

# CHILD NUTRITION PROGRAMS

CHILD AND ADULT CARE FOOD PROGRAM

FAMILY DAY CARE HOME  
SPONSOR/PROVIDER FORMS



Fiscal Year 2016

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**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: \_\_\_\_\_

D. Phone Number of Provider: \_\_\_\_\_

E. Is the home licensed?  Yes  No  
License Type:  DHS  Tribal \_\_\_\_\_  
Specify

F. License Number: \_\_\_\_\_

G. License Capacity: \_\_\_\_\_

H. Age Range of Enrolled Participants:  
From \_\_\_\_\_ to \_\_\_\_\_

I. Number Enrolled in CACFP: \_\_\_\_\_

B. Provider Information:

Full Last Name \_\_\_\_\_

Full First Name \_\_\_\_\_

Middle Initial \_\_\_\_\_

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

Last 4 Digits of Social Security Number: \_\_\_\_\_

J. Name and Address of Sponsoring Organization: \_\_\_\_\_

**Section 2A—Operating Data**

A. Hours of Operation:  
From \_\_\_\_\_ to \_\_\_\_\_ (hhmm)

B. Number of operating days per week? \_\_\_\_\_

C. Do you care for participants in shifts?  Yes  
 No  
(If Yes, explain.)

D. Months of Operation:

- |                                   |                                |                                    |                                   |
|-----------------------------------|--------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> January  | <input type="checkbox"/> April | <input type="checkbox"/> July      | <input type="checkbox"/> October  |
| <input type="checkbox"/> February | <input type="checkbox"/> May   | <input type="checkbox"/> August    | <input type="checkbox"/> November |
| <input type="checkbox"/> March    | <input type="checkbox"/> June  | <input type="checkbox"/> September | <input type="checkbox"/> December |

**Section 3A—Meal Service Data**

**A. MEAL TYPES—MONDAY - FRIDAY MEAL SERVICE**

MEAL SERVED	BREAKFAST		A.M. SNACK		LUNCH		P.M. SNACK		SUPPER		LATE P.M. SNACK	
	1st	2nd	1st	2nd	1st	2nd	1st	2nd	1st	2nd	1st	2nd
TYPE OF SHIFT												
BEGINNING TIME OF MEAL SERVICE												

**WEEKEND MEAL SERVICE**

MEAL SERVED	BREAKFAST		A.M. SNACK		LUNCH		P.M. SNACK		SUPPER		LATE P.M. SNACK	
	1st	2nd	1st	2nd	1st	2nd	1st	2nd	1st	2nd	1st	2nd
TYPE OF SHIFT												
BEGINNING TIME OF MEAL SERVICE												

**B. WEEKEND JUSTIFICATION STATEMENT (Maximum 300 Characters)**

**Section B—Directions (Maximum 1000 Characters)**

Please provide detailed directions to this home, starting from sponsoring organization.

**Section C—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 \_\_\_\_\_

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 above information is true and correct. I understand that this information is being given in connection with the receipt of federal funds; that Department officials may, for cause, verify information; and that deliberate misrepresentation may subject me to prosecution under applicable state and criminal statutes. The program must be made available to all eligible children regardless of age, sex, disability, race, color, or national origin.

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.

**PERMANENT AGREEMENT BETWEEN  
SPONSORING ORGANIZATION  
AND FAMILY DAY CARE HOME PROVIDER (FDCH) (§226.18[b])**

As a family day care home (FDCH) provider, I am aware that there are organizations available in Oklahoma to sponsor FDCHs in the Child and Adult Care Food Program (CACFP). I understand that I may not change sponsoring organizations (SOs) without approval of Child Nutrition Programs (CNP). I further understand that 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 either school eligibility data or census data for providers who cannot demonstrate that their household incomes meet the free or reduced-price eligibility standards. 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 a Tier I FDCH if information becomes available indicating that an FDCH is no longer in a qualified area.
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 the 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 FDCHs must have their first review during the first four weeks 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 weekend and/or late p.m. snacks, a review must be conducted during those times. If a provider is found to be seriously deficient, an unannounced follow-up review is required.
9. Initiate household contacts when required.
10. Show photographic identification when visiting providers.
11. Make all visits during the provider's normal operating hours.
12. 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 and proposed for termination and disqualification.
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 notice from the State Agency to any providers in compliance with CACFP Policies/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, or disability, and that there is no discrimination in the course of the food services.
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. Not approve meal services between the hours of 10 p.m. and 5 a.m.
23. 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.
24. 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 the sponsor's office and/or the provider's home.
25. Provide copies of *Building for the Future* fact sheet to all providers in adequate quantities for distribution to all households.

26. Have the right to propose to terminate this Application/Agreement to participate in the CACFP for cause or convenience. If proposed termination is for cause, notification must include SO's appeal procedures.
27. 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.
28. Reimburse for meals that only meet minimum meal pattern requirements.
29. Comply with all other USDA Regulations §226.
30. Provide appeal procedures to all providers annually and at any time a provider is suspended or proposed for termination.
31. 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 Application/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 ending date of the Application/Agreement. If the FDCH does not complete participation through the expiration date, approval to participate with another SO shall 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 annually shall be declared seriously deficient and proposed for termination and disqualification.
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, sex, age, disability, or national origin, 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.
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. The State Agency allows a 15-minute leeway *before or after* the approved beginning meal service time. Three hours shall elapse between the beginning of one main meal service and the next main meal service. At least two hours shall elapse between the beginning of a main meal and a snack. Meals served outside of the approved times are not eligible for reimbursement. No meal services are allowed between the hours of 10 p.m. and 5 a.m.
8. Develop and follow the approved 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 complete or update 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 shall 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 meals served to the provider's own children 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. **Provider's Own Children:** 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 house, 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.)
16. 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.
17. Receive reimbursement for the types of meals provided to participating children at the rates specified by USDA.
18. Submit necessary documentation for meals served for reimbursement in accordance with procedures established by the State Agency and the SO.
19. Provide monthly report of daily arrival/departure attendance records; daily record of meals served; weekly meals served; infant meal waivers, if applicable; and infant meals served, if applicable.

20. Maintain full and accurate records of the Program, including those set forth in this Application/Agreement. Records must be maintained daily. There shall be no grace period 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 shall be maintained past the three-year requirement until there is a resolution of the audit or review.
21. Upon request, make all records pertaining to the Program *immediately* available to the State Agency, USDA, and/or the SO for audit or administrative review or monitoring review purposes. Reviews and/or visits may be announced or unannounced.
22. Allow representatives with photographic identification from the SO, the State Agency, and USDA access to the home during normal business hours throughout the year for the purpose of reviewing CACFP operations.
23. 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.
24. 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.
25. 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 completed 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.
26. Be informed, if a Tier II home, that a request may be made to the sponsor to consider reclassification of home when new census data becomes available and that reclassification may be made at any time.
27. Make available information concerning WIC to the parents of children enrolled in FDCHs.
28. Distribute the *Building for the Future* fact sheet to all households enrolled in the FDCH.
29. Have the right to terminate this Application/Agreement to participate in the CACFP for cause or convenience.
30. 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.
31. Not claim another provider's own child.
32. Be aware that they could be declared seriously deficient and proposed for disqualification and termination for failure to comply with CACFP regulations.

