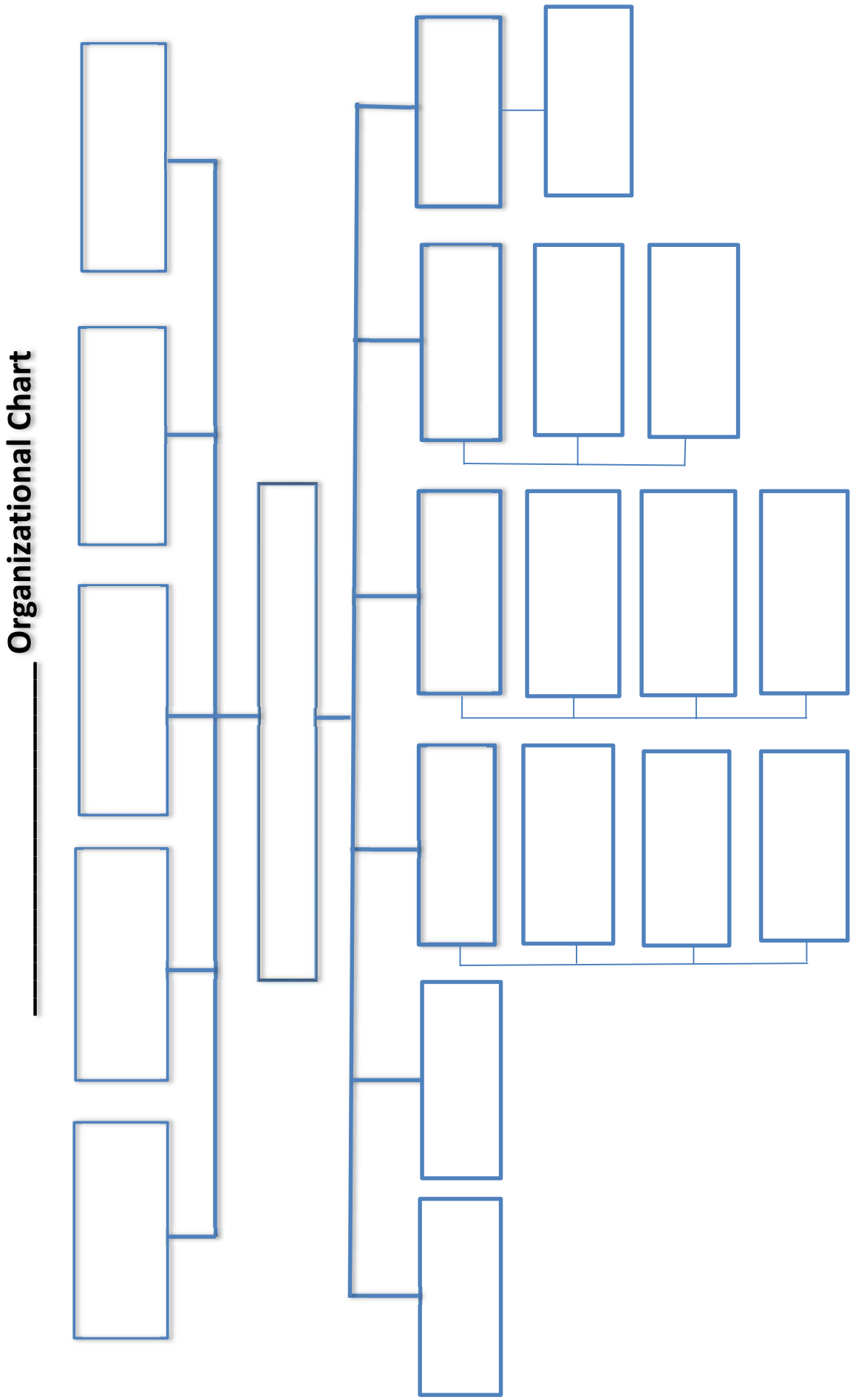
FDCH ORIGINALS


Organizational Chart

EXPENDITURE WORKSHEET

Maintain with sponsoring organization records. **MONTH:** _____ **YEAR:** _____

Date	Item Entry (Vendor or Personnel)	Check #	ADMINISTRATIVE COSTS ($)							
			CACFP Admin. Labor $ (1)	CACFP Admin. Supplies $ (2)	CACFP Admin. Expenses $ (3)	CACFP-Related Travel $ (4)	CACFP-Related Training/ Education $ (5)	Indirect Cost $ (6)	Other Admin. Services $ (7)	Misc. $ (8)

CLAIM DOCUMENTATION—MEAL COUNTS BY PROVIDER

Use this form to complete the claim for reimbursement

Month: _____ 20 _____ Sponsoring Organization: _____

Agreement Number: _____

Complete and maintain on file at the office of the SO with the claim for reimbursement. List only the names of the providers claiming for the month.

1	2	3	4	5						6	7	8
TIER STATUS OF PROVIDER I, II-H, II-L, OR II-M)*	PROVIDER NUMBER	LIST EACH PROVIDER UNDER CONTRACT Last Name Only	TIER LEVEL OF MEALS	NUMBER OF MEALS SERVED TO CHILDREN (Add first- and second-shift meals together)						TOTAL ENROLLMENT	ADA	NUMBER OF DAYS
				BREAKFASTS	AM SNACKS	LUNCHES	PM SNACKS	SUPPERS	LATE SNACKS			
			Tier 1 (Same as Tier II Higher)									
			Tier 2 (Same as Tier II Lower)									
			Tier 1 (Same as Tier II Higher)									
			Tier 2 (Same as Tier II Lower)									
			Tier 1 (Same as Tier II Higher)									
			Tier 2 (Same as Tier II Lower)									
			Tier 1 (Same as Tier II Higher)									
			Tier 2 (Same as Tier II Lower)									
			Tier 1 (Same as Tier II Higher)									
			Tier 2 (Same as Tier II Lower)									

I = Tier I home that receives Tier I reimbursement rates.

II-H = Tier II-Higher Tier II home that receives all Tier I reimbursement rates.

II-L = Tier II-Lower Tier II home that receives all Tier II reimbursement rates

*II-M = Tier II-Mixed Tier II home that receives both Tier I and Tier II reimbursement rates.

Agreement #: H-_____

Sponsor Name: _____

Claims Revision Form

Claim Month:_____

Provider:_____ Amount:_____

Provider:_____ Amount:_____

Provider:_____ Amount:_____

Provider:_____ Amount:_____

Provider:_____ Amount:_____

Provider:_____ Amount:_____

(Use another form if more spaces needed)

Total Revision:

_____Operating

_____Administrative

_____Total

Once the claim has been opened, then you must click the "SELECT" button on the Inactive claim.

Next, go to the provider's name, and make any adjustments needed. Enter the correct amounts that should have been paid the first time.

View the claim summary, and verify that the claim total is the correct amount; then certify the claim.

SDE office use only-

Date received:_____

Date entered:_____

Agreement #: H-_____

Sponsor Name: _____

Claim Month _____

Provider Name:_____

Provider Site Number: _____

Provider Tier: _____

Item	Previous Claim	Revised Claim	$ amount of change	Correct total
Number of days claimed			N/A	N/A
Breakfast				
AM Snack				
Lunch				
PM Snack				
Supper				
Late Snack				
Total operating revision				

Reason for Revision:_____

Provider Name:_____

Provider Site Number: _____

Provider Tier: _____

Item	Previous Claim	Revised Claim	$ amount of change	Correct total
Number of days claimed			N/A	N/A
Breakfast				
AM Snack				
Lunch				
PM Snack				
Supper				
Late Snack				
Total operating revision				

Reason for Revision:_____

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:

OKLAHOMA STATE DEPARTMENT OF EDUCATION
FAMILY DAY CARE HOME (FDCH)
PROVIDER APPLICATION
Fiscal Year: _____

Section A—General

A. Home Agreement Number:_____

C. Address of Provider:

Phone Number of Provider: _____

B. Provider Information:

Full Last Name: _____

Full First Name: _____

Middle Initial: _____

Date of Birth: _____

Primary Caregiver *(if different from Provider):*

_____

Primary Caregiver Date of Birth: _____

D. Is the home licensed? ☐ Yes ☐ No
License Type: ☐ DHS ☐ Tribal

E. License Number: _____

F. License Capacity: _____

H. Age Range of Enrolled Participants:
From _____ to _____

I. Number Enrolled in CACFP: _____

G. Name and Address of Sponsoring Organization

Section B—Operating Data

A. Hours of Operation:
From _____ to _____ (hhmm)

B. Number of operating days per week?_____

Days of the week:

☐ Monday
☐ Tuesday
☐ Wednesday
☐ Thursday
☐ Friday
☐ Saturday
☐ Sunday

Do you care for participants in shifts? ☐ Yes ☐ No

If Yes, explain:

OSDE Official Use Only

D. Months of Operation:

☐ January
☐ February
☐ March
☐ April
☐ May
☐ June
☐ July
☐ August
☐ September
☐ October
☐ November
☐ December

Section C—Meal Service Data

A. MEAL TYPES—MONDAY-FRIDAY MEAL SERVICE												
Meal Served	Breakfast		AM Snack		Lunch		PM Snack		Supper		Late PM Snack	
Type of Shift	1st	2nd	1st	2nd	1st	2nd	1st	2nd	1st	2nd	1st	2nd
Beginning Time of Meal Service												
WEEKEND MEAL SERVICE												
Meal Served	Breakfast		AM Snack		Lunch		PM Snack		Supper		Late PM Snack	
Type of Shift	1st	2nd	1st	2nd	1st	2nd	1st	2nd	1st	2nd	1st	2nd
Beginning Time of Meal Service												

Section D—Eligibility

A. Is family-size and income information available at the sponsoring organization to establish eligibility of children in a Tier II home receiving Tier I rates and provider's own children? ☐ Yes ☐ No	B. Number of children provider cares for that are: Provider's Own/Residential: _____ Nonresidential: _____

Justification to serve on a weekend:

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 of 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, sex (including gender identity and sexual orientation), national origin, disability, age, reprisal, and 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.

OKLAHOMA STATE DEPARTMENT OF EDUCATION
CHILD NUTRITION PROGRAMS (CNP)
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
Family Day Care Home (FDCH) Provider Agreement—FDCH-1B
PERMANENT AGREEMENT BETWEEN
SPONSORING ORGANIZATION (SO)
AND FAMILY DAY CARE HOME PROVIDER (§226.18[b])

As an FDCH provider, I am aware that organizations are available in Oklahoma to sponsor FDCHs in the CACFP. I understand that I may not change SOs during the current fiscal year. I further understand the SOs are nonprofit institutions that are not employed by the State Department of Education (the *State agency*) or the United States Department of Agriculture (USDA).

The Agreement entered into this date _____ between:

Name and Address of Sponsor: Name and Address of Provider:

Section A

RIGHTS AND RESPONSIBILITIES OF SPONSORING ORGANIZATION

In accordance with CACFP regulations, the SO agrees to:

1. Conduct on-site preapproval visit to discuss Program benefits, including tiering options, and verify that proposed food service does not exceed the capability of the FDCH provider. This visit must be documented and kept on file.
2. Make Tier I FDCH determinations based on elementary school, middle school, or high school eligibility data, census data, or free or reduced-price eligibility standards. SO must make reasonable efforts to establish area eligibility with school data prior to using census data. Providers must be informed of the tiering status determination.
3. Use the most currently available data in making the determination of an FDCH's eligibility as a Tier I FDCH. The determination shall be valid for one year if based on a provider's household income and five years if based on school or census data.
4. Annually, verify FDCH provider's income when provider qualifies as Tier I based on income. Provide written provider verification tiering results.
5. Change the determination of Tier I FDCH if information becomes available indicating that a home is no longer in a qualified area (after the current determination has expired).
6. Notify FDCHs qualifying as Tier II homes of their reimbursement options and annually inform Tier II homes that the provider may ask for a reclassification to be considered when new census data becomes available and that reclassification may be made at any time.
7. Be responsible, when requested by a provider qualifying as a Tier II FDCH, for collecting or providing to the Tier II FDCH Family-Size and Income Applications (FSIAs), for determining eligibility of children and for maintaining confidentiality of the information collected.
8. Monitor food service operations of all providers under the SO's administration. New FDCH's must have their first review during the first four weeks (28 days) of operation. Each review must include a meal analysis where children are present and a five-day

reconciliation of records. If the provider has been approved for supper, weekend, late snacks, and/or holiday meals, the SO review must monitor a "roughly proportional" number of those meal services. If a provider is found to be seriously deficient, an unannounced follow-up review may be conducted. This review does not count toward the three required reviews..

