Provider Number: \_\_\_\_\_\_\_\_\_\_\_ Provider 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 | |
| 1st shift | | 1st shift | | 1st shift | | 1st shift | | 1st shift | | 1st shift | |
| Beginning | Ending | Beginning | Ending | Beginning | Ending | Beginning | Ending | Beginning | Ending | Beginning | Ending |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 2nd shift | | 2nd shift | | 2nd shift | | 2nd shift | | 2nd shift | | 2nd 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 | | |
| 1st | 2nd | 1st | 2nd | 1st | 2nd | 1st | 2nd | 1st | 2nd | 1st | 2nd |
|  |  |  |  |  |  |  |  |  |  |  |  |

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 | |
| 1st shift | | 1st shift | | 1st shift | | 1st shift | | 1st shift | | 1st shift | |
| Beginning | Ending | Beginning | Ending | Beginning | Ending | Beginning | Ending | Beginning | Ending | Beginning | Ending |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 2nd shift | | 2nd shift | | 2nd shift | | 2nd shift | | 2nd shift | | 2nd 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 | | |
| 1st | 2nd | 1st | 2nd | 1st | 2nd | 1st | 2nd | 1st | 2nd | 1st | 2nd |
|  |  |  |  |  |  |  |  |  |  |  |  |

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 |
|  | I certify that, to the best of my knowledge, this home is not participating in the Child and Adult Care Food Program (CACFP) under any other sponsoring organization. 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.  Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Approving Official Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

No change to hours of operation