## MINIMUM MEAL REQUIREMENTS OF THE CHILD AND ADULT CARE FOOD PROGRAM

<b>BREAKFAST</b>				<b>FOOTNOTES FOR ALL MEALS</b>
<b>Food Components</b>	<b>Children Aged 1-2 Years</b>	<b>Children Aged 3-5 Years</b>	<b>Children Aged 6-12 Years</b>	
<b>MILK<sup>1</sup></b> Milk, fluid	1/2 cup	3/4 cup	1 cup	<sup>1</sup> Fluid milk must be fat-free or lowfat milk, fat-free or lowfat lactose-reduced milk, fat-free or lowfat lactose-free milk, fat-free or lowfat buttermilk, or fat-free or lowfat acidified milk. Milk served must be pasteurized fluid milk that meets state and local standards and may be flavored or unflavored. <i>Whole milk and reduced-fat (2%) milk may not be served to participants over two years of age.</i> <sup>2</sup> Or an equivalent quantity of any combination of vegetable(s), fruit(s), and juice. <sup>3</sup> Or an equivalent quantity of any combination of bread/bread alternate. Refer to Food and Nutrition Service (FNS) Instruction 783-1, Rev. 2, Exhibit A (Bread and Bread Alternate Requirements). <sup>4</sup> Either volume (cup) or weight (ounce), whichever is less. <sup>5</sup> Must include at least two kinds. <sup>6</sup> Full-strength vegetable or fruit juice may be counted to meet not more than 1/2 of this requirement. <sup>7</sup> Or an equivalent quantity of any combination of meat/meat alternate. <sup>8</sup> Cooked lean meat without bone. <sup>9</sup> May be used as the meat alternate or as part of vegetable/fruit component, but not as both components in the same meal. <sup>10</sup> Nuts and seeds are not recommended to be served to children aged 1 through 3 since they present a choking hazard. If served, they should be finely minced. <sup>11</sup> No more than 50 percent of the requirement shall be met with nuts or seeds. Nuts and seeds shall be combined with another meat/meat alternate to fulfill the requirement. For purposes of determining combinations, one ounce of nuts or seeds is equal to one ounce of cooked lean meat, poultry, or fish. <sup>12</sup> Juice may not be served when milk is served as the only other component. <sup>13</sup> Applies to commercially prepared yogurt, lowfat yogurt, and nonfat yogurt. It does not apply to nonstandardized yogurt products, such as frozen yogurt, yogurt-flavored products, yogurt bars, yogurt-covered fruit or nuts. Commercial flavorings may be added, such as fruit, fruit juice, nuts, seeds, granola, etc., but they shall not be credited toward meeting the second food component requirement in the snack. <sup>14</sup> Includes such products as hard pretzels or chips made of whole-grain or enriched meal or flour.
<b>VEGETABLES AND/OR FRUITS<sup>2</sup></b> Vegetable(s) or fruit(s) <i>or</i> Full-strength juice	1/4 cup	1/2 cup	1/2 cup	
<b>BREAD/BREAD ALTERNATES<sup>3</sup></b> Enriched or whole-grain bread	1/2 serving	1/2 serving	1 serving	
Cornbread, biscuits, rolls, muffins, etc.	1/2	1/2	1	
Cereal (cold, dry)	1/4 cup or 1/3 oz <sup>4</sup>	1/3 cup or 1/2 oz <sup>4</sup>	3/4 cup or 1 oz <sup>4</sup>	
Cooked pasta or noodle products	1/4 cup	1/4 cup	1/2 cup	
Cooked cereal or cereal grains	1/4 cup	1/4 cup	1/2 cup	
<b>LUNCH/SUPPER</b>				
<b>Food Components</b>	<b>Children Aged 1-2 Years</b>	<b>Children Aged 3-5 Years</b>	<b>Children Aged 6-12 Years</b>	
<b>MILK<sup>1</sup></b> Milk, fluid	1/2 cup	3/4 cup	1 cup	
<b>VEGETABLES AND/OR FRUITS<sup>2,5</sup></b> Vegetable(s) or fruit(s) <i>or</i> Full-strength juice <sup>6</sup>	1/4 cup total from 2 sources	1/2 cup total from 2 sources	3/4 cup total from 2 sources	
<b>BREAD/BREAD ALTERNATES<sup>3</sup></b> Enriched or whole-grain bread	1/2 serving	1/2 serving	1 serving	
Cornbread, biscuits, rolls, muffins, etc.	1/2	1/2	1	
Cooked pasta or noodle products	1/4 cup	1/4 cup	1/2 cup	
Cooked cereal or cereal grains	1/4 cup	1/4 cup	1/2 cup	
Nonsweet snack products <sup>14</sup>	1/2 serving	1/2 serving	1 serving	
<b>MEAT AND MEAT ALTERNATES<sup>7</sup></b> Lean meat or poultry or fish <sup>8</sup>	1 oz	1 1/2 oz	2 oz	
Cheese	1 oz	1 1/2 oz	2 oz	
Eggs	1/2 egg (large)	3/4 egg (large)	1 egg (large)	
Cooked dry beans or peas <sup>9</sup>	1/4 cup	3/8 cup	1/2 cup	
Peanut butter, soybean butter, or other nut or seed butters	2 Tbsp	3 Tbsp	4 Tbsp	
Peanuts, soybeans, or tree nuts or seeds <sup>10</sup>	1/2 oz = 50% <sup>11</sup>	3/4 oz = 50% <sup>11</sup>	1 oz = 50% <sup>11</sup>	
Yogurt, plain or flavored, unsweetened or sweetened <sup>13</sup>	4 oz or 1/2 cup	6 oz or 3/4 cup	8 oz or 1 cup	

**MINIMUM MEAL REQUIREMENTS OF THE CHILD AND ADULT CARE FOOD PROGRAM**  
(continued)

<b>SNACK (Choose 2 of the following components)</b>				<b>FOOTNOTES FOR ALL MEALS</b>
<b>Food Components</b>	<b>Children Aged 1-2 Years</b>	<b>Children Aged 3-5 Years</b>	<b>Children Aged 6-12 Years</b>	
<b>MILK<sup>1</sup></b> Milk, fluid	1/2 cup	1/2 cup	1 cup	<sup>1</sup> Fluid milk must be fat-free or lowfat milk, fat-free or lowfat lactose-reduced milk, fat-free or lowfat lactose-free milk, fat-free or lowfat buttermilk, or fat-free or lowfat acidified milk. Milk served must be pasteurized fluid milk that meets state and local standards and may be flavored or unflavored. <b>Whole milk and reduced-fat (2%) milk may not be served to participants over two years of age.</b> <sup>2</sup> Or an equivalent quantity of any combination of vegetable(s), fruit(s), and juice. <sup>3</sup> Or an equivalent quantity of any combination of bread/bread alternate. Refer to Food and Nutrition Service (FNS) Instruction 783-1, Rev. 2, Exhibit A (Bread and Bread Alternate Requirements). <sup>4</sup> Either volume (cup) or weight (ounce), whichever is less. <sup>5</sup> Must include at least two kinds. <sup>6</sup> Full-strength vegetable or fruit juice may be counted to meet not more than 1/2 of this requirement. <sup>7</sup> Or an equivalent quantity of any combination of meat/meat alternate. <sup>8</sup> Cooked lean meat without bone. <sup>9</sup> May be used as the meat alternate or as part of vegetable/fruit component, but not as both components in the same meal. <sup>10</sup> Nuts and seeds are not recommended to be served to children aged 1 through 3 since they present a choking hazard. If served, they should be finely minced. <sup>11</sup> No more than 50 percent of the requirement shall be met with nuts or seeds. Nuts and seeds shall be combined with another meat/meat alternate to fulfill the requirement. For purposes of determining combinations, one ounce of nuts or seeds is equal to one ounce of cooked lean meat, poultry, or fish. <sup>12</sup> Juice may not be served when milk is served as the only other component. <sup>13</sup> Applies to commercially prepared yogurt, lowfat yogurt, and nonfat yogurt. It does not apply to nonstandardized yogurt products, such as frozen yogurt, yogurt-flavored products, yogurt bars, yogurt-covered fruit or nuts. Commercial flavorings may be added, such as fruit, fruit juice, nuts, seeds, granola, etc., but they shall not be credited toward meeting the second food component requirement in the snack. <sup>14</sup> Includes such products as hard pretzels or chips made of whole-grain or enriched meal or flour.
<b>VEGETABLES AND/OR FRUITS<sup>2</sup></b> Vegetable(s) or fruit(s) <i>or</i> Full-strength juice <sup>12</sup>	1/2 cup	1/2 cup	3/4 cup	
<b>BREAD/BREAD ALTERNATES<sup>3</sup></b> Enriched or whole-grain bread	1/2 serving	1/2 serving	1 serving	
Cornbread, biscuits, rolls, muffins, etc.	1/2	1/2	1	
Cereal (cold, dry)	1/4 cup or 1/3 oz <sup>4</sup>	1/3 cup or 1/2 oz <sup>4</sup>	3/4 cup or 1 oz <sup>4</sup>	
Cooked pasta or noodle products	1/4 cup	1/4 cup	1/2 cup	
Cooked cereal or cereal grains	1/4 cup	1/4 cup	1/2 cup	
Nonsweet snack products <sup>14</sup>	1/2 serving	1/2 serving	1 serving	
<b>MEAT AND MEAT ALTERNATES<sup>7</sup></b> Lean meat or poultry or fish <sup>8</sup>	1/2 oz	1/2 oz	1 oz	
Cheese	1/2 oz	1/2 oz	1 oz	
Eggs	1/2 egg (large)	1/2 egg (large)	1/2 egg (large)	
Cooked dry beans or peas <sup>9</sup>	1/8 cup	1/8 cup	1/4 cup	
Peanut butter, soy nut butter, or other nut or seed butters	1 Tbsp	1 Tbsp	2 Tbsp	
Peanuts, soy nuts, or tree nuts or seeds <sup>10</sup>	1/2 oz	1/2 oz	1 oz	
Yogurt, plain or flavored, unsweetened or sweetened <sup>13</sup>	2 oz or 1/4 cup	2 oz or 1/4 cup	4 oz or 1/2 cup	