9. Initiation household contacts by the SO, State agency (SA), and Department when required.
10. Show photographic identification when visiting providers.
11. Make all visits by SO, SA, and Department during the provider's normal operating hours. Reference §226.18(b)(1)—the right of the SO, the State agency, the Department, and other state and federal officials to make announced or unannounced reviews of the day care home's operations and to have access to its meal service and records during normal hours of operation.
12. If required by the SO, Establish cycle menu requirements, including number of days. The SO must ensure that the approved cycle menu is being followed correctly.
13. Offer training sessions covering all required topics, not less frequently than annually, scheduled at a time and place convenient to providers. Providers who do not attend training at least annually shall be declared seriously deficient.
14. Inform all providers of CACFP regulations, SO policies, and the procedures for requesting an appeal upon signature of Application/Agreement. Provide technical assistance upon request to providers.
15. Provide CACFP record-keeping forms to providers.
16. Perform edit checks on all providers' record-keeping forms.
17. Disburse any reimbursement payments for food service within five working days after receipt of payment from the SA to any providers in compliance with CACFP policies and regulations.
18. Not charge a fee for services rendered.
19. Assure that all meals claimed for reimbursement are served to enrolled children at no separate charge, regardless of race, color, national origin, sex, age, disability, or reprisal or retaliation, and that there is no discrimination in the course of the food service.
20. Not make payments for meals of any FDCH approved unless the home has operated at least ten days of meal service in the first claiming month of Program participation.
21. Approve applications for FDCH providers for no more than five days per week unless the SO is furnished with justification for additional days and grants prior approval.
22. Provide information concerning the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to FDCH providers in order for the parents of children enrolled in FDCHs to be informed of WIC benefits.
23. Obtain a completed CACFP enrollment form annually on all enrolled children for every provider under the sponsorship. Copies of the forms must be readily available in both the SO's office and the provider's home.
24. Provide copies of *Building for the Future* (parental notification) fact sheet to all providers in adequate quantities for distribution to all households.
25. Have the right to propose to terminate this Agreement to participate in the CACFP for cause or convenience. If proposed termination is for cause, notification must include SO's appeal procedures.
26. Immediately suspend any FDCH found to be causing an imminent threat to the health or safety of enrolled children or engaging in activities that threaten the public health or safety of the children.
27. Reimburse for meals that meet only minimum meal pattern requirements.
28. Comply with all other USDA Regulations §226.
29. Provide appeal procedures to all providers annually and at any time a provider is suspended or proposed for termination.

30. Follow all seriously deficient procedures pertaining to providers.

Section B

RIGHTS AND RESPONSIBILITIES OF FAMILY DAY CARE HOME PROVIDER

In order to qualify for reimbursement under this Agreement in conducting the food service in an FDCH, the provider shall:

1. Follow all licensing standards required by the Department of Human Services (DHS) regarding the number of children present, ages of the children present, and the number of staff required to supervise the children. Meals served over license capacity may not be claimed, including the provider's own children.
2. Participate with the SO until the end of the fiscal year (September 30). If the FDCH does not complete participation through the expiration date, approval to participate with another SO will not be made until the following fiscal year. An exception may be made if a provider in good standing relocates to an area of the state in which the SO does not administer the Program. The SO would terminate the provider *for convenience* and keep this documentation in the provider's file.
3. Attend at least one CACFP training session annually conducted by the SO. Providers who do not attend training at least once annually shall be declared seriously deficient.
4. Allow all children equal access to its child care service and facilities and serve meals equally at no extra charge, regardless of race, color, national orgin, sex, age, disability, or reprisal or retaliation, and have no discrimination in the course of food service.
5. Operate at least ten days of meal service in the first claiming month of Program participation.
6. Serve and claim meals for reimbursement which meet the minimum meal pattern requirements for children aged birth through 12, unless caring for a child over the age of 12 who has been defined by the State as having mental or physical disabilities.
7. Serve only the meal types specified in its approved application in accordance with the meal pattern requirements. Providers shall not be approved to claim more than two shifts per meal per day. Serve meals at the approved times indicated on the application. Three hours must elapse between the beginning of one main meal service and the next main meal service. At least two hours must elapse between the beginning of a main meal and a snack. Meals served outside of the approved times are not eligible for reimbursement.
8. If required by SO, develop and follow a cycle menu for each main meal and snack served.
9. Not be reimbursed for more than two main meals and one snack or one main meal and two snacks per child daily. Documentation to ensure that no meals are claimed over the three-meal limit per child daily must be maintained and must reflect arrival and departure times. The record system must reflect the meal service participation for each child for each day that he or she is in attendance.
10. Have all parents of enrolled children completed and updated the CACFP enrollment form annually. A copy of this form must be submitted to the SO and/or retained by the provider. Meals may not be claimed for children without a completed enrollment form on file.
11. Have documentation on file and available for individual participating children who are unable, because of special dietary needs, to consume the required food components. Substitutions for the required components must be supported by a statement from a recognized medical authority and include recommended alternate foods. If a medical statement is not available, meals lacking the required components cannot be claimed for reimbursement.

12. Claim own child(ren) if household income qualifies for free or reduced-price meals and at least one nonresidential child is enrolled and receiving care, in attendance and participating in the same meal service. (Definition of providers own: All residential children in the provider's household who are part of the economic unit of the family. A family is a group of related or unrelated individuals who are not residents of an institution or boarding home, but who are living as one economic unit. Therefore, provider's own children include children by birth or adoption, foster children, grandchildren, or housemates' children who are part of the economic unit. Informal extended family situations frequently exist, and all such children should be included in the provider's household. Children whose parents or guardians have made a contractual agreement, either formal or informal, with a provider for residential care, and whose relationship is defined primarily by the child care situation, are not considered the provider's own.) (Reference All-States Directors' Memo 91-CACFP-5, 93-CACFP-9) only when:
    a. Such children are enrolled and are participating in the CACFP during the time of the meal service.
    b. Enrolled nonresidential children are present and participating during the time of the meal service.
    c. Provider has a completed and approved FSIA on file.
13. Not forbid the availability of the Program as disciplinary action. Meals cannot be used as a reward or as a punishment.
14. Not submit meals for reimbursement served to children who do not have CACFP enrollment data and are not participating in the CACFP or for meals served over license capacity, including the provider's own children. All children participating in the CACFP and claimed ***MUST BE NONRESIDENTIAL***, except for the provider's own children.
15. Maintain proper sanitation and health standards in the storage, preparation, and service of food in conformance with all applicable state and local laws and regulations as well as federal guidelines.
16. Receive reimbursement for the types of meals provided to participating children at the rates specified by USDA.
17. Submit necessary documentation for meals served for reimbursement in accordance with procedures established by the SA and the SO.
18. Provide monthly report of daily arrival and departure attendance records; daily records of meals served; weekly meals served; infant meal waivers; if applicable; and infant meals served, if applicable.
19. Maintain full and accurate records of the Program, including those set forth in this Agreement. Records must be maintained daily. No grace period will be allowed. Records must be completed through the end of the previous workday. Retain such records for a period of three years after the end of the fiscal year to which they pertain unless audit or review findings are not resolved. In which case, records must be maintained past the three-year requirement until there is a resolution of the audit or review.
20. Upon request, make all records pertaining to the Program ***IMMEDIATELY*** available to the SA, USDA, and/or the SO for audit or administrative review or monitoring review purposes. Reviews and visits may be announced or unannounced.
21. Allow representatives with photographic identification from the SO, the SA, and USDA access to the home during normal business hours throughout the year for the purpose of reviewing CACFP operations.
22. Inform the SO immediately of any changes in the daily operations of the Program (i.e., changes in enrollment, participation, meal times, license status, days of operation). Notify the SO in advance whenever the provider is planning to be out of his or her home during the meal service period. If this procedure is not followed and an unannounced review is conducted when the children are not present in the FDCH, claims for meals that would have been served during the unannounced review will be disallowed.

23. Provide all required monthly claiming records to the SO by the _____ day of the month. Failure to do so may result in the loss of payment.
24. Have three options with regard to how meals served in its FDCH are reimbursed when the provider qualifies as a Tier II home.
    a. ***OPTION 1:*** SO or Tier II FDCH distributes income applications to the households of all children enrolled in the FDCH. All meals served to enrolled children who are determined to meet the criteria for free or reduced-price meals are reimbursed at Tier I reimbursement rates. Meals served to enrolled children who are not eligible for free or reduced-price meals, or children from households whose complete income applications are not received, would be reimbursed at the Tier II reimbursement rate.
    b. ***OPTION 2:*** Provider elects to have the SO identify only those children who are categorically eligible based on their participation or their parents' participation in a federally or state-supported program with an income-eligibility limit that does not exceed the standard for free or reduced-price meals. If this option is chosen, the provider would receive the Tier I reimbursement rates for meals served to the categorically eligible children and the Tier II reimbursement rates for meals served to all other children.
    c. ***OPTION 3:*** Provider receives Tier II reimbursement for meals served to all children in the FDCH regardless of income. Under this option, the SO or Tier II FDCH would not collect any income applications nor would it need to attempt to identify categorically eligible children.
25. Be aware that a request may be made by a Tier II home to the sponsor to consider reclassification of the home when new census data becomes available and that reclassification may be made at any time.
26. Make available information concerning WIC to parents of children enrolled in FDCHs.
27. Distribute the *Building for the Future* (parental notification) fact sheet to all households enrolled in the FDCH.
28. Have the right to terminate the Agreement and Application to participate in the CACFP for cause or convenience.
29. Have the right to appeal a Notice of Proposed Termination by the SO or to appeal if the SO suspends participation due to health and safety concerns.
30. Not claim another provider's own child.
31 Be aware that the provider can be declared seriously deficient and proposed for disqualification and termination for failure to comply with CACFP regulations.
32. Be aware that while a provider can operate more than one FDCH, he or she may operate the CACFP in only one of them. However, a provider who owns one FDCH and a center(s) may have both institutions on the CACFP simultaneously. Any primary caregivers (in either the FDCH or center) must be identified in the application and all requirements apply to those individuals.

CHILD MEAL PATTERN

Breakfast (Select all three components for a reimbursable meal)				
Food Components and Food Items[1]	Ages 1-2	Ages 3-5	Ages 6-12	Ages 13-18[2] (At-Risk After-School Programs and Emergency Shelters)
Fluid Milk[3]	4 fluid ounces	6 fluid ounces	8 fluid ounces	8 fluid ounces
Vegetables, Fruits, or Portions of Both[4]	1/4 cup	1/2 cup	1/2 cup	1/2 cup
Grains (oz eq)[5, 6, 7]				
Whole grain-rich or enriched bread	1/2 oz eq	1/2 oz eq	1 oz eq	1 oz eq
Whole grain-rich or enriched bread product such as biscuit, roll, or muffin	1/2 oz eq	1/2 oz eq	1 oz eq	1 oz eq
Whole grain-rich, enriched, or fortified, cooked breakfast cereal[8], cereal grain, and/or pasta	1/4 cup	1/4 cup	1/2 cup	1/2 cup
Whole grain-rich, enriched, or fortified ready-to-eat breakfast cereal (dry, cold)[6,7]				
Flakes or rounds	1/2 cup	1/2 cup	1 cup	1 cup
Puffed cereal	3/4 cup	3/4 cup	1 1/4 cups	1 1/4 cups
Granola	1/8 cup	1/8 cup	1/4 cup	1/4 cup

1 Must serve all three components for a reimbursable meal. Offer versus Serve (OvS) is an option for At-Risk After-School participants.

