 through 5		X	6 fluid oz (3/4 cup)	=	
Aged 6 through 12		X	8 fluid oz (1 cup)	=	
Program Adults*		X	8 fluid oz (1 cup)	=	
					<b>Total Number of Fluid Ounces Needed</b>

There are 128 ounces of milk in one gallon.

MEAT/MEAT ALTERNATE					
Aged 1 through 2		X	1.0 oz	=	
Aged 3 through 5		X	1.5 oz	=	
Aged 6 through 12		X	2.0 oz	=	
Program Adults*		X	2.0 oz	=	
					<b>Total Ounces Needed</b>

VEGETABLE					
Aged 1 through 2		X	.5 (1/4 cup)	=	
Aged 3 through 5		X	1 (1/4 cup)	=	
Aged 6 through 12		X	2 (1/4 cup)	=	
Program Adults*		X	2 (1/4 cup)	=	
					<b>Total Number of 1/4 Cups Needed</b>

FRUIT					
Aged 1 through 2		X	.5 (1/4 cup)	=	
Aged 3 through 5		X	1 (1/4 cup)	=	
Aged 6 through 12		X	1 (1/4 cup)	=	
Program Adults*		X	1 (1/4 cup)	=	
					<b>Total Number of 1/4 Cups Needed</b>

GRAINS					
Aged 1 through 2		X	0.5 (1/2 oz eq)	=	
Aged 3 through 5		X	0.5 (1/2 oz eq)	=	
Aged 6 through 12		X	1 (1/2 oz eq)	=	
Program Adults*		X	1 (1/2 oz eq)	=	
					<b>Total Oz Eq Needed</b>

•Adult meals on this form are calculated using the 6- through 12-year-old serving size.

# SNACK

## HOW TO CALCULATE NUMBER OF SERVINGS NEEDED

(Choose two of the five food components.)

Children Present: \_\_\_\_\_ (Aged 1 - 2)      \_\_\_\_\_ (Aged 3 - 5)      \_\_\_\_\_ (Aged 6 - 12)

<b>Number of Children/Adults Served</b>					
<b>MILK (Only Approved Types Allowed)</b>					
Aged 1 through 2		X	4 fluid oz (1/2 cup)	=	
Aged 3 through 5		X	4 fluid oz (1/2 cup)	=	
Aged 6 through 12		X	8 fluid oz (1 cup)	=	
Program Adults*		X	8 fluid oz (1 cup)	=	
					<b>Total Number of Fluid Ounces Needed</b>
There are 128 ounces of milk in one gallon.					
<b>VEGETABLE</b>					
Aged 1 through 2		X	2 (1/4 cup)	=	
Aged 3 through 5		X	2 (1/4 cup)	=	
Aged 6 through 12		X	3 (1/4 cup)	=	
Program Adults*		X	3 (1/4 cup)	=	
					<b>Total Number of 1/4 Cups Needed</b>
<b>FRUIT</b>					
Aged 1 through 2		X	2 (1/4 cup)	=	
Aged 3 through 5		X	2 (1/4 cup)	=	
Aged 6 through 12		X	3 (1/4 cup)	=	
Program Adults*		X	3 (1/4 cup)	=	
					<b>Total Number of 1/4 Cups Needed</b>
<b>MEAT/MEAT ALTERNATE</b>					
Aged 1 through 2		X	.5 oz	=	
Aged 3 through 5		X	.5 oz	=	
Aged 6 through 12		X	1.0 oz	=	
Program Adults*		X	1.0 oz	=	
					<b>Total Ounces Needed</b>
<b>GRAINS</b>					
Aged 1 through 2		X	0.5 (1/2 oz eq)	=	
Aged 3 through 5		X	0.5 (1/2 oz eq)	=	
Aged 6 through 12		X	1 (1 oz eq)	=	
Program Adults*		X	1 (1 oz eq)	=	
					<b>Total Oz Eq Needed</b>

•Adult meals on this form are calculated using the 6- through 12-year-old serving size.

# PRODUCT FORMULATION STATEMENT FOR MEAT/MEAT ALTERNATE AND ALTERNATE PROTEIN PRODUCT CALCULATIONS

Provide a copy of the label in addition to the following information on company letterhead by an official representative of the company.

Product Name: \_\_\_\_\_ Code Number: \_\_\_\_\_

Manufacturer: \_\_\_\_\_ Case/Pack/Count/Portion Size: \_\_\_\_\_

## I. Meat/Meat Alternate (M/MA)

Please fill out the chart below to determine the creditable amount of Meat/Meat Alternate.