## CHILD AND ADULT CARE FOOD PROGRAM INFANT MEAL PATTERN

BREAKFAST	BIRTH THROUGH 3 MONTHS	4 THROUGH 7 MONTHS	8 THROUGH 11 MONTHS
	4-6 fluid oz breast milk <sup>2,3</sup> or formula <sup>1</sup>	4-8 fluid oz breast milk <sup>2,3</sup> or formula <sup>1</sup> 0-3 Tbsp infant cereal <sup>1,4</sup>	6-8 fluid oz breast milk <sup>2,3</sup> or formula <sup>1</sup> 2-4 Tbsp infant cereal <sup>1</sup> 1-4 Tbsp fruit or vegetable
<b>LUNCH/ SUPPER</b>			
	4-6 fluid oz breast milk <sup>2,3</sup> or formula <sup>1</sup>	4-8 fluid oz breast milk <sup>2,3</sup> or formula <sup>1</sup> 0-3 Tbsp infant cereal <sup>1,4</sup> 0-3 Tbsp fruit or vegetable <sup>4</sup>	6-8 fluid oz breast milk <sup>2,3</sup> or formula <sup>1</sup> 1-4 Tbsp fruit or vegetable  <b>AND AT LEAST ONE OF THE FOLLOWING:</b>  2-4 Tbsp infant cereal <sup>1</sup> 1-4 Tbsp meat, fish, poultry, egg yolk, or cooked dry beans or peas 1/2-2 oz cheese 1-4 oz (volume) cottage cheese 1-4 oz (weight) cheese food or cheese spread
<b>SNACK</b>			
	4-6 fluid oz breast milk <sup>2,3</sup> or formula <sup>1</sup>	4-6 fluid oz breast milk <sup>2,3</sup> or formula <sup>1</sup>	2-4 fluid oz breast milk <sup>2,3</sup> , formula <sup>1</sup> , or fruit juice <sup>5</sup> 0-1/2 slice bread <sup>4,6</sup> or 0-2 crackers <sup>4,6</sup>

<sup>1</sup> Infant formula and dry infant cereal shall be iron-fortified.

<sup>2</sup> It is recommended that breast milk be served in place of formula from birth through 11 months.

<sup>3</sup> 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.

<sup>4</sup> A serving of this component shall be optional.

<sup>5</sup> Fruit juice shall be full-strength.

<sup>6</sup> Bread and bread alternates shall be made from whole-grain or enriched meal or flour.

**NOTE:** Do not serve honey or use in food served to infants under one year old.

## Section C

### 1. Provider Civil Rights Data Collection

Actual enrollment data by ethnic/racial category for each FDCH shall be collected by the SO each year. Visual identification may be used by FDCHs to determine a child's ethnic/racial category, or the parents of a child may be asked to identify the ethnic/racial group of the child only after it has been explained and they understand that the collection of this information is strictly for statistical reporting requirements.

### 2. Ethnic/Racial 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 participant only after it has been explained and they understand 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

\_\_\_\_\_ Hispanic  
\_\_\_\_\_ Not Hispanic

#### Racial Breakdown

\_\_\_\_\_ American Indian/Alaskan Native  
\_\_\_\_\_ Asian  
\_\_\_\_\_ Black or African  
\_\_\_\_\_ Hawaiian or Pacific Islander  
\_\_\_\_\_ White

### 3. Tier I Eligible Homes

This home is eligible for Tier I reimbursement?  Yes  
 No

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

\_\_\_\_\_ School Data—If selected, enter school name: \_\_\_\_\_

\_\_\_\_\_ 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. **Tier II Homes—Options for Reimbursement**

**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 FSIA's and determine the income eligibility of enrolled children.
- I elect to collect FSIA's on my enrolled children and submit documentation to the SO for eligibility determination.
- I elect to have the SO identify only those children in Tier II homes who are considered categorically eligible by virtue of their participation, or their parent's 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 only possible 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 been convicted of a business-related offense during the past 7 years.  
 have not
- I  am on the CACFP National Disqualified List.  
 am not

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:**

- |                          |           |                          |                 |
|--------------------------|-----------|--------------------------|-----------------|
| <input type="checkbox"/> | Breakfast | <input type="checkbox"/> | A.M. Snack      |
| <input type="checkbox"/> | Lunch     | <input type="checkbox"/> | P.M. Snack      |
| <input type="checkbox"/> | Supper    | <input type="checkbox"/> | Late P.M. Snack |

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

7. **Provider record-keeping requirements:**

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

- License
- Annual 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 Statements/Signatures**

WE CERTIFY that the information in this Application/Agreement is true and correct to the best of our knowledge and that we will comply with the rights and responsibilities outlined in the Application/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 State Agency and SO officials may, with cause, verify information; and that deliberate misrepresentations may subject him or her to prosecution under applicable state and federal criminal statutes.

The provider certifies that he or she has never been terminated from a publicly funded program (federal, state, or local) nor has ever been convicted of fraud, antitrust violations, embezzlement, theft, forgery, falsification or destruction of records, making false statements or claims, receiving stolen property, or obstruction of justice.

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.

Effective date of Application/Agreement shall be \_\_\_\_\_, 20 \_\_\_\_\_ .

Signature of Provider		Date
Signature of Organization Representative	Title	Date

## PROVIDER LIST OF SERIOUS DEFICIENCIES

A provider is declared seriously deficient by the SO if any of the following areas of noncompliance exist:

1. Submission of false information on the application/agreement.
2. Submission of false claims for reimbursement.
3. Simultaneous participation under more than one SO.
4. Noncompliance with the Program meal pattern.
5. Failure to keep required records.
6. Conduct or conditions that threaten the health or safety of a child in care or the public health or safety.
7. A determination that the FDCH has been convicted of any activity that occurred during the past seven years and that indicated a lack of business integrity. 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 State Agency, or the concealment of such a conviction.
8. Failure to participate in training.
9. Any other circumstances related to nonperformance under the SO-FDCH agreement, as specified by the SO or the State Agency (including, but not limited to, fully and permanently correcting areas of noncompliance previously cited).

The SO must *INITIATE* action to terminate the Application/Agreement of an FDCH for cause if the SO determines the FDCH has committed any of the serious deficiencies listed above.

**NOTE:** Any provider who submits a claim in which adjustments result in a 25 percent or more error rate will be declared seriously deficient (see Payment Voucher/Disbursement Record).

## APPEAL PROCEDURES

Each sponsoring organization (SO) must develop appeal procedures for family day care home (FDCH) providers. These procedures must be distributed to each provider during the initial application process.

1. The SO must offer an appeal to an FDCH provider *only when* the intent of the SO is to terminate the provider's agreement for cause or when the intent of the SO is to suspend the provider's participation in the Child and Adult Care Food Program (CACFP).
2. A provider will be notified in writing by certified mail, *return receipt requested*, of the grounds upon which the SO based its action. The notice will inform the provider of his or her right to appeal. The provider may request a review of the records. Upon receipt of such a request, the SO will appoint a review official to conduct the review.
3. The written request for a review of records must be filed by the provider no later than the number of calendar days established by the SO. The number of days established by the SO shall begin on the day the notice of action was received. The SO will acknowledge the receipt of the request for appeal within the time frame established by the SO.
4. The provider may refute the information contained in the notice of action in person or by written documentation presented to the review official. The provider must have the opportunity to review the record on which the sponsor's action was based. In order to be considered, written documentation must be filed with the review official not later than the time frame established by the SO. The time frame shall begin on the day the notice of action was received. The provider may be represented by legal counsel or another person; if legal counsel is to be present, the SO must be notified of the counsel's name and address. The following applies to the appeal for a review of records:
  - Upon receipt of an appeal requesting a review of the records, the review official will notify the provider and the SO of the timelines for submission of documents.
  - Written notification submitted after the review official's timeline will not be considered.
  - Failure to submit written documentation to refute the action taken by the SO within the time frame will constitute the provider's waiver of the appeal, resulting in the action taken by the SO being upheld.
5. Sponsors may choose to offer in-person hearings, but there is no requirement that they do so. The person hearing the appeal must be independent and impartial, and he or she must *NOT* have been involved in the action that is the subject of the appeal. Also, he or she must *NOT* have a direct personal or financial interest in the outcome. The hearing official may be an employee or board member of the sponsor or a contractor, such as a member of a statewide sponsor association.
6. Documents and information relating to the provider and the action taken will be available for inspection and copying pursuant to the Open Records Fee Schedule at the office of the SO.
7. The review official will be an independent and impartial official other than, and not accountable to, any person authorized to make decisions that are subject to appeal.
8. The review official will make a determination based on information provided by the SO, the provider, and the laws and regulations governing the Child Nutrition Program (CNP).
9. Within the established time frame, the review official's determination must be delivered to the provider and the SO.
10. Participating providers may continue to operate under the Program during an appeal of proposed termination unless the action is based on imminent danger to the health or welfare of participants. If the provider has been terminated for this reason, the SO must specify this in its notice of action.
11. The determination by the review official is the final administrative determination to be afforded to the provider.
12. Pursuant to the federal regulations, appeals will not be allowed on decisions made by Food and Nutrition Service (FNS).