2 Larger portion sizes than specified may need to be served to children aged 13 through 18 to meet their nutritional needs.

3 Must be unflavored whole milk for children aged one. Must be unflavored lowfat (1 percent) or unflavored fat-free (skim) milk for children aged two through five. Must be unflavored lowfat (1 percent), unflavored fat-free (skim), or flavored fat-free (skim) milk for children aged six and older.

4 Pasteurized full-strength juice may only be used to meet the vegetable or fruit requirement at one meal, including snack, per day.

5 At least one serving per day, across all eating occasions, must be whole grain-rich. Grain-based desserts do not count toward meeting the Grains requirement.

6 Meat and Meat Alternates may be used to meet the entire Grains requirement a maximum of three times a week. One ounce of Meat and Meat Alternates is equal to one ounce equivalent (oz eq) of Grains.

7 Breakfast cereals must contain no more than 6 grams of sugar per dry ounce (no more than 21.2 grams sucrose and other sugars per 100 grams of dry cereal).

CHILD MEAL PATTERN

Lunch and Supper (Select all five components for a reimbursable meal)				
Food Components and Food Items[1]	Ages 1-2	Ages 3-5	Ages 6-12	Ages 13-18[2] (At-Risk After-School Programs and Emergency Shelters)
Fluid Milk[3]	4 fluid ounces	6 fluid ounces	8 fluid ounces	8 fluid ounces
Meat/Meat Alternates				
Lean meat, poultry, or fish	1 ounce	1 1/2 ounces	2 ounces	2 ounces
Tofu, soy product, or alternate protein products[4]	1 ounce	1 1/2 ounces	2 ounces	2 ounces
Cheese	1 ounce	1 1/2 ounces	2 ounces	2 ounces
Large egg	1/2	3/4	1	1
Cooked dry beans or peas	1/4 cup	3/8 cup	1/2 cup	1/2 cup
Peanut butter or soy nut butter or other nut or seed butters	2 Tbsp	3 Tbsp	4 Tbsp	4 Tbsp
Yogurt, plain or flavored, unsweetened or sweetened[5]	4 ounces or 1/2 cup	6 ounces or 3/4 cup	8 ounces or 1 cup	8 ounces or 1 cup
The following may be used to meet no more than 50 percent of the requirement: Peanuts, soy nuts, tree nuts, or seeds, as listed in Program guidance, or an equivalent quantity of any combination of the above Meat/Meat Alternates (1 oz of nuts/seeds = 1 oz of cooked, lean meat, poultry, or fish)	1/2 ounce = 50%	3/4 ounce = 50%	1 ounce = 50%	1 ounce = 50%
Vegetables[6]	1/8 cup	1/4 cup	1/2 cup	1/2 cup
Fruits[6, 7]	1/8 cup	1/4 cup	1/4 cup	1/4 cup
Grains (oz eq)[8, 9]				
Whole grain-rich or enriched bread	1/2 oz eq	1/2 oz eq	1 oz eq	1 oz eq
Whole grain-rich or enriched bread product such as biscuit, roll, or muffin	1/2 oz eq	1/2 oz eq	1 oz eq	1 oz eq
Whole grain-rich, enriched or fortified cooked breakfast cereal[10], cereal grain, and/or pasta	1/4 cup	1/4 cup	1/2 cup	1/2 cup

1 Must serve all five components for a reimbursable meal. Offer versus Serve (OvS) is an option for At-Risk After-School participants.

2 Larger portion sizes than specified may need to be served to children aged 13 through 18 to meet their nutritional needs.

3 Must be unflavored whole milk for children aged one. Must be unflavored lowfat (1 percent) or unflavored fat-free (skim) milk for children aged two through five. Must be unflavored lowfat (1 percent), unflavored fat-free (skim), or flavored fat-free (skim) milk for children aged six and older.

4 Alternate protein products must meet the requirements in Appendix A to Part 226.

5 Yogurt must contain no more than 23 grams of total sugars per 6 ounces.

6 Pasteurized full-strength juice may only be used to meet the vegetable or fruit requirement at one meal, including snack, per day.

7 A vegetable may be used to meet the entire fruit requirement. When two vegetables are served at lunch or supper, two different kinds of vegetables must be served.

8 At least one serving per day, across all eating occasions, must be whole grain-rich. Grain-based desserts do not count toward meeting the Grains requirement.

9 Breakfast cereals must contain no more than 6 grams of sugar per dry ounce (no more than 21.2 grams sucrose and other sugars per 100 grams of dry cereal).

CHILD MEAL PATTERN

Snack (Select two of the five components for a reimbursable snack)				
Food Components and Food Items[1]	Ages 1-2	Ages 3-5	Ages 6-12	Ages 13-18[2] (At-Risk After-School Programs and Emergency Shelters)
Fluid Milk[3]	4 fluid ounces	4 fluid ounces	8 fluid ounces	8 fluid ounces
Meat/Meat Alternates				
Lean meat, poultry, or fish	1/2 ounce	1/2 ounce	1 ounce	1 ounce
Tofu, soy product, or alternate protein products[4]	1/2 ounce	1/2 ounce	1 ounce	1 ounce
Cheese	1/2 ounce	1/2 ounce	1 ounce	1 ounce
Large egg	1/2	1/2	1/2	1/2
Cooked dry beans or peas	1/8 cup	1/8 cup	1/4 cup	1/4 cup
Peanut butter or soy nut butter or other nut or seed butters	1 Tbsp	1 Tbsp	1 Tbsp	2 Tbsp
Yogurt, plain or flavored, unsweetened or sweetened[5]	2 ounces or 1/4 cup	2 ounces or 1/4 cup	4 ounces or 1/2 cup	4 ounces or 1/2 cup
Peanuts, soy nuts, tree nuts, or seeds	1/2 ounce	1/2 ounce	1 ounce	1 ounce
Vegetables[6]	1/2 cup	1/2 cup	3/4 cup	3/4 cup
Fruits[6]	1/2 cup	1/2 cup	3/4 cup	3/4 cup
Grains (oz eq)[7, 8]				
Whole grain-rich or enriched bread	1/2 oz eq	1/2 oz eq	1 oz eq	1 oz eq
Whole grain-rich or enriched bread product such as biscuit, roll, or muffin	1/2 oz eq	1/2 oz eq	1 oz eq	1 oz eq
Whole grain-rich, enriched or fortified cooked breakfast cereal[9], cereal grain, and/or pasta	1/4 cup	1/4 cup	1/2 cup	1/2 cup
Whole grain-rich, enriched, or fortified ready-to-eat breakfast cereal (dry, cold)[8]				
Flakes or rounds	1/2 cup	1/2 cup	1 cup	1 cup
Puffed cereal	3/4 cup	3/4 cup	1 1/4 cups	1 1/4 cups
Granola	1/8 cup	1/8 cup	1/4 cup	1/4 cup

1 Select two of the five components for a reimbursable snack. Only one of the two components may be a beverage.

2 Larger portion sizes than specified may need to be served to children aged 13 through 18 to meet their nutritional needs.

3 Must be unflavored whole milk for children aged one. Must be unflavored lowfat (1 percent) or unflavored fat-free (skim) milk for children aged two through five. Must be unflavored lowfat (1 percent), unflavored fat-free (skim), or flavored fat-free (skim) milk for children aged six and older.

4 Alternate protein products must meet the requirements in Appendix A to Part 226.

5 Yogurt must contain no more than 23 grams of total sugars per 6 ounces.

6 Pasteurized full-strength juice may only be used to meet the vegetable or fruit requirement at one meal, including snack, per day.

7 At least one serving per day, across all eating occasions, must be whole grain-rich. Grain-based desserts do not count toward meeting the Grains requirement.

8 Breakfast cereals must contain no more than 6 grams of sugar per dry ounce (no more than 21.2 grams sucrose and other sugars per 100 grams of dry cereal).

CHILD AND ADULT CARE FOOD PROGRAM
INFANT MEAL PATTERN

BREAKFAST	
Birth Through 5 Months	**6 Through 11 Months**
4-6 fluid ounces (fl oz) breast milk[1] or formula[2]	6-8 fl oz breast milk[1] or formula[2] ***and*** 0-4 tablespoons (Tbsp) infant cereal[2] meat fish poultry whole egg cooked dry beans ***or*** cooked dry peas ***or*** 0-2 oz of cheese ***or*** 0-4 oz (volume) of cottage cheese ***or*** 0-4 oz or 1/2 cup of yogurt[3] ***or*** a combination of the above[4] ***and*** 0-2 Tbsp vegetable or fruit or a combination of both[4, 5]

1 Breast milk or formula, or portions of both, must be served; however, it is recommended that breast milk be served in place of formula from birth through 11 months. For some breastfed infants who regularly consume less than the minimum amount of breast milk per feeding, a serving of less than the minimum amount of breast milk may be offered, with additional breast milk offered at a later time if the infant will consume more.

2 Infant formula and dry infant cereal must be iron-fortified.

3 Yogurt must contain no more than 23 grams of total sugars per six ounces.

4 A serving of this component is required when the infant is developmentally ready to accept it.

5 Fruit and vegetable juices must not be served.

CHILD AND ADULT CARE FOOD PROGRAM
INFANT MEAL PATTERN

LUNCH AND SUPPER	
Birth Through 5 Months	**6 Through 11 Months**
4-6 fluid ounces (fl oz) breast milk[1] or formula[2]	6-8 fl oz breast milk[1] or formula[2] ***and*** 0-4 tablespoons (Tbsp) infant cereal[2] meat fish poultry whole egg cooked dry beans ***or*** cooked dry peas ***or*** 0-2 oz of cheese ***or*** 0-4 oz (volume) of cottage cheese ***or*** 0-4 oz or 1/2 cup of yogurt[4] ***or*** a combination of the above[4] ***and*** 0-2 Tbsp vegetable or fruit or a combination of both[4,5]

1 Breast milk or formula, or portions of both, must be served; however, it is recommended that breast milk be served in place of formula from birth through 11 months. For some breastfed infants who regularly consume less than the minimum amount of breast milk per feeding, a serving of less than the minimum amount of breast milk may be offered, with additional breast milk offered at a later time if the infant will consume more.

2 Infant formula and dry infant cereal must be iron-fortified.

3 Yogurt must contain no more than 23 grams of total sugars per six ounces.

4 A serving of this component is required when the infant is developmentally ready to accept it.

5 Fruit and vegetable juices must not be served.

CHILD AND ADULT CARE FOOD PROGRAM
INFANT MEAL PATTERN

SNACK	
Birth Through 5 Months	**6 Through 11 Months**
4-6 fluid ounces (fl oz) breast milk[1] or formula[2]	2-4 fl oz breast milk[1] or formula[2] ***and*** 0-1/2 slice bread[3,4] ***or*** 0-2 crackers[3,4] ***or*** 0-4 tablespoons (Tbsp) infant cereal[2,3,4], ***or*** ready-to-eat breakfast cereal[3,4,5] ***and*** 0-2 Tbsp vegetable or fruit ***or*** a combination of both[5,6]

1 Breast milk or formula, or portions of both, must be served; however, it is recommended that breast milk be served in place of formula from birth through 11 months. For some breastfed infants who regularly consume less than the minimum amount of breast milk per feeding, a serving of less than the minimum amount of breast milk may be offered, with additional breast milk offered at a later time if the infant will consume more.

2 Infant formula and dry infant cereal must be iron-fortified.

3 A serving of grains must be whole grain-rich, enriched meal, or enriched flour.

4 Breakfast cereals must contain no more than six grams of sugar per dry ounce (no more than 21.2 grams sucrose and other sugars per 100 grams of dry cereal.)

5 A serving of this component is required when the infant is developmentally ready to accept it.

6 Fruit and vegetable juices must not be served.

NOTE: Do not serve honey or use in food served to infants under 1 year of age.