Description of Creditable Ingredients Per <i>Food-Buying Guide</i>	Ounces Per Raw Portion of Creditable Ingredient	Multiply	Food-Buying Guide Yield	Creditable Amount*
		X		
		X		
		X		
<b>A. Total Creditable Amount<sup>1</sup></b>				

\*Creditable Amount—Multiply ounces per raw portion of creditable ingredient by the *Food-Buying Guide* yield.

## II. Alternate Protein Product (APP)

If the product contains APP, please fill out the chart below to determine the creditable amount of APP. If APP is used, you must provide documentation as described in Attachment A for each APP used.

Description of APP, Manufacturer's Name, and Code Number	Ounces Dry APP Per Portion	Multiply	% of Protein As-Is*	Divide by 18**	Creditable Amount APP***
		X	%	÷ 18	
		X	%	÷ 18	
		X	%	÷ 18	
<b>B. Total Creditable Amount<sup>1</sup></b>					
<b>C. TOTAL CREDITABLE AMOUNT (A + B rounded down to nearest 1/4 oz)</b>					

- \* Percent of protein As-Is is provided on the attached APP documentation.
- \*\* 18 is the percent of protein when fully hydrated.
- \*\*\* Creditable amount of APP equals ounces of dry APP multiplied by the percent of protein as-is divided by 18.
- <sup>1</sup> Total Creditable Amount must be rounded **DOWN** to the nearest 0.25 oz (1.49 would round down to 1.25 oz meat equivalent). Do **NOT** round up. If you are crediting both M/MA and APP, you do not need to round down in Box A until after you have added the creditable APP amount from Box B.

Total weight (per portion) of product as purchased: \_\_\_\_\_

Total creditable amount of product (per portion): \_\_\_\_\_ (Reminder: Total creditable amount cannot count for more than the total weight of product.)

I certify that the above information is true and correct and that a \_\_\_\_\_ - ounce serving of the above product (ready-for-serving) contains \_\_\_\_\_ ounces of equivalent meat/meat alternate when prepared according to directions.

I further certify that any APP used in the product conforms to the Food and Nutrition Service (FNS) Regulations (7 CFR Parts 210, 220, 225, 226, Appendix A) as demonstrated by the attached supplier documentation (Attachment A).

Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## PRODUCT FORMULATION STATEMENT FOR PREPARED GRAINS/BREADS

Product Name: \_\_\_\_\_ Code Number: \_\_\_\_\_

Case/Pack/Count/Portion Size: \_\_\_\_\_

Total Weight (Grams or Ounces) of One Ready-to-Eat Serving of Product: \_\_\_\_\_

List the exact types and weights of each enriched and/or whole-grain meal, flour, bran, or germ per product serving:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that the above information is true and correct and that \_\_\_\_\_ (specify serving weight) ready-to-eat serving of the specified product contains \_\_\_\_\_ serving(s) of Grains/Breads\* for the USDA Child Nutrition Programs.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number

\* For crediting as a Grains/Breads component, FNS Child Nutrition Programs require (1) all grains/breads items must be enriched or whole grain, made from enriched or whole-grain flour. If using a cereal, it must be whole grain, enriched, or fortified. Bran and germ are credited the same as enriched or whole-grain meal or flour; (2) the exact or minimum amount of creditable grains must be documented to assure that 16 grams of creditable grains equals one grains/breads serving. Grains/breads may be credited in 1/4-serving increments. See FNS Instruction 783-1, Rev. 2, to equal 1 serving Grains/Breads or FNS *Food-Buying Guide*, revised November 2001.

## PRODUCT FORMULATION STATEMENT FOR PREPARED FRUIT/VEGETABLE

Product Name: \_\_\_\_\_ Code Number: \_\_\_\_\_

Case/Pack/Count/Portion Size: \_\_\_\_\_

Volume and Weight of One Serving of Product: \_\_\_\_\_

- Weight of Total Product Per Batch: \_\_\_\_\_
- Number of Portions/Servings Per Batch: \_\_\_\_\_

I certify that the above information is true and correct and that one \_\_\_\_\_ serving (specify serving volume/weight) of the above product (ready-to-eat) contains \_\_\_\_\_ servings of Fruit/Vegetable\*\* for the Child Nutrition Programs.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number

\* CNP requires 14.75 grams of whole-grain or enriched flour or meal, bran or germ, or an equivalent amount of cereal as provided in FNS Instruction 783-1, Rev. 2, to equal 1 serving Grains/Breads. Grains/Breads may be credited in 1/4-serving increments.