# LETTER TO HOUSEHOLD—TIER II FAMILY DAY CARE HOMES (FDCH)

(October 1, 2014 - September 30, 2015)

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's (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).

- 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, (Sponsor's Name) \_\_\_\_\_. 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 (Provider's Name) \_\_\_\_\_ to collect your form and provide it to the sponsor. (Provider's Name) \_\_\_\_\_ will not review your form.
- 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.
- 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.
- 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.
- May I fill out an application if someone in my household is not a 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.
- 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 may include any foster children living with you.
- 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, however, notify us 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.
- 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.
- 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. Households wishing to apply for such benefits for foster children should contact (Sponsoring Organization [SO] Name) \_\_\_\_\_, (SO Address) \_\_\_\_\_, (SO Phone Number) \_\_\_\_\_.
- We are in the military; do we include our housing and supplemental allowances 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.

In the operation of CACFP, this institution is an equal opportunity provider and employer. If you have other questions or need help, call (Phone Number) \_\_\_\_\_.

Sincerely,  
(Signature)

**LETTER TO PROVIDER—TIER I OR PROVIDER’S OWN CHILDREN**  
**(October 1, 2014 - September 30, 2015)**

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 1 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 your 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 kind 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 1 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 your 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 everyone 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), Temporary Assistance to Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) case number, you will remain eligible for those benefits for the rest of the fiscal year. You should, however, notify us 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 are eligible for free meals regardless of their personal income or the income of the household with whom they reside. Households wishing to apply for such benefits for foster children should contact (Sponsoring Organization [SO] Name) \_\_\_\_\_, (SO Address) \_\_\_\_\_, (SO Phone Number) \_\_\_\_\_. Additionally, foster children may be included as members of the household for determining the eligibility of other children in the household for free and reduced-price meals.
11. **We are in the military; do we include our housing and supplemental allowances 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.

In the operation of CACFP, this institution is an equal opportunity provider and employer. If you have other questions or need help, call (Phone Number) \_\_\_\_\_.

Sincerely,  
(Signature) \_\_\_\_\_



**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.* (See Privacy Act Statement below.)

*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, the 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:  
 Hispanic or Latino  
 Not Hispanic or Latino

Mark one or more racial identities:  
 Asian  
 White  
 American Indian or Alaska 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. Insitution officials may give information from my FSIA to SoonerCare Health Benefit officials so that they can send me information about free or low-cost health insurance for my children.  
 No, I **DO NOT** want information from my FSIA shared with SoonerCare 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	21,775
2	29,471
3	37,167
4	44,863
5	52,559
6	60,255
7	67,951
8	75,647
Each additional person:	7,696

**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 (FDPPIR) case number or other FDPPIR 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.

The United States Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by USDA. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the **USDA Program Discrimination Complaint Form**, found online at <[http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html)>, or at any USDA office, or call 866-632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to USDA by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, DC 20250-9410, by fax 202-690-7442, or e-mail at <[program.intake@usda.gov](mailto:program.intake@usda.gov)>.

Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339 or 800-845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

**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: \_\_\_\_\_

# INSTRUCTIONS FOR COMPLETING THE FDCH FAMILY-SIZE AND INCOME APPLICATION (FSIA)

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. 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 age(s) and birth date(s) 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. 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 the enrolled children. For each enrolled child, include his/her age and birth date. 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*) \_\_\_\_\_. 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) who share income and expenses. 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, 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, federal education benefits. For **ONLY** the self-employed, under *Earnings From Work*, report income after expenses. This is for 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. 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 child(ren), list age(s) and birth date(s). 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:** 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) who share income and expenses. 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, 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, federal education benefits. For **ONLY** the self-employed, under *Earnings From Work*, report income after expenses. This is for 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. You are not required to complete this to get meal benefits.

**PRIVACY ACT STATEMENT:** This explains how we will use the information you give us.

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

## WORKSHEET TO DETERMINE CURRENT MONTHLY INCOME

(Without a Tax Return)

**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) (formerly the Food Stamp Program), *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	<b>LAST MONTH'S CURRENT NET INCOME</b>

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

**OKLAHOMA STATE DEPARTMENT OF EDUCATION  
CHILD AND ADULT CARE FOOD PROGRAM**

**HOUSEHOLD-SIZE INCOME SCALES  
FOR FREE AND REDUCED-PRICE MEALS  
Fiscal Year 2016**

To be used for applications obtained from July 1, 2015, through June 30, 2016.

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

<b>ELIGIBILITY SCALE FOR FREE MEALS</b>					
<b>130 Percent of Poverty Level</b>					
<b>Household Size</b>	<b>Income</b>				
	<b>Annual</b>	<b>Monthly</b>	<b>Twice Per Month</b>	<b>Every Two Weeks</b>	<b>Weekly</b>
<b>1</b>	15,301	1,276	638	589	295
<b>2</b>	20,709	1,726	863	797	399
<b>3</b>	26,117	2,177	1,089	1,005	503
<b>4</b>	31,525	2,628	1,314	1,213	607
<b>5</b>	36,933	3,078	1,539	1,421	711
<b>6</b>	42,341	3,529	1,765	1,629	815
<b>7</b>	47,749	3,980	1,990	1,837	919
<b>8</b>	53,157	4,430	2,215	2,045	1,023
For each additional family member, add:	5,408	451	226	208	104

<b>ELIGIBILITY SCALE FOR REDUCED-PRICE MEALS</b>					
<b>185 Percent of Poverty Level</b>					
<b>Household Size</b>	<b>Income</b>				
	<b>Annual</b>	<b>Monthly</b>	<b>Twice Per Month</b>	<b>Every Two Weeks</b>	<b>Weekly</b>
<b>1</b>	21,775	1,815	908	838	419
<b>2</b>	29,471	2,456	1,228	1,134	567
<b>3</b>	37,167	3,098	1,549	1,430	715
<b>4</b>	44,863	3,739	1,870	1,726	863
<b>5</b>	52,559	4,380	2,190	2,022	1,011
<b>6</b>	60,255	5,022	2,511	2,318	1,159
<b>7</b>	67,951	5,663	2,832	2,614	1,307
<b>8</b>	75,647	6,304	3,152	2,910	1,455
For each additional family member, add:	7,696	642	321	296	148



## 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 is a provider who has indicated that he or she now receives SNAP, TANF, or FDPIR benefits. On the chart below, please indicate if the household is 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)

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

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

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

1. Submit this form to the Department of Human Services (DHS) or Tribal Agency to verify that a provider is receiving SNAP, TANF, or FDPIR benefits.
2. Duplicate and place in provider's file.

## PROVIDER 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) (formerly the Food Stamp Program), *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)

In accordance with federal law and United States Department of Agriculture (USDA) policy, participating institutions are prohibited from discrimination on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, write USDA, Office of Adjudication, 1400 Independence Avenue, SW, Washington, DC, 20250-9410, or call toll-free 866-632-9992 (Voice). Individuals who are hearing-impaired or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339 or 800-845-6136 (Spanish). USDA is an equal opportunity provider and employer.

## **PROVIDER VERIFICATION RESULTS INSTRUCTIONS**

1. Use this form to notify providers of the verification results of their Tier I status when submitting household income information.
2. Maintain a copy of the results of verification with each provider's file.

**NOTE:** This form must be sent to each provider each time household income is reevaluated.







## **EXPENDITURE WORKSHEET INSTRUCTIONS**

The Expenditure Worksheet is a summary report of all allowable CACFP administrative costs incurred during the month. All administrative costs recorded on the Expenditure Worksheet must be further supported by appropriate documentation (i.e., receipts/invoices, payroll records, canceled checks). In addition, all costs reported must be approved on the SO's administrative budget.