Section C

1. **PROVIDER CIVIL RIGHTS DATA COLLECTION.** Actual enrollment data by ethnic/racial category for each FDCH must be collected by the SO each year. Visual identification may be used by homes to determine a child's ethnic or racial category, or the parents of a child may be asked to identify the ethnic or racial group of the child only after the parents are given an explanation and understand that the collection of this information is strictly for statistical requirements.
2. **ETHNIC BREAKDOWN. Home's Current Enrollment by Ethnic/Racial Group**
(Enter whole numbers for each ethnic/racial group.)
Actual enrollment data by ethnic/racial category for all institutions and their facilities must be collected by the institution each year. Visual identification may be used by institutions to determine an enrollee's ethnic/racial category, or the family may be asked to identify the ethnic/racial group of the enrollee. Families may be asked to identify the ethnic/racial group of the participants only after an explanation has been given and the family understands that the collection of this information is strictly for statistical reporting requirements.

   Institution's ***actual enrollment data*** by ethnic/racial category for each facility under its jurisdiction:

   Data must be reported in whole numbers only.

   Ethnic Breakdown *(Actual Enrollment)*
   _____ Hispanic
   _____ Not Hispanic
   _____ Not Reported
   Racial Breakdown *(Actual Enrollment)*
   _____ American Indian/Alaskan Native
   _____ Asian
   _____ Black or African
   _____ Hawaiian or Pacific Islander
   _____ White
   _____ Not Reported
   _____ 2 or more races
3. **TIER I ELIGIBLE HOMES.**

   This home is eligible for Tier Reimbursement? ☐ Yes ☐ No

   If *Yes*, this determination was made from the following source of information:

   ☐ School Data—If selected, enter school name: _____
   Enter fiscal year Low Income School List that was used for determination ___

   ☐ Enter free/reduced percentage for the school listed above _____%

   ☐ Census Data—_____ %
   Income-Eligible/Categorical (FSIA on file and income or categorical eligibility has been verified)

If Categorical, is it based on SNAP? ☐ Yes ☐ No
If *Yes*, provide SNAP Number: _____

Date of Determination: _____ Date Determination Expires: _____

4. **FOR TIER II HOMES ONLY: (Check One)**

☐ I elect to receive reimbursement at the Tier II rate for all children in my home.
☐ I elect to require the SO to collect free and reduced-price applications and determine the income eligibility of enrolled children.
☐ I elect to collect FSIAs on my enrolled children and submit documentation to the SO for eligibility determination.
☐ I elect to have SO identify only those children in Tier II homes who are considered categorically eligible by virtue of their participation, or their parents' participation, in a federally or state-supported program with an income-eligibility limit that does not exceed the standard for free or reduced-price meals. (This option is possible only in those limited situations where the provider knows which enrolled children are categorically eligible or when the SO has direct access to eligibility information for other qualifying programs.)

5. **PROVIDER MUST ANSWER EACH OF THE FOLLOWING QUESTIONS—SELECT AN ANSWER:**

I ☐ have not ☐ have been convicted of a business-related offense during the past seven years.

I ☐ am ☐ am not on the CACFP National Disqualified List.

I was placed on the CACFP National Disqualified List on _____ (date).

I understand that proposed termination or suspension for health or safety violations is appealable. I have received a copy of the appeal procedures for FDCH providers.

6. **MEALS REQUESTED FOR REIMBURSEMENT PURPOSES:**

☐ Breakfast
☐ Lunch
☐ Supper
☐ AM Snack
☐ PM Snack
☐ Late PM Snack

Only three meals per day per child may be claimed for reimbursement. This can be ***two main meals and one snack*** or ***two snacks and one main meal***.

7. **PROVIDER RECORD-KEEPING REQUIREMENTS.**
The provider must keep full and accurate records respecting its food service to serve as a basis for the reimbursement and for audit and review purposes. The records to be maintained include, but are not limited to, the following:

License
Annual CACFP Enrollment Form
Daily Arrival and Departure Record (Attendance Records)
Daily Record of Meals Served (Recorded daily on a meal-by-meal basis)
Weekly Meals Served (Recorded daily on a meal-by-meal basis)
Infant Meals Served, if applicable (Recorded daily on a meal-by-meal basis)
Infant Meal Waiver, if applicable
Menu cycle for each main meal and snack served
Child Nutrition (CN) labels/product formulation statements, if applicable
Medical statements for dietary substitutions, if applicable
Milk Substitution Request, if applicable
WIC brochure
Building for the Future fact sheet

8. **CERTIFICATION STATEMENT SIGNATURES**

We certify that the information in this Agreement is true and correct to the best of our knowledge and that we will comply with the rights and responsibilities outlined in the Agreement and any attachments. The provider also certifies that he or she is not currently participating in the CACFP under any other SO. The provider further understands that this information is being given in connection with the receipt of federal funds; that SA and SO officials may, with cause, verify information; and that deliberate misrepresentation may subject him or her to prosecution under applicable state and federal criminal statutes.

We certify that neither the institution nor any of its principals has been convicted of any activity that occurred during the past seven years that indicated a lack of business integrity (7 CFR §226.6[b][1][xiv][B]). A lack of business integrity includes fraud, antitrust violations, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, obstruction of justice, or any other activity indicating a lack of business integrity as defined by the SA.

The provider further certifies that he or she has never been terminated from a publicly funded program (federal, state, or local).

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

Effective date of Agreement is _____ , 20 _____

Printed Name of Provider	Printed Name of SO Representative
Signature of Provider	Signature of SO Representative
Date	Title of SO Representative
	Date

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)

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

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

Provider Helper Form

Provider Name: _____

Helper Name: _____

Helper Birth Date: _____

Effective Date: _____

End Date: 9/30/_____

*Any disqualified person cannot participate in any way with the food program.

Provider Status Change Form

Agreement #: _____ Sponsor Name: _____

Provider Site #: _____ Provider Name: _____

Type of Change (select one):

☐ Update information ☐ New Add ☐ Inactive ☐ Drop/Close

Address: _____

Phone Number: _____

Primary Caregiver Name (if different than provider): _____

Primary Caregiver Date of Birth: _____

If adding new, complete this section: ☐ N/A

Provider Date of Birth: _____

License/Permit #: _____ Capacity: _____

If license is a temporary permit or any other type of license with an expiration, please supply expiration date: _____

NDL search has been conducted and proper identification is on file? ☐ Yes ☐ No

Was the preapproval visit conducted *prior* to the provider participating? ☐ Yes ☐ No

Effective Date (this date must match the date listed on the preapproval form and agreement: _____

If making site inactive, complete this section: ☐ N/A

Date provider wishes to become inactive: _____

Will the provider be inactive beyond the current fiscal year? ☐ Yes ☐ No

If yes, the provider may be required to drop and re-apply later.

Date provider plans to become active again: _____

Reason for inactive status: _____

If dropping the program or closing, complete this section: ☐ N/A

Reason for drop/closure: _____

Will you be submitting any additional claims for this provider? ☐ Yes ☐ No

If yes, do not submit this form at this time, please wait until last claim has been paid

Last Claim Month: _____

Last Operating Day (must be within last claim month): _____

If updating any other information, complete this section: ☐ N/A

Meal time changes must use the meal time change form, NOT this form

Requested change: _____

_____

_____

_____

_____

Did you approve this change prior to implementation? ☐ Yes ☐ No

If no, please explain: _____

Effective Date of Change: _____

LETTER TO PROVIDER—TIER I OR PROVIDER'S OWN CHILDREN
Fiscal Year _____

Dear Provider:

To qualify for Tier I reimbursement or if you wish to receive reimbursement for meals served to your own children under the United States Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP), you must complete, sign, and return to us the enclosed Family-Size and Income Application (FSIA).

1. **How do I qualify for the Tier I reimbursement for meals served to children enrolled in my home?** You must either (a) live in an area that is eligible based on economic need as determined by school enrollment or census data or (b) establish economic need through the information provided on the enclosed FSIA.

2. **Who determines my eligibility as a Tier I FDCH?** Our office will determine our eligibility status. We will use the information you provide on the FSIA. Make sure you complete and sign the form; report all household income (not just your FDCH business income), and provide appropriate records of your income. ***Return the completed application and other papers to: (Name)*** _____ _____ ***, Address*** _____ _____ ***, Phone Number*** _____ .

3. **What kinds of records should I submit with my FSIA?** If you operated an FDCH business last year, attach a copy of your most recent tax return, including Schedule C; if your recent tax return and Schedule C are no longer indicative of your income, you may submit documentation of your current income and expenses. To do so, include payment statements for work and other forms of income. The papers you send must show the name of the person who received the income, the date it was received, how much was received, and how often it was received.

4. **How do I get reimbursed for meals served to my own children?** You are required by law to complete this application if you wish to claim meals served to your own children. Even if you live in an area identified as one of economic need or you have already been classified as a Tier I home, you must complete this application. Our office ***MAY*** verify the income information you submit.

5. **If I do not live in an area of economic need or do not want to submit the FSIA, what are my options for reimbursement?** You will receive lower rates of reimbursement for meals served to children enrolled in our FDCH.

6. **Will the information I give be verified?** Maybe. We may ask you to send written proof to verify the information you submitted on the form. **What if I disagree with the decision about the information I complete on this application?** You should talk to your sponsoring organization (SO).

7. **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) who shares income and expenses. You must include yourself and all children who live with you.

8. **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 Chart, you will receive a higher level of reimbursement. Once properly approved for the higher reimbursement rate, whether through income or proof of benefits as supported by a current Supplemental Nutrition Assistance Program (SNAP) case number, you will remain eligible for those benefits for the rest of the current fiscal year. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income during the period of unemployment causes your household income to be within the eligibility standards.

9. **May I fill out a form if someone in my household is not a U.S. citizen?** Yes. You or your children do not have to be U.S. citizens.

10. **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. Households wishing to apply for such benefits for foster children should contact ***(Name)*** _____ , ***(Address)*** _____ , ***(Phone Number)*** _____ .

11. **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,

INSTRUCTIONS FOR COMPLETING THE FDCH FAMILY-SIZE AND INCOME APPLICATION

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

Part 1: a. List all enrolled children.
b. List all household members, including the enrolled children. For each enrolled child, include his/her age and birth date.

Part 2: List the case number for any household member (including adults) receiving ***SNAP, TANF,*** or ***FDPIR*** benefits.

Part 3: Skip this part.

Part 4: Skip this part.

Part 5: Skip this part**.**

Part 6: Sign the form. The last four digits of a social security number are ***NOT*** necessary.

Part 7: Answer this question if you choose.

Part 8: ***OTHER BENEFITS.*** You may be eligible for free or low-cost health insurance for your children. Look at Part 7 on the back of the FSIA. This part must be signed if you want health insurance. You are not required to complete this to get meal benefits.

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

- **If *ALL* children you are applying for are foster children or if you are only applying for benefits for the foster child:**

Part 1: a. List all enrolled foster children.
b. List all foster children with ages and birth dates of those enrolled. Check the box indicating the child is a foster child.

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Skip this part.

Part 5: Skip this part.

Part 6: Sign the form. The last four digits of a social security number are ***NOT*** necessary.

Part 7: Answer this question if you choose.

Part 8: ***OTHER BENEFITS***. You may be eligible for free or low-cost health insurance for your children. Look at Part 7 on the back of the FSIA. This part must be signed if you want health insurance. You are not required to complete this to get meal benefits.

- **If some of the children in the household are foster children:**

Part 1: a. List all enrolled children.
b. List all household members, including foster children, with ages and birth dates of those enrolled. Check the box indicating the child is a foster child. For any person, including children, with no income, you must check the ***No Income*** box.

Part 2: If the household does not have a case number, skip this part.

Part 3: If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call ***your school, homeless liaison, or migrant coordinator*** at _____ . If not, skip this part.

Part 4: Follow these instructions to report total household income from this month or last month.