\*\*CNP requires a minimum of 1/8 cup fruit/vegetable to equal 1 serving Fruit/Vegetable.

# ATTACHMENT A

Company Name: \_\_\_\_\_

APP Product: \_\_\_\_\_

- A. \_\_\_\_\_ certifies that \_\_\_\_\_ meets all requirements for APP intended for use in foods manufactured for Child Nutrition Programs as described in Appendix A of 7 CFR 210, 220, 225, and 226.
- B. \_\_\_\_\_ certifies that \_\_\_\_\_ has been processed so that some portion of the nonprotein constituents have been removed by fractionating. This product is produced from \_\_\_\_\_.
- C. The Protein Digestibility Corrected Amino Acid Score (PDCAAS) for \_\_\_\_\_ is \_\_\_\_\_. It was calculated by multiplying the lowest uncorrected amino acid score by true protein digestibility as described in the Protein Quality Evaluation Report from the Joint Expert Consultation of the Food and Agriculture Organization/World Health Organization of the United Nations, presented December 4-8, 1989, in Rome, Italy. The PDCAAS is required to be greater than 0.8 (80 percent of casein).
- D. The protein level of \_\_\_\_\_ is at least 18 percent by weight when fully hydrated at a ratio of \_\_\_\_\_ parts water to one part product.
- E. The protein level of \_\_\_\_\_ is certified to be at least \_\_\_\_\_ on an As-Is basis for the As-Purchased product. **NOTE: Protein is often provided on a moisture-free basis (MFB), which is not the information Food and Nutrition Service (FNS) requires.**

All of the above information is required for APP.

**NOTE: It is also helpful to have the ingredients statement for the APP product. For example, if the product is uncolored and unflavored, the ingredients statement might be soy protein concentrate or if the product is colored and textured, the ingredients statement might be textured vegetable protein (soy flour, caramel color).**

A manufacturer's Product Formulation Statement (PFS) is a signed, certified document that provides a way for a manufacturer to demonstrate how a product may contribute to the meal pattern requirements of USDA's CNP. A PFS is typically provided for processed products that do not have a CN label. Program operators must request a signed manufacturer's PFS when purchasing a processed product with a CN label. Program operators are responsible for ensuring menu items meet meal pattern requirements; therefore, program operators should review and verify the crediting statement on a manufacturer's PFS before purchasing the product.

## CHECKLIST FOR EVALUATING A MANUFACTURER'S PFS

(If *N* is checked for any question below, contact the manufacturer to request the information)

Y	N	Is the PFS on signed company letterhead? The signature on the PFS can be handwritten, stamped, or electronic.
Y	N	Does the PFS include product name, product code number, and serving/portion size?
Y	N	Do the creditable ingredients* listed on the PFS match or have a similar description as the ingredients listed on the product label? For example, if the PFS lists <i>ground beef (not more than 20% fat)</i> , the product label should also list <i>ground beef (not more than 20% fat)</i> .
Y	N	Do the creditable ingredients* listed on the PFS match or have a similar description to a food item listed in the <i>Food-Buying Guide (FBG) for School Meal Programs</i> or <i>FBG for Child Nutrition Programs</i> (available at <a href="http://www.fns.usda.gov/tn/food-buying-guide-school-meal-programs">http://www.fns.usda.gov/tn/food-buying-guide-school-meal-programs</a> or <a href="http://www.fns.usda.gov/tn/food-buying-guide-for-child-nutrition-programs">http://www.fns.usda.gov/tn/food-buying-guide-for-child-nutrition-programs</a> )?
Y	N	If the product is a meat/meat alternate, does it contain an Alternate Protein Product (APP) such as soy concentrate? If <i>Yes</i> , does the manufacturer provide supporting documentation that meets USDA's APP requirements? Specific requirements for APP products and examples of supporting documentation are available at <a href="http://www.fns.usda.gov/cnlabeling/food-manufacturersindustry">http://www.fns.usda.gov/cnlabeling/food-manufacturersindustry</a> .
Y	N	Does the PFS demonstrate how creditable ingredients* contribute toward the meal pattern requirement(s) (i.e., provides information to calculate crediting)?
Y	N	Are the manufacturer's calculations correct and verified?