**Month and Year:** Record the month and year during which the costs were incurred in the upper right-hand corner.

For each expenditure:

**Date:** Record the date the specific cost was incurred.

**Item Entry:** Record the name of the vendor or the first and last names of personnel receiving payment.

**Check Number:** Record the number of the check issued.

**Page 1, Columns 1-7** Record the amount of the expenditure under the appropriate columns. Total each column.

**Page 2, Columns 8-14** Record the amount of the expenditure under the appropriate columns. Total each column.

**Page 3, Columns 15-21** Record the amount of the expenditure under the appropriate columns. Total each column.

# SPONSOR TRAINING RECORD

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

Location: \_\_\_\_\_

City: \_\_\_\_\_

Key Staff's Signature	Position	Certificate Issued

Required Topics Addressed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Note: Attach copy of training session's agenda.*

**NAME OF SPONSOR**

**KEY STAFF TRAINING**

**Date:**

**Location:**

**Time:**

**Topics**



## **PROVIDER TRAINING RECORD**

### **Training**

Sponsors are required to offer training sessions annually (October through September), scheduled at a time and place convenient to all providers listed on Schedule A and subsequently on the Schedule A Update. Providers who do not attend training at least annually shall be declared seriously deficient and proposed for termination by the sponsor. Training must include the five topics listed below. Sponsors must document and have readily available all training records, including date, location, signatures of providers attending, and topics covered. Technical assistance given to a provider during a home visit does not qualify as sponsor training unless all training requirements mentioned below are met. Sponsoring organizations must ensure each provider receives certification of training.

### **Required Minimum Training Topics**

1. CACFP Meal Pattern
2. Reimbursement Process
3. Accurate Meal Counts
4. Claims Submission
5. Record Keeping

Provider Number: \_\_\_\_\_

## PREAPPROVAL VISIT FORM

Provider's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Provider's Address: \_\_\_\_\_

<b>The following items were discussed and reviewed:</b>	<b>Provider Agrees to Comply</b>
1. Provider's Application and Agreement	
a. License	1a.
b. Tiering Procedures	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 Departure Record	2b.
c. Daily Record of Meals 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 Statements	3d.
e. Special Dietary Needs	3e.
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

## PREAPPROVAL VISIT FORM INSTRUCTIONS

### Preapproval Visits

Sponsors are required to conduct an on-site preapproval visit of each new FDCH prior to the beginning of CACFP operations. These visits must be documented and kept on file.

Provider Number:	Once an agreement number has been assigned, record the provider's agreement number.
Provider's Name and Address:	Record the provider's name and address.
Date:	Record the date of the preapproval visit.
Provider Agrees to Comply After Training:	Check if the provider agrees to comply.
Comments:	Make comments as needed.
Approval Recommended:	Check <i>Yes</i> or <i>No</i> .
Provider's Signature and Date:	The provider must sign and date the Preapproval Visit Form.
SO Representative's Signature and Date:	The SO representative who made the preapproval visit must sign and date the Preapproval Visit Form.

**NOTE:** Preapproval visits **CANNOT** be counted as annual provider training.



F. Food Service/Meal Observation		Yes/No/NA		Yes/No/NA			
1.	Meal service times as approved.	1.	<input type="checkbox"/>	6.	Special dietary needs documentation available.	6.	<input type="checkbox"/>
2.	All components served.	2.	<input type="checkbox"/>	7.	Proper milk substitute provided.	7.	<input type="checkbox"/>
3.	Required quantities served.	3.	<input type="checkbox"/>	8.	If milk substitute is provided, is it an approved	8.	<input type="checkbox"/>
4.	Plates and servings adjusted for age groups.	4.	<input type="checkbox"/>		milk substitution and is the correct documentation		<input type="checkbox"/>
5.	Meal supervision provided.	5.	<input type="checkbox"/>		available?		<input type="checkbox"/>
				9.	Proper milk type served (FF/1%).	9.	<input type="checkbox"/>
				10.	Current product formulation/Child Nutrition (CN)	10.	<input type="checkbox"/>
					label on file and available at time of review.		<input type="checkbox"/>
				11.	Is further training needed?	11.	<input type="checkbox"/>

**G. Meal Analysis for Aged 1 Through 12**

<b>Meal Observed:</b> Breakfast	A.M. Snack	Lunch	P.M. Snack	Supper	Late P.M. Snack
<b>Time Served:</b> _____					

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				
Fruit/Vegetable/Juice				
Grains/Breads				
Meat/Meat Alternate				

**H. Infant Meal Analysis**

N/A—No infants in care/participating in meal service.

<b>Meal Observed:</b> (Circle One)					
a. Breakfast	b. A.M. Snack	c. Lunch	d. P.M. Snack	e. Supper	f. Late P.M. Snack
<b>NOTE:</b> Record only infants without an Infant Meal Waiver.					

**Infant's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

Meal Component	Food Item	Quantity Served	Amount Needed	Amount + or -
Formula/Milk/Breast Milk				
Fruit/Vegetable/Juice				
Infant Cereal/Bread/Crackers				
Meat/Meat Alternate				

**Infant's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

Meal Component	Food Item	Quantity Served	Amount Needed	Amount + or -
Formula/Milk/Breast Milk				
Fruit/Vegetable/Juice				
Infant Cereal/Bread/Crackers				
Meat/Meat Alternate				

**Infant's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

Meal Component	Food Item	Quantity Served	Amount Needed	Amount + or -
Formula/Milk/Breast Milk				
Fruit/Vegetable/Juice				
Infant Cereal/Bread/Crackers				
Meat/Meat Alternate				

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

YES/NO

YES/NO

**I. License**

- 1. Current license or permit available.
- 2. License capacity: \_\_\_\_\_
- 3. Second caregiver employed? Yes/No/NA
- 4. Provider meets licensing standards.

1.	<input type="checkbox"/>
2.	<input type="checkbox"/>
3.	<input type="checkbox"/>
4.	<input type="checkbox"/>

**J. Provider's Own Children**

- 1. Provider claims own children.  
If *Yes*,
  - a. Provider's own children participating in child care.
  - b. Other enrolled children in care and participating in a meal service.
  - c. Complete and approved Family-Size and Income Application (FSIA) on file.

1.	<input type="checkbox"/>
1.	<input type="checkbox"/>
a.	<input type="checkbox"/>
b.	<input type="checkbox"/>
c.	<input type="checkbox"/>

**K. Record-Keeping Requirements**

- 1. Daily Arrival and Departure Record up-to-date.  
Date of last entry: \_\_\_\_\_
- 2. Daily Record of Meals Served form up-to-date.  
Date of last entry: \_\_\_\_\_
  - a. More than three meals per day claimed for any child.
- 3. Weekly Meals Served form up-to-date.  
Date of last entry: \_\_\_\_\_
- 4. Infant meals served under one year old claimed?
  - a. If *Yes*, infant meal pattern followed.
  - b. Provider furnishes food items, if applicable.
  - c. Infant Meals Served form maintained.  
Date of last entry: \_\_\_\_\_
  - d. Infant Meal Waiver on file.  
Yes/No/NA
- 5. Cycle Menu available.
  - a. Current cycle menu being followed.
  - b. If *No*, substitution was made.
  - c. Contains all required components.
  - d. Product formulation statement/Child Nutrition (CN) label for applicable item.
- 6. *Building for the Future* fact sheet distributed to parents.
- 7. WIC information made available to parents.
- 8. Do the enrollment records, attendance records, and meal count records reconcile for a five-day period?

1.	<input type="checkbox"/>
2.	<input type="checkbox"/>
a.	<input type="checkbox"/>
3.	<input type="checkbox"/>
4.	<input type="checkbox"/>
a.	<input type="checkbox"/>
b.	<input type="checkbox"/>
c.	<input type="checkbox"/>
d.	<input type="checkbox"/>
5.	<input type="checkbox"/>
a.	<input type="checkbox"/>
b.	<input type="checkbox"/>
c.	<input type="checkbox"/>
d.	<input type="checkbox"/>
6.	<input type="checkbox"/>
7.	<input type="checkbox"/>
8.	<input type="checkbox"/>

**L. Sanitation**

- 1. Chemicals and medicines are properly stored in a separate location.
- 2. Refrigerator's temperature: \_\_\_\_\_
- 3. Freezer's temperature: \_\_\_\_\_
- 4. Clean kitchen floors, cupboards, and equipment.
- 5. Dining surface and countertops sanitized.
- 6. Proper method of dishwashing.
- 7. Proper handwashing techniques.
- 8. Pet-free kitchen during food preparation and service.
- 9. Proper food-handling procedure followed (food storage, thawing, time, temperature)
- 10. Home maintained in a clean, sanitary, and orderly manner.

1.	<input type="checkbox"/>
2.	<input type="checkbox"/>
3.	<input type="checkbox"/>
4.	<input type="checkbox"/>
5.	<input type="checkbox"/>
6.	<input type="checkbox"/>
7.	<input type="checkbox"/>
8.	<input type="checkbox"/>
9.	<input type="checkbox"/>
10.	<input type="checkbox"/>

**M. Safety of Children**

- 1. Children are in safe environment.
- 2. Conduct of provider does not place children in imminent danger.

1.	<input type="checkbox"/>
2.	<input type="checkbox"/>

**N. Prior Review**

- 1. Were deficiencies corrected?