- **Column A—Name**: List only the first and last name 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 and How Often It Was Received**: For each household member who receives income, list each type of income received for the month. You must tell us how often the money is received—weekly, every other week, twice a month, or monthly.
  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 you boss can tell you In Box 2, list the amount each person got for the month from welfare, child support, alimony.

In Box 3, list retirement, Social Security, Supplemental Security Income (SSI), veteran's benefits (VA benefits), and disability benefits.

In Box 4, list ***All Other Income Sources***, including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. Do not include income from SNAP, TANF, FDPIR, WIC, or federal education benefits. For ***ONLY*** the self-employed, under *Earnings From Work*, **report income after expenses. This is your business, farm, or rental property. If you are in the Military Privatized Housing Initiative or get Combat Pay, do not include these allowances as income.**

Part 5: ***EXPANDED CATEGORICAL ELIGIBILITY:*** For parent/guardian of enrolled children to complete, if applicable. Indicate by checking if household participates in any of the listed programs. Skip Parts 2, 3, and 4. An adult household member must sign the application in Part 6. A social security number is not required. (Providers do not qualify for expanded categorical eligibility.)

Part 6: Adult household member must sign the form and list the last four digits of his/her social security number or mark the box if he/she does not have one.

Part 7: Answer this question if you choose.

Part 8: ***OTHER BENEFITS***. You may be eligible for free or low-cost health insurance for your children. Look at Part 7 on the back of the FSIA. This part must be signed if you want health insurance. You are not required to complete this to get meal benefits.

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

Part 1:

a. List all enrolled children.

b. List all household members; for the enrolled children, list ages and birth dates. For any person, including children, with no income, you must check the ***No Income*** box.

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Follow these instructions to report total household income from this month or last month.

- **Column A—Name**: List only the first and last name 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 and How Often It Was Received**: For each household member, list each type of income received for the month. You must tell us how often the money is received—weekly, every other week, twice a month, or monthly.

  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.

  In Box 2, list the amount each person got for the month from welfare, child support, alimony.

  In Box 3, list retirement, Social Security, SSI, VA benefits, and disability benefits.

  In Box 4, list ***All Other Income Sources***, including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. Do not include income from SNAP, TANF, FDPIR, WIC, or federal education benefits. For ***ONLY*** the self-employed, under *Earnings From Work*, **report income after expenses. This is your business, farm, or rental property. If you are in the Military Privatized Housing Initiative or get Combat Pay, do not include these allowances as income.**

Part 5: ***EXPANDED CATEGORICAL ELIGIBILITY:*** For parent/guardian of enrolled children to complete, if applicable. Indicate by checking if household participates in any of the listed programs. Skip Parts 2, 3, and 4. An adult household member must sign the application in Part 6. A social security number is not required. (Providers do not qualify for expanded categorical eligibility.)

Part 6: Adult household member must sign the form and list the last four digits of his/her social security number or mark the box if he/she does not have one.

Part 7: Answer this question if you choose.

Part 8: ***OTHER BENEFITS***. You may be eligible for free or low-cost health insurance for your children. Look at Part 7 on the back of the FSIA. This part must be signed if you want health insurance. You are not required to complete this to get meal benefits.

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
FAMILY-SIZE AND INCOME APPLICATION (FSIA)
FOR FAMILY DAY CARE HOMES (FDCH)

FOR SPONSOR USE ONLY:

1. Indicate type of application: ☒ Provider ☐ Parent/Guardian
2. Provider's Name: MARTHA LINDSAY Provider Number: 26

PART 1. ALL HOUSEHOLD MEMBERS

a. Name(s) of Enrolled Child(ren) JIMMY LINDSAY, LISA LINDSAY

b. Names of *ALL* Household Members (First, Middle Initial, Last)	**Age of Enrolled Child(ren)**	**Birth Date of Enrolled Child(ren)**	**Check If a Foster Child (The Legal Responsibility of a Welfare Agency or Court)*** ***If all children indicated below are foster children, skip to Part 5 to sign this form.**	**Check if *NO* Income**
			☐	☐
			☐	☐
			☐	☐
			☐	☐

PART 2. BENEFITS

If any member of your household receives *SNAP*, *TANF*, or *FDPIR* benefits, provide the name and case number for the ***ONE*** person who receives benefits. ***If no one receives these benefits, skip to Part 3.***

NAME: _____ CASE NUMBER: _____

PART 3. IF ANY CHILD YOU ARE APPLYING FOR IS HOMELESS, MIGRANT, OR A RUNAWAY, CHECK THE APPROPRIATE BOX AND CALL *YOUR SCHOOL, HOMELESS LIAISON,* OR *MIGRANT COORDINATOR AT PHONE NUMBER:* _____ .

☐ **Homeless** ☐ **Migrant** ☐ **Runaway**

PART 4. TOTAL HOUSEHOLD GROSS INCOME. You must tell us how much and how often.

A. NAME (List only household members with income)	**B. GROSS INCOME AND HOW OFTEN IT IS RECEIVED**			
	Earnings From Work Before Deductions	**Welfare, Child Support, Alimony**	**Pensions, Retirement, Social Security, SSI, VA Benefits**	**All Other Income**
(Example) Jane Smith	**$ 200/Weekly**	**$ 150/Twice a Month**	**$ 100/Monthly**	
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$

PART 5. *Expanded Categorical Eligibility for PARENT/GUARDIAN OF TIER II HOMES ONLY*

☐ Women, Infants, and Children (WIC) ☐ Federally Funded Head Start	☐ Title XX ☐ Energy Program (LIHEAP)	☐ Refugee Assistance ☐ National School Lunch/School Breakfast Programs (NSLP/SBP)	☐ Commodity Supplement Food ☐ Program Child Development Fund

PART 6. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN).

An adult household member must sign this form. ***If Part 4 is completed, the adult signing the form also must list the last four digits of his or her social security number or mark the*** **I do not have a social security number** ***box.***

I certify that all information on this form is true and that all income is reported. I understand that the FDCH 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.

Sign Here: _____ Print Name: _____
Date: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____

Last four digits of social security number: **** - ** - ___ ___ ___ ___ ☐ I do not have a social security number.

PART 7: PARTICIPANT'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

Mark one ethnic identity:	*Mark one or more racial identities:*		
☐ Hispanic or Latino ☐ Not Hispanic or Latino	☐ Asian ☐ White	☐ American Indian or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander	☐ Black or African American

PART 8: OTHER BENEFITS: You do not have to complete this part to participate in the CACFP.

Health Insurance ☐ Yes, I want health insurance for my children. Institution officials may give information from my FSIA to Sooner Care Health Benefit officials so that they may send me information about free or low-cost health insurance for my children.

☐ No, I ***DO NOT*** want information from my FSIA shared with Sooner Care Health Benefits officials.

I certify that I am the parent/guardian of the children for whom application is being made.

I understand that I will be releasing information that will show that I applied for free or reduced-price meals for my children. I give up my rights to confidentiality for this purpose only.

Signature of Parent/Guardian: _____ Date: _____

The participant in the day care facility may qualify for free or reduced-price meals if your household income falls within the limits of this chart.

185 % of Poverty Level	
Household Size	Yearly
1	26,973
2	36,482
3	45,991
4	55,500
5	65,009
6	74,518
7	84,027
8	93,536
Each Additional Person:	9,509

"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) identifi er 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 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-OAS-CR%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 This institution is an equal opportunity provider

DO NOT FILL OUT THIS PART. THIS IS FOR OFFICIAL USE ONLY.					
Annual Income Conversion:		Weekly x 52	Every 2 Weeks x 26	Twice a Month x 24	Monthly x 12
Total Income:	Per Week:	Every 2 Weeks:	Twice a Month:	Month:	Year:
Household Size:					
Categorical Eligibility:	Date Withdrawn:	Eligibility: Free	Reduced	Denied	Tier I Tier II
Reason:					
Determining Official's Signature:			Date:		

LETTER TO HOUSEHOLD—TIER II FAMILY DAY CARE HOMES (FDCH)
FISCAL YEAR _____

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled at a family day care home (FDCH). **(Name of FDCH)** _____ 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 Family-Size and Income Application (FSIA).

1. **Am I required to complete an FSIA in order for my child(ren) to receive CACFP benefits?** No, but if you choose to do so, your provider may receive a higher reimbursement for the meals served to your child(ren). If you do complete the FSIA, you have the option of returning it directly to your provider or to the provider's sponsor. If you would like to provide your FSIA directly to the sponsor, return the completed form to: **(Sponsor's Name)** _____ , **(Address)** _____, **(Phone Number)** _____ .

   _____ Initial here if you consent to allowing to collect your form and provide it to the sponsor.
   (Provider's Name) _____ will not review your form.

2. **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 home. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information.

3. **Who qualifies for the higher reimbursement without providing income information?** Your provider will receive a higher reimbursement for meals served to foster children and children in households getting Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR). Children in households participating in Women, Infants, and Children (WIC) also ***MAY*** qualify for the higher reimbursement.

4. **Who qualifies for the higher reimbursement based on income?** Your provider may receive a higher reimbursement for the meals served to your children if your household income is within the reduced-price limits on the Income-Eligibility Guidelines, shown on this application. Children in households participating in WIC ***MAY*** be eligible for the higher reimbursement.

5. **May I fill out an application 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 FDCH.

6. **Who should I include as members of my household?** You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who share income and expenses. You must include yourself and all children who live with you. You also must include any foster children living with you.

7. **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 Chart, the FDCH will receive a higher level of reimbursement. Once properly approved for the higher reimbursement rate, whether through income or by providing a current SNAP, TANF, or FDPIR case number, you will remain eligible for those benefits for the rest of the fiscal year. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income during the period of unemployment causes your household income to be within the eligibility standards.

8. **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.

9. **What if I have foster children?** Foster children who are under the legal responsibility of a foster care agency or court automatically qualify for the higher reimbursement. Any foster child in the household qualifies 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.

10. **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.

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

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CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
FAMILY-SIZE AND INCOME APPLICATION (FSIA)
FOR FAMILY DAY CARE HOMES (FDCH)

FOR SPONSOR USE ONLY:

1. Indicate type of application: ☐ Provider ☐ Parent/Guardian
2. Provider's Name: _____ Provider Number: _____

PART 1. ALL HOUSEHOLD MEMBERS

a. Name(s) of Enrolled Child(ren)

b. Names of *ALL* Household Members (First, Middle Initial, Last)	**Age of Enrolled Child(ren)**	**Birth Date of Enrolled Child(ren)**	**Check If a Foster Child (The Legal Responsibility of a Welfare Agency or Court)*** ***If all children indicated below are foster children, skip to Part 5 to sign this form.**	**Check if *NO* Income**
			☐	☐
			☐	☐
			☐	☐
			☐	☐

PART 2. BENEFITS

If any member of your household receives *SNAP*, *TANF*, or *FDPIR* benefits, provide the name and case number for the ***ONE*** person who receives benefits. ***If no one receives these benefits, skip to Part 3.***

NAME: _____ CASE NUMBER: _____

PART 3. IF ANY CHILD YOU ARE APPLYING FOR IS HOMELESS, MIGRANT, OR A RUNAWAY, CHECK THE APPROPRIATE BOX AND CALL *YOUR SCHOOL, HOMELESS LIAISON,* OR *MIGRANT COORDINATOR AT PHONE NUMBER:* _____ .

☐ **Homeless** ☐ **Migrant** ☐ **Runaway**

PART 4. TOTAL HOUSEHOLD GROSS INCOME. You must tell us how much and how often.

A. NAME (List only household members with income)	**B. GROSS INCOME AND HOW OFTEN IT IS RECEIVED**			
	Earnings From Work Before Deductions	**Welfare, Child Support, Alimony**	**Pensions, Retirement, Social Security, SSI, VA Benefits**	**All Other Income**
(Example) Jane Smith	**$ 200/Weekly**	**$ 150/Twice a Month**	**$ 100/Monthly**	
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$

PART 5. *Expanded Categorical Eligibility for PARENT/GUARDIAN OF TIER II HOMES ONLY*

☐ Women, Infants, and Children (WIC) ☐ Federally Funded Head Start	☐ Title XX ☐ Energy Program (LIHEAP)	☐ Refugee Assistance ☐ National School Lunch/School Breakfast Programs (NSLP/SBP)	☐ Commodity Supplement Food ☐ Program Child Development Fund

x PART 6. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN).