- The total creditable amount should **NEVER** be rounded up. The total creditable amount must **round down** to the nearest 0.25 oz (e.g., total creditable amount of 0.99 oz must **round down** to 0.75 oz.).
- The meat/meat alternate credit cannot exceed the total serving size of the product (e.g., a 2.15-oz beef patty may not credit more than 2.00 oz meat/meat alternate).
- Fruits and vegetables (including purees) credit on the volume served (cup servings). For example, if 1/2 cup red/orange vegetables is served, then the contribution toward the red/orange vegetables subgroup is 1/2 cup credit.

### ***The only exceptions are:***

- Tomato paste and tomato puree are credited based on their whole food equivalency using the percent natural tomato soluble solids in the paste or puree. See FBG for additional information on calculated volume.
- Dried fruits credit as double the volume served in school meals only (e.g., 1/4 cup raisins credit as 1/2 cup fruit). All other CN programs credit dried fruit on the volume served.
- Raw leafy vegetables credit as half the volume served in school meals only (e.g., 1 cup raw spinach credits as 1/2 cup dark-green vegetable). All other CN programs credit as volume served.
- A PFS may include crediting information for more than one meal component. For instance, a cheese pizza may credit toward the meat/meat alternate, grains, and the red/orange vegetable subgroup. The crediting information for each meal component may be documented on the same PFS.
- PFS templates for each meal component are available on the CN labeling Web site at <http://www.fns.usda.gov/cnlabeling/food-manufacturersindustry>. Manufacturers may use PFS templates as a guide to help develop a PFS; however, they are not required to use the same format as the USDA's template, but they must present the same information on their company letterhead.

\* A **creditable ingredient** is a food/ingredient that contributes to one of the food components of USDA's meal pattern requirements.

**CONTRACT MEAL SERVICE DELIVERY RECEIPT**  
**(Keep in your institution's monthly folder. USE ONE RECEIPT PER MEAL SERVICE.)**

DATE: \_\_\_\_\_  
 MEAL TYPE: Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ AM/PM/LATE PM Snack \_\_\_\_\_ Supper \_\_\_\_\_  
 (Circle One)

SITE PREPARING MEAL: \_\_\_\_\_  
 SITE RECEIVING MEAL: \_\_\_\_\_  
 DELIVERY TIME: \_\_\_\_\_ NUMBER OF MEALS ORDERED/DELIVERED: \_\_\_\_\_

**FOOD ITEMS AND QUANTITIES DELIVERED**

Menu	Quantity Delivered: Number of 1-2 _____ Number of 3-5 _____ Number of 6-12 _____  Bulk Delivery: _____ Preportioned: _____	*Crediting/Portioning Information	Temperature at Delivery
Milk	Milk provided by:  SITE            VENDOR (Circle One)  Record Quantity: _____		
Vegetable/Juice			
Fruit/Juice			
Grains/Breads			
Meat/Meat Alternate			
Extras			

\* Crediting/portioning information: i.e., 1 cup spaghetti sauce = 2 ounces meat/meat alternate, 6 chicken nuggets = 2 ounces meat/meat alternate and 1 ounce grains/breads serving, 2 cheese sticks = 1 ounce meat/meat alternate

I acknowledge that the above items and quantities were delivered to this contract site. I did complete the necessary portioning/crediting information. Child Nutrition (CN) labels, Production Information Statements, and/or recipes are available for all combination food items or other applicable components.

\_\_\_\_\_  
 Signature From Preparation Kitchen

I acknowledge that the above items and quantities were delivered to this contract site.  
 INSPECTION DELIVERY: Was the food delivered in a safe/sanitary method? Yes or No  
 Were food temperatures proper? Yes or No

Comments: \_\_\_\_\_

\_\_\_\_\_  
 Signature From Site Receiving Food  
**FOR INSTITUTION TO USE WHEN CONTRACTING MEALS FROM OUTSIDE VENDOR OR WITHIN OWN INSTITUTION; KEPT IN INSTITUTION'S MONTHLY FOLDER.**



## INFANT MEAL WAIVER

I wish to decline my child's participation in the Child and Adult Care Food Program (CACFP). I understand that the facility will not be claiming my child's meals for CACFP reimbursement.