1.	<input type="checkbox"/>
----	--------------------------

**NOTE:** Any items, if in noncompliance, could contribute to a serious deficient status.

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

## FIVE-DAY MEAL RECONCILIATION REPORT

### Provider FDCH Attendance Record

Provider Name:	Month/Year:	Number of Operating Days/Week:					
Child's Name	Enrollment		Attendance				
	Days Attended	A.M./P.M. Time	Day 1	Day 2	Day 3	Day 4	Day 5
<b>TOTALS</b>							

### MEAL COUNTS

	Breakfast 2nd Shift <input type="checkbox"/>	AM Snack 2nd Shift <input type="checkbox"/>	Lunch 2nd Shift <input type="checkbox"/>	PM Snack 2nd Shift <input type="checkbox"/>	Supper 2nd Shift <input type="checkbox"/>	Evening Snack 2nd Shift <input type="checkbox"/>
Day 1						
Day 2						
Day 3						
Day 4						
Day 5						
<b>TOTAL</b>						



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

## On-Site Monitor Review

There are two different methods in which a sponsor may conduct reviews to comply with USDA requirements:

- a. Conduct one announced and two unannounced\* reviews of Program operations to assess compliance with meal patterns, record keeping, and other requirements, with not more than six months elapsing between reviews. Each review must include a meal analysis where children are present. All reviews must be documented and kept on file.
  
- b. An SO may do **review averaging** by conducting an average of three reviews per provider per year. If an SO conducts one unannounced review\* of a facility in a year and finds no serious deficiencies, the SO may choose not to conduct a third review of the facility that year and may make its second review announced, provided that the SO conducts an average of three reviews of all of its facilities that year and that it conducts an average of two unannounced reviews of all of its facilities that year. When the SO uses this averaging provision and a specific facility receives two reviews in one review year, its first review in the next review year must occur no more than nine months after the previous review. If choosing this method, not more than nine months can elapse between reviews and all seriously deficient providers must have at least three reviews per year. If **review averaging** is selected, the SO must have a written plan with detailed procedures for tracking review. Each review must include a meal analysis where children are present. All reviews must be documented and kept on file.

\* Sponsors must ensure that the timing of the unannounced reviews is varied in a way that would ensure they are unpredictable to the facility.

### A. General Data

1. Reviewer: Record the name(s) of the reviewer(s) or monitor(s).
2. Provider's Name: Record the FDCH provider's name.
3. Provider's Address: Record the FDCH provider's address.
4. Tier Type: Circle the appropriate tier for which the home is currently determined.
5. Unannounced or Announced: Indicate if the review is unannounced or announced.
6. Provider's Number: Record the FDCH provider's agreement number.
7. Date of Visit: Record the date of the monitor review.
8. Time of Visit: Record the time of the monitor review.
9. Review Cycle: Circle the appropriate cycle.
10. Review Type: Circle the appropriate answer to identify which review is being conducted.
11. Provider Is Home: If *No*, indicate if the sponsor was notified.

### B. Children in Attendance

1. Name: Record the first and last names of the children in attendance.
2. Age: Record the age of each child.

- 3. CACFP Enrollment on File: If the child’s annual CACFP enrollment form is on file at the provider’s home, indicate *Yes*. If not, indicate *No*.
- 4. Meal Claimed Today: Indicate *Yes* if the child will be participating in the observed meal and if the provider will claim the child’s meal. If not, indicate *No*.
- 5. CACFP Enrollment Forms Available for All Children Participating in the Current Month: Indicate *Yes* if all CACFP enrollment forms are on file for all children who have participated during the current month. If not, indicate *No*.

C. Meal Requirements

- 1. Meal Service Times: Record the approved and verified meal service time for each meal service.
- 2. Meal Served at Approved Time: Indicate with a *Yes* or *No* whether all meals are being served at their approved meal service times.
- 3. Sponsor Was Notified of a Meal Change: Indicate with a *Yes* or *No* whether the SO was notified of the provider’s change in meal service times.

D. Training

Record the date and location of the training session attended during this fiscal year. If no more training sessions will be offered this fiscal year and the provider has not attended training this fiscal year, the provider is seriously deficient.

E. Civil Rights

Observe whether or not the provider is in compliance with civil rights regulations. Circle *Yes* or *No*.

F. Meal Observation

Items 1—7: Observe the meal service, and answer each item accordingly.

G. Meal Analysis for Aged 1-12:  
Meal Observed:

Circle the appropriate meal which is being observed.

Time Served: Record the time the meal was actually served.

Children Served by Age:

- 1 through 2 years: Record how many children in this age group participated in the meal service.
- 3 through 5 years: Record how many children in this age group participated in the meal service.
- 6 through 12 years: Record how many children in this age group participated in the meal service.
- Total Children: Record how many total claimable children participated in the meal service.
- Nonclaimable Children Served: Record how many nonclaimable children participated in the meal service. This could be, but is not limited to, children over the license capacity; children who have already participated in three meal services during the day; children who are not served a reimbursable meal, etc.

Components and Quantities:

In the appropriate box, record the food item, quantity served, amount needed, and the difference in the amount needed and the amount served. (Be specific.)

H. Infant Meal Analysis

Meal Observed: Circle the appropriate meal that is being observed.

NA: Check if no infants are in care on day of visit.

Infants Served by Age:

Birth through 3 months

4 through 7 months

8 to 12 months

Record the number of infants in the appropriate age group who are participating in the meal service.

Each Infant's Analysis:

Record each infant who is participating in the meal by his or her name and age. In the appropriate box, record the food item, quantity served, amount needed, and the difference between the amount needed and the amount served. (Be specific.)

I—N: Read each statement, and answer each item accordingly.

O. Review Summary Record all areas which require corrective action. Make appropriate comments and recommendations.

P. Provider Is in Compliance/Noncompliance:

Check the appropriate box. If any items with an asterisk indicates a *No* answer, the provider is seriously deficient.

Provider Is Seriously Deficient: Circle the appropriate response.

Unannounced Follow-Up Visit: Circle *Yes* if a follow-up is required to view that corrective action has taken place. Circle *No* if no areas of noncompliance have been noted. A follow-up visit is not necessary. If the answer is *Yes*, then documentation must be available to show that a follow-up visit was made. **NOTE:** A follow-up visit does not count as a second monitor review. The follow-up visit must be unannounced.

Provider Signature and Date: The provider must sign and date the On-Site Monitor Review form.

Reviewer Signature and Date: The reviewer must sign and date the On-Site Monitor Review form.

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

**Provider's Name:** \_\_\_\_\_

**CHILD'S INFORMATION**

1. Child's Name: _____	Date of Birth: _____														
2. Normal Days in Attendance:	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center; font-size: 8px;">SUN</td><td style="text-align: center; font-size: 8px;">MON</td><td style="text-align: center; font-size: 8px;">TUE</td><td style="text-align: center; font-size: 8px;">WED</td><td style="text-align: center; font-size: 8px;">THU</td><td style="text-align: center; font-size: 8px;">FRI</td><td style="text-align: center; font-size: 8px;">SAT</td></tr></table>								SUN	MON	TUE	WED	THU	FRI	SAT
SUN	MON	TUE	WED	THU	FRI	SAT									
3. School Age—Hours Attend															
A.M. <input type="checkbox"/>	P.M. <input type="checkbox"/>	All Day <input type="checkbox"/>													
4. <b>Special Dietary Needs*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No															
5. Normal Hours of Attendance: _____ to: _____ <span style="font-size: 8px; margin-left: 100px;">a.m./p.m.</span> <span style="margin-left: 100px;">a.m./p.m.</span>															
6. Normal Meals Eaten:															
<input type="checkbox"/> Breakfast	<input type="checkbox"/> Lunch	<input type="checkbox"/> Supper													
<input type="checkbox"/> A.M. Snack	<input type="checkbox"/> P.M. Snack	<input type="checkbox"/> Late P.M. Snack													
7. Signature of Parent/Guardian: _____ Date: _____															

\*Attach signed medical statement.

**PARENT'S INFORMATION**

Name of Parent/Guardian: _____		
Address: _____	City: _____	Zip: _____
Home Telephone Number: _____		

**RENEWAL UPDATES**

If there are no changes to the above information, sign and date. If there are changes, a new enrollment form must be completed, signed, and dated.

**Parent/Guardian Signature**

**Date**

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**Drop Date:** \_\_\_\_\_

## **ANNUAL CACFP ENROLLMENT FORM INSTRUCTIONS**

This form must be completed *ANNUALLY* for every child enrolled. Complete in duplicate. One copy must be retained in the provider's home, and one copy must be retained at the SO's office.

### **CHILD'S INFORMATION**

- Name of Provider: Record the name of the provider.
- Provider Number: Record the provider agreement number.
- Child's Name and Date of Birth: Record the name and date of birth of the child being enrolled. Use one enrollment form per child.
- Normal Days in Attendance: Check appropriate days child is in attendance.
- Normal Hours of Attendance: Record hours the child is in attendance.
- Special Dietary Needs: Check appropriate box. If *Yes*, attach a signed medical statement.
- Normal Meals Provided: Check meals served to the child.