An adult household member must sign this form. ***If Part 4 is completed, the adult signing the form also must list the last four digits of his or her social security number or mark the*** **I do not have a social security number** ***box.***

I certify that all information on this form is true and that all income is reported. I understand that the FDCH 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.

Sign Here: _____ Print Name: _____
Date: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____

Last four digits of social security number: **** - ** - ___ ___ ___ ___ ☐ I do not have a social security number.

PART 7: PARTICIPANT'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

Mark one ethnic identity:	*Mark one or more racial identities:*		
☐ Hispanic or Latino ☐ Not Hispanic or Latino	☐ Asian ☐ White	☐ American Indian or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander	☐ Black or African American

PART 8: OTHER BENEFITS: You do not have to complete this part to participate in the CACFP.

Health Insurance ☐ Yes, I want health insurance for my children. Institution officials may give information from my FSIA to Sooner Care Health Benefit officials so that they may send me information about free or low-cost health insurance for my children.

☐ No, I ***DO NOT*** want information from my FSIA shared with Sooner Care Health Benefits officials.

I certify that I am the parent/guardian of the children for whom application is being made.

I understand that I will be releasing information that will show that I applied for free or reduced-price meals for my children. I give up my rights to confidentiality for this purpose only.

Signature of Parent/Guardian: _____ Date: _____

The participant in the day care facility may qualify for free or reduced-price meals if your household income falls within the limits of this chart.

185 % of Poverty Level	
Household Size	Yearly
1	26,973
2	36,482
3	45,991
4	55,500
5	65,009
6	74,518
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"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 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 This institution is an equal opportunity provider.

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Annual Income Conversion:		Weekly x 52	Every 2 Weeks x 26	Twice a Month x 24	Monthly x 12
Total Income:	Per Week:	Every 2 Weeks:	Twice a Month:	Month:	Year:
Household Size:					
Categorical Eligibility:	Date Withdrawn:	Eligibility: Free	Reduced	Denied	Tier I Tier II
Reason:					
Determining Official's Signature:			Date:		

WORKSHEET TO DETERMINE CURRENT MONTHLY INCOME
(Without a Tax Return)
DO NOT USE FOR PROVIDERS WHO ARE AREA-ELIGIBLE

Provider Name: _____ **Provider Number:** _____
Date: _____

Your family day care home (FDCH) is not located in an area that qualifies you for Tier I rates. However, you may apply for these higher rates by completing a Family-Size and Income Application (FSIA). (See attached.) If your current household income is within the Tier I eligibility guidelines, you must provide written proof of all income before the determination can be made. Current participation in the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) program will also be verified with the appropriate agencies. If your income information qualifies you as a Tier I home, all meals served to enrolled children will be reimbursed at the higher rate.

If you choose to provide a copy of your last year's tax return for verification purposes, it must be representative of your current income as a self-employed day care provider. Any other household members who are wage earners must supply last month's proof of income (pay stub, etc.) instead of using tax return information. FDCHs operating for less than the full tax period will take net profits and divide by the number of months in operation to determine current net income. New providers not operating an FDCH last year will need to calculate their current income. Below is a worksheet to help assess your income and to determine what documents must be provided for verification. Once you have determined your household income information, complete the FSIA and attach copies of receipts, pay stubs, etc., along with this worksheet. Any business expense without proper documentation will not be deducted from gross profits.

Last Month's Gross Income of Provider:

Parent fee (provide copy of payment records)	$_____
DHS/Tribal copayments (provide copy of payment records)	$_____
DHS/Tribal payments (provide copy of claim)	$_____
Other:	$_____

CHILD AND ADULT CARE FOOD PROGRAM: **$**_____
(The amount of your reimbursement from last month [if applicable])

GRAND TOTAL OF PROVIDER'S GROSS INCOME: **$** _____ (A)

Last Month's Business Expenses of Provider:
(You must attach itemized receipts for any expense you wish deducted)

Day care home food and food-related supplies*	$_____
Day care business-related expenses	
Advertising	$_____
Toys/books/art supplies	$_____
Bank/legal fees	$_____
Rent (X Time and Space %)**	$_____
Utilities (X Time and Space %)**	$_____
Child care supplies (diapers, cleaning supplies)	$_____
Other:	$_____

GRAND TOTAL OF ALL BUSINESS EXPENSES: **$** _____ (B)

$_____		$= =		= $= =	
=	(A) Gross Income	=	(B) Business Expenses	=	**CURRENT NET INCOME LAST MONTH**

* In lieu of receipts, meals claimed multiplied by Tier I rates would be acceptable.
** Internal Revenue Service (IRS) Publication 587 must be used to document business use of your home.

MONTHLY RECORD OF INCOME AND EXPENSES

Provider: _____ **Agreement Number:** _____

Month: _____ **Year:** _____

Itemized receipts must accompany every entry.

INCOME: PARENT PAYMENTS	AMOUNT $	EXPENSES: FOOD/SUPPLIES/OTHER	AMOUNT $
TOTAL		**TOTAL**	

PROVIDER TIER VERIFICATION RESULTS

Dear _____ : Home #: _____ Date: _____

As a result of verification efforts required by Child and Adult Care Food Program (CACFP) Family Day Care Home (FDCH) Tiering Regulations, your eligibility status is as follows:

☐ Tier I status is granted beginning on _____

☐ Tier I status is denied due to the following reason:

- ☐ Income is over allowable amount.
- ☐ You did not provide complete proof of eligibility.
- ☐ Your Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF), Food Distribution Program on Indian Reservations (FDPIR) participation could not be verified.

If you did not qualify as a Tier I home but have a decrease in household income, a household member becomes unemployed, or have a change in household size, you may reapply for Tier I status. If you did not qualify due to incomplete proof of eligibility and you now have complete documentation, you may reapply for Tier I benefits. You may contact our office at _____ to discuss this possibility.

(Phone Number)

Sincerely,

_____ _____

(Sponsoring Organization Representative) (Title)

_____

(Sponsoring Organization Name)

Privacy Act Statement: 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 is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) case number 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 Programs.

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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

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LETTER TO SNAP, TANF, OR FDPIR OFFICE FROM CACFP SPONSORING ORGANIZATION

Dear _____ Date: _____

The regulations for the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF), and Food Distribution Program on Indian Reservations (FDPIR) programs permits release of eligibility information to administrators of the Child and Adult Care Food Program (CACFP) to ensure that family day care home (FDCH) providers are eligible to receive Tier I rates of reimbursement.

The receipt of SNAP, TANF, or FDPIR automatically qualifies an FDCH participating in the CACFP for Tier I rates. Listed below are providers who have indicated that they now receive SNAP, TANF, or FDPIR benefits. On the chart below, please indicate if the households are currently participating in the SNAP, TANF, or FDPIR program.

Your prompt return of this letter will be appreciated. A self-addressed return envelope is also enclosed for your convenience. If you have any questions or need additional information, please contact.

_____ at _____
(Sponsoring Organization Representative) (Sponsoring Organization Name)

at _____
Telephone Number)

FAMILY DAY CARE HOME PROVIDER (Last Name, First Name)	SNAP, TANF, OR FDPIR NUMBER	CURRENT PARTICIPATION IN SNAP, TANF, OR FDPIR	
		YES	NO

(Signature of SNAP/TANF/FDPIR Representative) (Date)

SPONSOR TRAINING RECORD

Location: _____ **Date:** _____

City: _____

Key Staff's Signature	Position	Certificate Issued

Required Topics Addressed: _____

_____

_____

NOTE: Attach copy of training session's agenda with supporting documentation for each topic discussed.

PROVIDER TRAINING RECORD

Date: _____

Location: _____

City: _____

Provider's Printed Name	Telephone Number	Provider Agreement #	Certificate Issued

Required Topics Addressed: _____

_____

_____

NOTE: Attach copy of training session's agenda with supporting documentation for each topic discussed.

Provider's Name: ________________________

Provider Number: ________________________

CHILD AND ADULT CARE FOOD PROGRAM (CACFP) ENROLLMENT FORM

CHILDREN'S INFORMATION

1. Child's Name:					Date of Birth:		
2. Normal Days in Attendance:	☐ Sunday	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday
3. Normal Hours of Attendance:		a.m./p.m. **to**			a.m./p.m.		
4. Normal Meals Eaten:		Breakfast ☐	A.M. Snack ☐	Lunch ☐	P.M. Snack ☐	Supper ☐	Late P.M. Snack ☐
5. Race (Optional): ☐ American Indian/Alaskan Native ☐ Black or African ☐ Hawaiian or Pacific Islander ☐ Asian ☐ White					6. Ethnicity (Optional): ☐ Hispanic ☐ Not Hispanic		

1. Child's Name:					Date of Birth:		
2. Normal Days in Attendance:	☐ Sunday	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday
3. Normal Hours of Attendance:		a.m./p.m. **to**			a.m./p.m.		
4. Normal Meals Eaten:		Breakfast ☐	A.M. Snack ☐	Lunch ☐	P.M. Snack ☐	Supper ☐	Late P.M. Snack ☐
5. Race (Optional): ☐ American Indian/Alaskan Native ☐ Black or African ☐ Hawaiian or Pacific Islander ☐ Asian ☐ White					6. Ethnicity (Optional): ☐ Hispanic ☐ Not Hispanic		

1. Child's Name:					Date of Birth:		
2. Normal Days in Attendance:	☐ Sunday	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday
3. Normal Hours of Attendance:		a.m./p.m. **to**			a.m./p.m.		
4. Normal Meals Eaten:		Breakfast ☐	A.M. Snack ☐	Lunch ☐	P.M. Snack ☐	Supper ☐	Late P.M. Snack ☐
5. Race (Optional): ☐ American Indian/Alaskan Native ☐ Black or African ☐ Hawaiian or Pacific Islander ☐ Asian ☐ White					6. Ethnicity (Optional): ☐ Hispanic ☐ Not Hispanic		

PARENT'S INFORMATION

Name of Parent/Guardian:		
Address:	City:	Zip:
Home Telephone Number:		
Signature:	**Date:**	

FDCH Notification of Meal Service Change

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

☐ No change to hours of operation

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:_____

DAILY ARRIVAL AND DEPARTURE RECORD

Name of Provider: _____ **Provider Number:** _____ **Month and Year:** _____

	CHILDREN'S NAMES									
DATE	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
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

Provider's Name: ______________________ Home Agreement Number: __________ Month and Year: ______________________

Check meals served each child.

FOR SPONSOR USE ONLY

Names of Children	Type of 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	Breakfast	Lunch	Supper	Snack	Tier
	Breakfast																																				
	A.M. Supp																																				
	Lunch																																				
	P.M. Supp																																				
	Supper																																				
Age: ______	Late Supp																																				
	Breakfast																																				
	A.M. Supp																																				
	Lunch																																				
	P.M. Supp																																				
	Supper																																				
Age: ______	Late Supp																																				
	Breakfast																																				
	A.M. Supp																																				
	Lunch																																				
	P.M. Supp																																				
	Supper																																				
Age: ______	Late Supp																																				
	Breakfast																																				
	A.M. Supp																																				
	Lunch																																				
	P.M. Supp																																				
	Supper																																				
Age: ______	Late Supp																																				

I hereby 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 State Department of Education and sponsoring organization officials may verify information; and that deliberate misrepresentation may subject me to prosecution under applicable state and federal criminal statutes.