Name of Infant: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

# CHILD MEAL WAIVER

*A new waiver from must be obtain every fiscal year*

I wish to decline my child's participation in the Child and Adult Care Food Program (CACFP). I understand that the facility will not be claiming my child's meals for CACFP reimbursement.

Name of Child: \_\_\_\_\_

Age: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

# INFANT MEALS AS SERVED

**TOTAL INFANTS SERVED:** \_\_\_\_\_ **FORM COMPLETED BY:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Breakfast:** \_\_\_\_\_ **Lunch/Supper:** \_\_\_\_\_ **Snack:** \_\_\_\_\_ *REMEMBER TO ADD INFANT MEALS TO THE MEAL COUNT WORKSHEET.*

Meal Type	Names and Ages	Quantity Served Meat/Meat Alternate	Quantity Served Breads/Cereals	Quantity Served Fruit/Vegetable	Quantity Served Formula/Breast Milk
Breakfast					
1.					
2.					
3.					
4.					
5.					
Lunch/Supper					
1.					
2.					
3.					
4.					
5.					
Snack					
1.					
2.					
3.					
4.					
5.					
Supper					
1.					
2.					
3.					
4.					
5.					

Place an asterisk (\*) beside the formula or breast milk provided by the parent/guardian.

# MENUS AS SERVED

- Regular Meals
- At-Risk Meals

**Comments/Special Dietary Needs:**

Date: \_\_\_\_\_

Form completed by: \_\_\_\_\_

MEAL TYPE	QTY SERVED: MEAT/MEAT ALTERNATE	QTY SERVED: GRAINS	QTY SERVED: VEGETABLE/ JUICE	QTY SERVED: FRUIT/JUICE	QTY SERVED: MILK
<b>BREAKFAST</b> Total children served: _____  Number of children served: 1-2: _____ 3-5: _____ 6-12: _____  Program Adults: _____		WG <input type="checkbox"/>			
<b>AM SNACK</b> Total children served: _____  Number of children served: 1-2: _____ 3-5: _____ 6-12: _____  Program Adults: _____		WG <input type="checkbox"/>			
<b>LUNCH</b> Total children served: _____  Number of children served: 1-2: _____ 3-5: _____ 6-12: _____  Program Adults: _____		WG <input type="checkbox"/>			
<b>PM SNACK</b> Total children served: _____  Number of children served: 1-2: _____ 3-5: _____ 6-12: _____  Program Adults: _____		WG <input type="checkbox"/>			
<b>SUPPER</b> Total children served: _____  Number of children served: 1-2: _____ 3-5: _____ 6-12: _____  Program Adults: _____		WG <input type="checkbox"/>			
<b>LATE PM SNACK</b> Total children served: _____  Number of children served: 1-2: _____ 3-5: _____ 6-12: _____  Program Adults: _____		WG <input type="checkbox"/>			

# MENUS AS SERVED

(This form can be used for entities who only serve these 3 meals per day)

Regular Meals

At-Risk Meals

Comments/Special Dietary Needs:

Form completed by: \_\_\_\_\_

MEAL TYPE	QTY SERVED: MEAT/MEAT AL- TERNATE	QTY SERVED: GRAINS	QTY SERVED: VEGETABLE/ JUICE	QTY SERVED: FRUIT/JUICE	QTY SERVED: MILK
<b>BREAKFAST</b> Date: _____ Total children served: ____  Number of children served: 1-2: ____ 3-5: ____ 6-12: ____  Program Adults: ____		WG <input type="checkbox"/>			
<b>LUNCH</b> Date: _____ Total children served: ____  Number of children served: 1-2: ____ 3-5: ____ 6-12: ____  Program Adults: ____		WG <input type="checkbox"/>			
<b>PM SNACK</b> Date: _____ Total children served: ____  Number of children served: 1-2: ____ 3-5: ____ 6-12: ____  Program Adults: ____		WG <input type="checkbox"/>			
<b>BREAKFAST</b> Date: _____ Total children served: ____  Number of children served: 1-2: ____ 3-5: ____ 6-12: ____  Program Adults: ____		WG <input type="checkbox"/>			
<b>LUNCH</b> Date: _____ Total children served: ____  Number of children served: 1-2: ____ 3-5: ____ 6-12: ____  Program Adults: ____		WG <input type="checkbox"/>			
<b>PM SNACK</b> Date: _____ Total children served: ____  Number of children served: 1-2: ____ 3-5: ____ 6-12: ____  Program Adults: ____		WG <input type="checkbox"/>			