### **PARENT'S INFORMATION**

- Name of Parent/Guardian, Address, and Home Telephone Number: Record the name of the child's parent or guardian, address, and home telephone number.
- Parent's or Guardian's Signature and Date: Have the parent or guardian sign the form.
- Date Child Dropped: Record the date the child drops from the FDCH.

**NOTE:** Enrollment forms are valid for 12 months. It is the sponsor's decision to obtain enrollment forms according to the federal fiscal year (October 1 through September 30) or alternate dates.

## MEDICAL STATEMENT

**Part I** (to be filled out by *institution or parent/guardian*)

Name of Student: \_\_\_\_\_ Age: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

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

**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):

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List food(s) to be omitted from diet:

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List food(s) that may be substituted (diet plan):

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Additional information:

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\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Licensed Physician, Physician's  
Assistant, or Nurse Practitioner

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

## **EXCEPTIONS FOR SPECIAL DIETARY NEEDS**

Documentation must be on file and available for individual participants who are unable, because of medical or other special dietary needs, to consume certain foods. Substitutions due to medical needs shall be supported by a statement from a recognized licensed physician, physician's assistant, or nurse practitioner and should include recommended alternate foods. If a medical statement is not available, meals lacking the required components/quantities cannot be claimed for reimbursement.

The facility must provide all required food components for the meals served in order to claim reimbursement. This includes any substitutions made to a meal served to a child with special dietary needs unless supported by the medical statement.

Facilities may consider ethnic and religious preferences when requested by a household. Food substitutions may be made, if requested by parents/guardians. Food items substituted must be a creditable item from the same food component if the meal is claimed for reimbursement. Variations on an experimental or continuing basis in the food components must have written approval from the United States Department of Agriculture (USDA).

## MILK SUBSTITUTION REQUEST

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_

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

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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 Nutritional 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 222 mg
- Phosphorus 349 mg
- Riboflavin 0.44 mg
- Vitamin B-12 1.1 mg

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 remain unchanged.

**DAILY ARRIVAL AND DEPARTURE RECORD**

Name of Provider: \_\_\_\_\_ Provider Number: \_\_\_\_\_ Month and Year: \_\_\_\_\_

DATE	CHILDREN'S NAMES									
	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
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30										
31										

## **DAILY ARRIVAL AND DEPARTURE RECORD INSTRUCTIONS**

- Name of Provider: Record the name of the FDCH provider.
- Provider Number: Record the provider agreement number.
- Month and Year: Record the current month and year.
- Time In/Time Out: Record the actual time the child arrived at the FDCH and the actual time the child left the FDCH for each day that he or she attended.



## **DAILY RECORD OF MEALS SERVED INSTRUCTIONS**

- Provider's Name: Record the provider's name.
- Provider's Number: Record the provider's number.
- Month and Year: Record the current month and year.
- Names of Children and Age: Record each child's name and age.
- Type of Meal: Place a mark each day for every meal being claimed for reimbursement. **NOTE:** No more than three meals per day per child may be claimed for reimbursement.

***SPONSORING ORGANIZATION ONLY:***

- Tier: (The sponsoring organization must fill in this section.) Record the child's tier determination, which has been identified by the sponsor.
  - Breakfast, Lunch, Supper, and Snack: Total all breakfasts for each child for the month. Total all lunches for each child for the month. Total all suppers for each child for the month. Total all snacks for each child for the month.
  - Total Meal Counts: (This must be filled in by the sponsoring organization.) Total all Tier I breakfasts, lunches, suppers, and snacks. Total all Tier II-Higher breakfasts, lunches, suppers, and snacks. Total all Tier II-Lower breakfasts, lunches, suppers, and snacks. Total all breakfasts (Tier I, II-H, and II-L), lunches (Tier I, II-H, and II-L), suppers (Tier I, II-H, II-L), and snacks (Tier I, II-H, and II-L).
- Signature of Provider: The provider must sign the FDCH Daily Record of Meals Served.

## WEEKLY MEALS SERVED

Provider's Name: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Month: \_\_\_\_\_ Provider Number: \_\_\_\_\_

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
	1/2 cup	3/4 cup	1/2 cup	1/2 serving**	1/2 cup	1/2 cup							
<b>BREAKFAST</b>													
Fluid milk*	1/2 cup	3/4 cup	1/2 cup	1/2 serving**	1 cup								
Vegetables, fruits, or juices	1/4 cup	1/2 cup	1/2 serving**		1/2 cup								
Bread and/or bread alternate	1/2 serving**				1 serving**								
Meat/meat alternate (optional)													
<b>LUNCH</b>													
Fluid milk*	1/2 cup	3/4 cup	1 cup		1 cup								
Meat and/or meat alternate	1 oz**	1 1/2 oz**	2 oz**		2 oz**								
Vegetables, fruits, or juices	1/4 cup Total	1/2 cup Total	3/4 cup Total		3/4 cup Total								
Bread and/or bread alternate	1/2 serving**	1/2 serving**	1 serving**		1 serving**								
Other													
<b>SUPPER</b>													
Fluid milk*	1/2 cup	3/4 cup	1 cup		1 cup								
Meat and/or meat alternate	1 oz**	1 1/2 oz**	2 oz**		2 oz**								
Vegetables, fruits, or juices	1/4 cup Total	1/2 cup Total	3/4 cup Total		3/4 cup Total								
Bread and/or bread alternate	1/2 serving**	1/2 serving**	1 serving**		1 serving**								
<b>SNACKS</b>													
(Choose 2 of these 4)							A.M.						
Fluid milk*	1/2 cup	1/2 cup	1 cup		1 cup								
Vegetables, fruits, or juices	1/2 cup	1/2 cup	3/4 cup		3/4 cup								
Bread and/or bread alternate	1/2 serving**	1/2 serving**	1 serving**		1 serving**								
Meat and/or meat alternate	1/2 oz**	1/2 oz**	1 oz**		1 oz**								

\*Milk offered must be fat-free or lowfat (1%).

\*\*Or an equivalent quantity of alternate(s).

## **WEEKLY MEALS SERVED INSTRUCTIONS**

- Record food items served to children at each meal service.
- Provider's Name and Agreement Number: Record the FDCH provider's name and agreement number.
- Record the dates from the beginning of the week to the end of the week.
- Menu Number and Date: Record the cycle menu number (if applicable) and date of the meal.

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

## INFANT MEAL WAIVER INSTRUCTIONS

Infants who are enrolled for child care must have access to CACFP meals. Meals served to infants from birth up to eight months that contain only iron-fortified formula provided by the parent or caregiver or bottled breast milk provided by the **PARENT** may be claimed for reimbursement. To receive reimbursement, the caregiver must always offer a complete developmentally appropriate meal. Infants 8 to 12 months must be served the additional required items at breakfast and lunch that are provided by the caregiver.

If a parent or guardian does not want his or her child to participate in the CACFP, an *Infant Meal Waiver* form must be completed and on file for each infant. The provider will not be able to claim the infant meals for reimbursement. The sponsor, as well as the provider, must have the Infant Meal Waiver on file.

- Record the infant's first and last names.
- Record the infant's birth date.
- Parent/guardian must sign waiver.
- Record the date the parent/guardian signs.

**NOTE:** If a parent/guardian wishes for his or her infant to participate in CACFP infant meals at a later date, annotate at bottom of form the date in which this change is to occur.