Signature of Provider: ______________________ Date: ______________

FOR SPONSORS ONLY:

	Breakfast	Lunch	Supper	Snack
Tier I Totals				
Tier II-H Totals				
Tier II-L Totals				
Total Meal Counts				

WEEKLY MEALS SERVED

Provider's Name: _____ Provider Number: _____

Month: _____ From: _____ To: _____

MINIMUM MEAL PATTERN REQUIREMENTS	Ages 1-2 Years	Ages 3-5 Years	Ages 6-12 Years	Menu #_____ Date: _____ MONDAY	Menu #_____ Date: _____ TUESDAY	Menu #_____ Date: _____ WEDNESDAY	Menu #_____ Date: _____ THURSDAY	Menu #_____ Date: _____ FRIDAY	Menu #_____ Date: _____ SATURDAY	Menu #_____ Date: _____ SUNDAY
BREAKFAST Fluid milk*	1/2 cup	3/4 cup	1 cup							
Vegetables, fruits	1/4 cup	1/2 cup	1/2 cup							
Grains WG ☐	1/2 serving	1/2 serving	1 serving							
LUNCH Fluid milk*	1/2 cup	3/4 cup	1 cup							
Meat and/or meat alternate	1 oz	1 1/2 oz	2 oz							
Vegetables	1/8 cup	1/4 cup	1/2 cup							
Fruits	1/8 cup	1/4 cup	1/2 cup							
Grains WG ☐	1/2 serving	1/2 serving	1 serving							
SUPPER Fluid milk*	1/2 cup	3/4 cup	1 cup							
Meat and/or meat alternate	1 oz	1 1/2 oz	2 oz							
Vegetables	1/8 cup	1/4 cup	1/2 cup							
Fruits	1/8 cup	1/4 cup	1/2 cup							
Grains WG ☐	1/2 serving	1/2 serving	1 serving							
SNACKS (Choose 2 of these 5) Fluid milk*	1/2 cup	1/2 cup	1 cup	A.M.						
Vegetables	1/2 cup	1/2 cup	3/4 cup							
Fruits	1/2 cup	1/2 cup	3/4 cup	P.M.						
Grains WG ☐	1/2 serving	1/2 serving	1 serving							
Meat and/or meat alternate	1/2 oz	1/2 oz	1 oz	LATE P.M.						

* Milk offered must be unflavored whole for children aged one; must be unflavored fat-free or unflavored lowfat (1%) for children two through five; and must be unflavored lowfat, unflavored fat-free, or flavored fat-free for children six and over.

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

Provider Number: _____

PREAPPROVAL VISIT FORM

Provider's Name: _____ Date: _____

Center Address: _____

The following items were discussed and reviewed:		Provider Agrees to Comply
1. Provider's Application and Agreement		
a. Obtained on enrolled children	1a.	
b. Approved by institution official	1b.	
c. Claiming own children	1c.	
d. Sponsoring organization (SO) policies	1d.	
e. Civil rights compliance	1e.	
2. Record-Keeping Requirements		
a. Enrollment data	2a.	
b. Daily Arrival and Department Record	2b.	
c. Daily Record of Meal Served	2c.	
d. Weekly Meals Served/Infant Meals Served	2d.	
3. Meal Patterns		
a. Minimum meal pattern requirements (components and quantities)	3a.	
b. Meal limitation/time frame	3b.	
c. Infant Meal Pattern requirements	3c.	
d. Child Nutrition (CN) Labels/Product Formulation Statement	3d.	
e. Special dietary needs	3e.	
f. f. Planning and following cycle menus	3f.	
4. Sanitation and Safety	4.	
5. Child and Adult Care Food Program (CACFP) Training Requirement	5.	
6. Reimbursement/Claiming Procedures	6.	

Comments: _____

_____

_____

Approval Recommendation: Yes ☐ Effective Date: _____

No ☐ Explain: _____

I certify that the above areas were discussed and my responsibilities explained. I also understand that failure to comply with regulations and policies could result in being declared seriously deficient and proposed for disqualification and termination from participation in the CACFP.

_____ _____

Provider's Signature Date

_____ _____

Sponsoring Organization Representative's Signature Date

FDCH End of Year Report

Sponsor Name: _____ Agreement #: _____

Month (Beginning with first month of your SO fiscal year)	TOTAL ANNUAL ADMINISTRATIVE COSTS ($)							
	CACFP Admin. Labor (1)	CACFP Admin. Supplies (2)	CACFP Admin. Expenses (3)	CACFP-Related Travel (4)	CACFP Related Training/ Education (5)	Indirect Cost (6)	Other Admin. Services (7)	Misc. (8)
Total								

Grand total of all annual administrative expenditures: _____

Total Administrative Funds received for the same period: _____

Carryover amount calculated: _____

If applicable, does your SO elect to carry over up to 10%?

☐ Yes ☐ No

FAMILY DAY CARE HOME (FDCH) ON-SITE MONITOR REVIEW

A. General Data

1. Reviewer: _____
2. Provider's Name: _____
3. Provider's Address: _____
4. Tier Type: I II-H II-L II-M (Circle One)
5. Unannounced Review ☐ Announced Review ☐
6. Provider's Number: _____
7. Date of Visit: _____
8. Time of Visit: _____
9. Review Cycle: 1 2 3
10. Review Type: (Circle One) Standard Weekend Late P.M. Snack Follow-Up
11. Provider Is Home: Yes ☐ No ☐
    If ***No***, Sponsor Notified: Yes ☐ No ☐

B. Children in Attendance

1. Name	2. Age	3. CACFP Enrollment on File	4. Meal Claimed Today
		Yes/No	Yes/No

C. Meal Service Times	Approved	Verified
1. Meal Service Times		
Breakfast		
A.M. Snack		
Lunch		
P.M. Snack		
Supper		
Late P.M. Snack		
		Yes/No
2. Meals served at approved times.	2.	☐
3. If ***No***, sponsor was notified of meal change.	3.	☐

D. Training*

1. List dates and locations of training sessions attended this fiscal year.

_____

_____

_____

_____

E. Civil Rights

All children served the same meal at no separate charge regardless of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation, and there is no discrimination in the course of food service. (Circle One)

Yes **No**

* Any area in noncompliance with an asterisk (*), the provider may be declared seriously deficient.

		YES/ NO/NA
F. Food Service/Meal Observation		
1. Meal service times as approved	1.	
2. All components served	2.	
3. Required quantities served	3.	
4. Plates and servings adjusted for age groups	4.	
5. Meal supervision provided	5	
6. Special dietary needs documentation available	6.	
7. Proper milk substitute provided	7.	

		YES/ NO/NA
8. If milk substitute is provided, is it an approved milk substitution and is the correct documentation available?	8.	
9. Proper milk type served (FF/1%)	9.	
10. Current Product Formulation/Child Nutrition (CN) Label on file and available at time of the review	10.	
11. Is further training needed?	11.	
12. Is water offered throughout the day?	12.	
13. Is deep-fat frying occurring?	13.	

G. Meal Analysis for Aged 1 Through 12						
Meal Observed:	Breakfast	AM Snack	Lunch	PM Snack	Supper	Late PM Snack
Time Served: _____						

Children Served by Age				Nonclaimable Children Served	Comments:
1-2 Years	3-5 Years	6-12 Years	Total		

Meal Component	Food Item	Quantity Served	Amount Needed	Amount + or -
Milk				
Vegetable/Juice				
Fruit/Juice				
Grains				
Meat/Meat Alternate				

H. Infant Meal Analysis	☐ NA—No infants in care/participating in meal service

Meal Observed: Breakfast AM Snack Lunch PM Snack Supper Late PM Snack
(Circle One)

NOTE: Record only infants without an Infant Meal Waiver.

Birth - 5 Months	6 - 11 Months

Child's Name:			Age:	
Meal Component	**Food Item**	**Quantity Served**	**Amount Needed**	**Amount + or -**
Formula/Milk/Breast Milk				
Fruit/Vegetable				
Infant Cereal/Bread/ Crackers				
Meat/Meat Alternate				

Child's Name:			Age:	
Meal Component	**Food Item**	**Quantity Served**	**Amount Needed**	**Amount + or -**
Formula/Milk/Breast Milk				
Fruit/Vegetable				
Infant Cereal/Bread/ Crackers				
Meat/Meat Alternate				

Child's Name:			Age:	
Meal Component	**Food Item**	**Quantity Served**	**Amount Needed**	**Amount + or -**
Formula/Milk/Breast Milk				
Fruit/Vegetable				
Infant Cereal/Bread/ Crackers				
Meat/Meat Alternate				

Child's Name:			Age:	
Meal Component	**Food Item**	**Quantity Served**	**Amount Needed**	**Amount + or -**
Formula/Milk/Breast Milk				
Fruit/Vegetable				
Infant Cereal/Bread/ Crackers				
Meat/Meat Alternate				

		YES/ NO/NA
I. License		
1. Current license or permit available	1.	
2. License capacity: _____		
3. Second caregiver employed	3.	
4. Provider meets licensing standards	4.	
J. Provider's Own Children		
1. Provider claims own children If *Yes*,	1.	
a. Provider's own children participating in child care	a.	
b. Other enrolled children in care and participating in a meal service	b.	
c. Complete and approved Family-Size and Income Application (FSIA) on file	c.	
K. Record-Keeping Requirements		
1. Daily Arrival and Departure Record up-to-date Date of last entry: _____	1.	*
2. Daily Record of Meals Served form up-to-date Date of last entry: _____	2.	*
3. Weekly Meals Served form up-to-date Date of last entry: _____	3.	*
4. Infant meals served under one year old claimed	4.	
a. If ***Yes***, infant meal pattern followed	a.	*
b. Provider furnishes food items, if applicable	b.	
c. Infant Meals Served form maintained Date of last entry: _____	c.	*
d. Infant Meal Waiver on file	d.	
5. Cycle Menu available (Optional)	5.	
a. Current cycle menu being followed	a.	
b. If ***No***, substitution was made	b.	
c. Contains all required components	c.	
d. Product Formulation Statement/Child Nutrition (CN) label for applicable item	d.	
6. *Building for the Future* fact sheet distributed to parents	6.	
7. WIC information made available to parents	7.	
8. Do the enrollment records, attendance records, and meal count records reconcile for a five-day period?	8.	

		YES/ NO/NA
L. Sanitation		
1. Chemicals and medicines are properly stored in a separate location	1.	
2. Refrigerator's temperature: _____	2.	
3. Freezer's temperature: _____	3.	
4. Clean kitchen floors, cupboards, and equipment	4.	
5. Dining surface and countertops sanitized	5.	
6. Proper method of dishwashing	6.	
7. Proper handwashing technique	7.	
8. Pet-free kitchen during food preparation and service	8.	
9. Proper food-handling procedure followed (food storage, thawing time, temperature)	9.	
10. Home maintained in a clean, sanitary, and orderly manner	10.	
M. Safety of Children		
1. Children are in safe environment	1.	*
2. Conduct of provider does not place children in imminent danger	2.	*
N. Prior Review		
1. Were deficiencies corrected?	1.	*

NOTE: Any items, if in noncompliance, may contribute to a seriously deficient status.

Any area in noncompliance with an asterisk (*), the provider may be declared seriously deficient.

O. FIVE-DAY MEAL RECONCILIATION REPORT

Provider FDCH Attendance Record

PROVIDER NAME:	Month/Year:	Number of Operating Days/Week:

	Enrollment Data		Attendance Data				
Child's Name	Days Attended	A.M./P.M. Time	Day 1	Day 2	Day 3	Day 4	Day 5
TOTALS							

MEAL COUNTS

	Breakfast/ 2nd Shift ☐	A.M. Snack/ 2nd Shift ☐	Lunch/ 2nd Shift ☐	P.M. Snack/ 2nd Shift ☐	Supper/ 2nd Shift ☐	Evening Snack/ 2nd Shift ☐
Day 1						
Day 2						
Day 3						
Day 4						
Day 5						
TOTAL						

P. Review Summary

Corrective action needed, comments, or recommendations: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Q. Provider is in compliance. ☐ **In noncompliance.** ☐

Provider is seriously deficient. (Circle One) Yes No

Is an unannounced follow-up review required to view corrective action? (Circle One)

Yes No

We certify that this review has been completed while in the provider's home. All areas of non-compliance have been discussed.

_____ _____

Signature of Provider Date Signature of Reviewer Date

HOUSEHOLD CONTACT DOCUMENTATION

The _____ is conducting a review of _____ .
(Sponsor Name) (Provider Name and Number)

Please complete the information, and return this form in the envelope provided. Please call _____ if you have questions. (Phone Number of Sponsor)

This questionnaire *MUST* be filled out by the parent/guardian only. If more than one child is listed, the information below applies to all of them. If not, a different form for each child will be used.

1. Child(ren): _____ Birth Date: _____
   _____ _____
   _____ _____
   _____ _____

2. Please indicate which of the past 12 months your child was in care:

   Oct ☐ Nov ☐ Dec ☐ Jan ☐ Feb ☐ Mar ☐

   Apr ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐

3. Please indicate the normal hours and days your child is in care.

   Monday: _____ to _____ Thursday: _____ to _____
   Tuesday: _____ to _____ Friday: _____ to _____
   Wednesday: _____ to _____ Saturday: _____ to _____
   Sunday: _____ to _____

4. Which meals/snacks does your child receive while in care?

   Breakfast ☐ Lunch ☐ Supper ☐

   A.M. Snack ☐ P.M. Snack ☐ Late P.M. Snack ☐

5. Do you supply any food? Yes ☐ No ☐

   If *Yes*, please explain:

   _____
   _____
   _____

6. If your child is no longer in care, what was his or her last date of care?

   _____

Statement of Affidavit

I hereby certify that the information that I have provided is true and accurate to the best of my knowledge.

Parent/Guardian Signature _____ Date _____

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 licensed physician, physician's assistant, or nurse practitioner remain unchanged.

CYCLE MENU

BREAKFAST	LUNCH	SNACK

*If commercially prepared, a CN label or product formulation statement must be maintained.

MEDICAL STATEMENT

Part I (to be filled out by *parent/guardian)*	
Name of Child:	Age:
Name of Parent/Guardian:	Telephone Number:
Name of Provider:	

Part II (to be filled out by a *medical authority*)
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

INFANT MEAL WAIVER

I wish to decline my child's participation in infant meals. 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 SERVED

Infant's Name: _____ **Age:** _____

	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
BREAKFAST	**BREAKFAST**	**BREAKFAST**	**BREAKFAST**	**BREAKFAST**	**BREAKFAST**	**BREAKFAST**
Birth Through 5 Months 4-6 fluid oz breast milk[2] or formula[1]						
6 Through 11 Months 6-8 fluid oz breast milk[2] or formula[1] 0-2 Tbsp fruit and/or vegetable[4,5] 0-4 Tbsp infant cereal[1,4] 0-4 Tbsp meat, fish, poultry, whole egg, or cooked dry beans or peas, or 0-2 oz cheese, or 0-4 oz (volume) cottage cheese, or 0-4 oz or 1/2 cup yogurt[3,4]						
LUNCH/SUPPER	**LUNCH**	**LUNCH**	**LUNCH**	**LUNCH**	**LUNCH**	**LUNCH**
Birth Through 5 Months 4-6 fluid oz breast milk[2] or formula[1]						
6 Through 11 Months 6-8 fluid oz breast milk[2] or formula[1] 0-2 Tbsp fruit and/or vegetable[4,5] 0-4 Tbsp infant cereal[1,4] 0-4 Tbsp meat, fish, poultry, whole egg, or cooked dry beans or peas, or 0-2 oz cheese, or 0-4 oz (volume) cottage cheese, or 0-4 oz or 1/2 cup yogurt[3,4]	**SUPPER**	**SUPPER**	**SUPPER**	**SUPPER**	**SUPPER**	**SUPPER**
SNACK	**A.M. SNACK**	**A.M. SNACK**	**A.M. SNACK**	**A.M. SNACK**	**A.M. SNACK**	**A.M. SNACK**
Birth Through 5 Months 4-6 fluid oz breast milk[2] or formula[1]						
6 Through 11 Months 2-4 fluid oz breast milk[2] or formula[1] 0-2 Tbsp fruit and/or vegetable[4,5] 0-4 Tbsp infant cereal[1,4,6] or ready-to-eat cereal[4,6,7] or 0-1/2 serving bread[4,6] or 0-2 crackers[4,6]	**P.M. SNACK**	**P.M. SNACK**	**P.M. SNACK**	**P.M. SNACK**	**P.M. SNACK**	**P.M. SNACK**
	LATE P.M. SNACK	**LATE P.M. SNACK**	**LATE P.M. SNACK**	**LATE P.M. SNACK**	**LATE P.M. SNACK**	**LATE P.M. SNACK**

[1] Infant formula and dry infant cereal must be iron-fortified.

[2] It is recommended that breast milk be served in place of formula from birth through 11 months. For some breast-fed infants who regularly consume less than the minimum amount of breast milk per feeding, a serving of less than the minimum amount of breast milk may be offered with additional breast milk offered if the infant is still hungry.

*Food item provided by the parent.

[3] Yogurt must contain no more than 23 grams of total sugars per 6 oz.

[4] A serving of this component is required when the infant is developmentally ready.

[5] Fruit and vegetable juice cannot be served.

[6] Grains shall be made from whole-grain or enriched meal or flour.

[7] Breakfast cereals *MUST* contain no more than 6 grams of sugar per dry ounce.

Provider MUST complete in full sentences. Ex: (Provider name) will keep CAP documentation in file cabinet by the kitchen in the home.

CORRECTIVE ACTION PLAN

PROVIDER NAME:_____ PROVIDER #: _____

PROVIDER ADDRESS:_____ PROVIDER D.O.B: _____

WHAT: ARE THE SERIOUS DEFICIENCY(IES) AND THE PROCEDURES THAT WILL BE IMPLEMENTED TO ADDRESS THE SERIOUS DEFICIENCY(IES)?	**HOW:** WILL THE PROVIDER CORRECT THE SERIOUSLY DEFICIENCY(IES)?	**WHEN:** WILL THE CORRECTION OF THE SD ITEM BE IMPLEMENTED? (I.E., WILL THE PROCEDURE BE DONE DAILY, WEEKLY, MONTHLY, OR ANNUALLY, AND THE DATE IT WILL BEGIN (E.G. 10/1/XX)	**WHO:** WILL ADDRESS THE SERIOUS DEFICIENCY(IES)? LIST THE PERSONNEL RESPONSIBLE FOR THIS TASK AND JOB TITLE.	**WHERE:** WILL THE CAP DOCUMENTATION BE RETAINED? (THE ACTUAL LOCATION AT THE HOME WHERE THIS DOCUMENTATION WILL BE MAINTAINED.)

_____ _____

Signature of Provider Date

This corrective action plan MUST be RECEIVED (not postmarked) by the deadline stated in the serious deficiency notice.

CORRECTIVE ACTION PLAN

PROVIDER NAME:_____ PROVIDER #_____

PROVDER ADDRESS: _____ PROVIDER D.O.B.:_____

Provider MUST complete in full sentences. Ex: (Provider name) will keep CAP documentation in the file cabinet by the kitchen in the home.

1) **WHAT:** are the serious deficiency(ies) AND the procedures that will be implemented to address the serious deficiency(ies)?_____

2) **HOW:** will the provider correct the serious deficiency(ies)? _____

3) **WHEN:** will the correction of the SD item be implemented? (Ex: will the procedure be done daily, weekly, monthly, or annually, and the date it will begin (Ex: 10/1/XX):_____

4) **WHO:** will address the serious deficiency(ies)? List the personnel responsible for this task and job title.

5) **WHERE:** will the CAP documentation be retained? (The actual location at the home where this documentation will be maintained.):_____

_____ _____

Signature of Provider Date

This corrective action plan MUST be RECEIVED (not postmarked) by the deadline stated in the seriously deficiency notice.

Child and Adult Care Food Program (CACFP)
Report of Disqualification From Participation
Family Day Care Home (FDCH) Provider

State agency (SA) Imposing Disqualification: **Oklahoma State Department of Education (OSDE)**

Name of Provider: Last Name _____ First Name/MI: _____

Also Known As (AKA): _____

Address of Provider: _____

Date of Birth (DOB) of Provider: _____(mm/dd/yyyy)

Termination Date: _____(mm/dd/yyyy)

Has the PROVIDER failed to repay debts owed under the Program? Yes/No (Circle One)
Amount: $_____

Sponsoring Organization (SO) Name: _____

SO Adress: _____

Reason(s) for Disqualification: (Check all that apply)	
☐ Submission of false information on application	☐ Failure to keep required records
☐ Submission of false claims for reimbursement	☐ Conduct or conditions that threaten the health or safety of children in care or the public
☐ Simultaneous participation under more than one SO	☐ Noncompliance with Program meal pattern
☐ A determination that the FDCH has been convicted of any activity that occurred during the past 7 years and that indicated a lack of business integrity. A lack of business integrity includes fraud, forgery, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, obstruction of justice, or any other activity indicating a lack of business integrity as defined by the SA, or concealment of such a conviction.	☐ Any other circumstances related to nonperformance under the SO-FDCH agreement, as specified by the SO or the SA.
☐ Other:	☐ Failure to participate in training

Child and Adult Care Food Program (CACFP)
Report of Disqualification From Participation
Family Day Care Home (FDCH) Provider

Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Print Name of Sponsoring Organization Authorized Representative

Signature of Sponsoring Organization Authorized Representative

_____ _____

Title

Date (mm/dd/yyyy)

Site Information

License Type: _____ Site Number _____
(Required to be 4 digits)

Tribe: _____

License Number: _____

Operating Name _____

Physical Address

Address Line 1 _____

Address Line 2 _____

Zip Code _____ City _____

State _____ County _____

Telephone _____

Status _____ License Capacity_____

Owner/Provider/Director Information

Last Name _____ First Name _____

Middle Initial _____ ITIN/EIN/Last 4 SSN _____

Date of Birth _____

OSDE Use Only:

Effective Date: _____ Date Entered into System: _____

CNP End Date: _____

NOTES:

Sponsor Information

Agreement Number _____

Sponsor Name _____

Monitor Staffing Ratio

1. Full-Time Employees (FTE) Required for Number of Homes Served:

a. Metro Counties Served	# Homes in County	
		5
	Total Metro Homes = _____ ÷ 75 Metro Limit = _____ FTE	
b. Rural Counties Served	# Homes in County	
	Total Rural Homes = _____ ÷ 60 Rural Limit = _____ FTE	
c. Total FTE required to monitor homes = _____ FTE (a + b)		
2. FTE Devoted to Monitoring Activities:		
a. List Names of Monitoring Personnel	# Hours Per Week Spent on Monitoring Duties	

b. Total hours spent on monitoring duties each week = ***165*** ÷ 40 hours per week = _____ FTE devoted to monitoring activities. The number of FTE devoted to monitoring duties must be equal to or exceed the total FTE required to monitor homes (1c). This sponsor is short 1.63 FTE and has an inadequate monitoring/staffing ratio.

*Refers to only those activities listed on the previous page that may count as monitoring.

TIER I PROVIDER BASED ON SNAP ELIGIBILITY

Sponsoring Organization: _____ Agreement Number: _____

INSTRUCTIONS:
1. List each household member name.
2. List the SNAP case number (must be six- or nine-digit number).

A list of providers qualifying for Tier I reimbursement based on *Supplemental Nutrition Assistance Program* (SNAP) eligibility must be submitted by March 15 of each year to the State agency. The list must include the provider's name and his or her SNAP case number.

HOUSEHOLD MEMBER (Last Name, First Name)	SNAP NUMBER

This form must be completed and submitted to the following address by March 15 of each year:

Oklahoma State Department of Education
Child Nutrition Programs Section, Ste 310
2500 North Lincoln Boulevard
Oklahoma City, Oklahoma 73105-4599
Fax: (405) 521-2239