# INFANT MEALS SERVED

Infant's Name: \_\_\_\_\_ Age: \_\_\_\_\_

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

	BREAKFAST	BREAKFAST	BREAKFAST	BREAKFAST	BREAKFAST	BREAKFAST
<b>BREAKFAST</b>  <b>BIRTH THROUGH 3 MONTHS</b> 4-6 fluid oz breast milk <sup>2,3</sup> or formula <sup>1</sup>  <b>4 THROUGH 7 MONTHS</b> 4-8 fluid oz breast milk <sup>2,3</sup> or formula <sup>1</sup> 0-3 Tbsp infant cereal <sup>1,4</sup>  <b>8 THROUGH 11 MONTHS</b> 6-8 fluid oz breast milk <sup>2,3</sup> or formula <sup>1</sup> 2-4 Tbsp infant cereal <sup>1</sup> 1-4 Tbsp fruit and/or vegetable	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH
	LUNCH/SUPPER	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH
	<b>BIRTH THROUGH 3 MONTHS</b> 4-6 fluid oz breast milk <sup>2,3</sup> or formula <sup>1</sup>  <b>4 THROUGH 7 MONTHS</b> 4-8 fluid oz breast milk <sup>2,3</sup> or formula <sup>1</sup> 0-3 Tbsp infant cereal <sup>1,4</sup> 0-3 Tbsp fruit and/or vegetable <sup>4</sup>  <b>8 THROUGH 11 MONTHS</b> 6-8 fluid oz breast milk <sup>2,3</sup> or formula <sup>1</sup> 1-4 Tbsp fruit and/or vegetable AND AT LEAST ONE OF THE FOLLOWING: 2-4 Tbsp infant cereal <sup>1</sup> 1-4 Tbsp meat, fish, poultry, egg yolk, or cooked dry beans or peas 1 1/2-2 oz cheese 1-4 oz (volume) cottage cheese 1-4 oz (weight) cheese food or cheese spread	SUPPER	SUPPER	SUPPER	SUPPER	SUPPER
<b>SNACK</b>  <b>BIRTH THROUGH 3 MONTHS</b> 4-6 fluid oz breast milk <sup>2,3</sup> or formula <sup>1</sup>  <b>4 THROUGH 7 MONTHS</b> 4-6 fluid oz breast milk <sup>2,3</sup> or formula <sup>1</sup>  <b>8 THROUGH 11 MONTHS</b> 2-4 fluid oz breast milk <sup>2,3</sup> or formula <sup>1</sup> or fruit juice <sup>5</sup> 0-1/2 serving bread <sup>6,9</sup> or 0-2 crackers <sup>8,6</sup>	A.M. SNACK	A.M. SNACK	A.M. SNACK	A.M. SNACK	A.M. SNACK	A.M. SNACK
	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

**NOTE:** Record the food items served to each infant at each meal service. *Indicate food items provided by the parent with an asterisk (\*).*

1 Infant formula and dry infant cereal shall be iron-fortified.  
 2 It is recommended that breast milk be served in place of formula from birth through 11 months.  
 3 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.  
 4 A serving of this component shall be optional.  
 5 Fruit juice shall be full-strength.  
 6 Bread and bread alternates shall be made from whole-grain or enriched meal or flour.  
 9 **Note:** Do not serve honey or use it in food served to infants under one year old.

## **INFANT MEALS SERVED INSTRUCTIONS**

1. Infant's Name and Age: Record the infant's name and age.
2. Record the food items served to each infant at each meal service. Indicate food items provided by the parent with an asterisk (\*).
3. Date: Record the date of each meal.
4. Meals Served: Record food items served to each infant at each meal service.

Refer to the Infant Meal Pattern Requirements Section for further information.

# 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 more than 2.6 million 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 four groups)
Milk* Fruit or Vegetable Grains or Bread	Milk* Meat or Meat Alternate Grains or Breads Two different servings of fruits or vegetables	Milk* Meat or Meat Alternate Grains or Breads Fruit or Vegetable

*\*Note: Milk served to children aged 2 or above must be 1% or fat-free.*

## 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

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

USDA is an equal opportunity provider and employer.

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

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

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

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

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

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

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

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

### II. Alternate Protein Product (APP)

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

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

\*Percent of protein As-Is is provided on the attached APP documentation.

\*\*18 is the percent of protein when fully hydrated.

\*\*\*Creditable amount of APP equals ounces of dry APP multiplied by the percent of protein as-is divided by 18.

<sup>1</sup> Total Creditable Amount must be rounded **DOWN** to the nearest 0.25 oz (1.49 would round down to 1.25 oz meat equivalent). Do **NOT** round up. If you are crediting both M/MA and APP, you do not need to round down in Box A until after you have added the creditable APP amount from Box B.

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

Total creditable amount of product (per portion): \_\_\_\_\_

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

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

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

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

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

## ATTACHMENT A

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

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

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

All of the above information is required for APP.

## Reviewer Checklist for Evaluating Manufacturer-Completed Product Formulation Statements for Meat/Meat Alternate (M/MA) Products and Alternate Protein Product Products

<b>Circle Y or N</b>	<b>Steps for Evaluation Page 1</b>
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### GENERAL INFORMATION

Y	N	A copy of the product label is attached.  The label should have the product name, ingredients statement, net weight, manufacturer/distributor name and address, and for meat/poultry products, an inspection legend. The Nutrition Facts panel is voluntary for institutional product labels unless a nutrition or health claim is made.
Y	N	Product Name is provided and matches the name on the product label.
Y	N	Product Code Number is provided and matches the code number on the product label.
Y	N	Manufacturer name is provided.
Y	N	Case/pack/count/portion/size are included as applicable.

### MEAT/MEAT ALTERNATE

Y	N	I have my copy of the Food-Buying Guide for Child Nutrition Programs (FBG), and it has the written in corrections as noted in the Pen and Ink Changes document provided by FNS.  Available at < <a href="http://teammnutrition.usda.gov/Resources/foodbuyingguide.html">http://teammnutrition.usda.gov/Resources/foodbuyingguide.html</a> >
Y	N	The food items in Section 1. Meat/Meat Alternate match a description in Column 1 (Food As Purchased) of the FBG.  Example: <i>Beans, Kidney, dry</i> matches a description in Column 1 of the FBG, but <i>Kidney Beans</i> does not match a description in Column 1 of the FBG (you do not know if the kidney beans are dry, canned, or frozen).
Y	N	The description does not match Column 1, but it does match a description in Column 4 (Serving Size Per Meal Contribution) or Column 6 (Additional Information) of the FBG.  If the answer is Y, then you will need to convert the yield data from Column 6.

<b>Circle Y or N</b>	<b>Steps for Evaluation Page 2</b>
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**MEAT/MEAT ALTERNATE continued**

Y	N	<p>The FBG Yield (servings per purchase unit) provided aligns with the correct description in Column 1, the description of how the food is served in Column 4, and the correct unit for the serving size in Column 4 to provide answers in units of 1 ounce. For meat/poultry, use the percent yield in Column 6.</p> <p>Example 1: A burrito is being evaluated. <i>Kidney beans, dry, canned, whole (pages 1 through 7, FBG)</i> matches a description in Column 1, the product is served heated which matches a description as served in Column 4; therefore, the FBG yield that should be used is 38.9 1/4-cups heated beans for 108 oz No. 10 can (38.9/108). The yield for drained beans (which is unheated) should not be used. For dry beans/legumes/peas/lentils, keep in mind that 1/4 cup cooked, drained beans/legumes/peas/lentils is equivalent to 1.0 oz meat alternate.</p> <p>Example 2: A sandwich is being evaluated. <i>Peanut butter (pages 1 through 40, FBG)</i> matches a description in Column 1, and 2 Tbsp (1 oz meat alternate) matches the unit we want our answer in. For this example, there are three acceptable yield ratios: (1) 97.5 1-oz servings per 108 oz, (2) 28.8 1-oz servings per 28 oz, or (3) 14.4 1-oz servings per 16 oz. When purchase units are 1 lb, always use 16 oz in the yield ratio. Do not use the yield ratios for 3 Tbsp peanut butter, since this will put the answer in units of 1 1/2 oz.</p> <p>Example 3: A chicken patty is being evaluated. <i>Chicken, boneless, raw (pages 1 through 31, FBG)</i> matches a description in Column 1, cooked matches a description in Column 4. The yield in Column 6 is 70 percent (you will multiply using the decimal form which is 0.70).</p>
Y	N	<p>The answer provided in the Creditable Amount column for each separate ingredient has been verified using a calculator, and the answer was not rounded up.</p>
Y	N	<p>The total creditable amount for the meat/meat alternate section, Total A, is correct, and the answer was not rounded up.</p>
Y	N	<p>All of the creditable ingredients listed on the form match ingredients listed in the ingredients statement on the product label.</p> <p>Example: It is not acceptable for the documentation to list <i>ground beef (not more than 30 percent fat)</i> if the label only lists <i>beef</i>. This means that the manufacturer does not have to actually use ground beef (not more than 30 percent fat), but can use any type of beef. <i>Beef</i> is not creditable since there is no one single FBG yield that can cover all beef items. Because the correct description is not on the label, the product cannot be accepted with the documentation.</p>

<b>Circle Y or N</b>	<b>Steps for Evaluation Page 3</b>
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**ALTERNATE PROTEIN PRODUCT (APP)**

Y	N	<p>The APPs listed are single ingredients such as soy flour, soy protein concentrate, soy protein isolate, whey protein concentrate, and nonfat dry milk.</p> <p>Examples of ingredients that do not meet the APP requirements are: wheat proteins, tofu, surimi, soy burgers, soy crumbles.</p>
Y	N	<p>The product itself is an entrée item or an integral part of an entrée item.</p> <p>Example: entrée items <b>ARE</b> sandwich patties, meat fillings or crumbles, pizzas, burritos, etc. Entrée items are <b>NOT</b> drinks, smoothies, desserts, muffins, cakes, protein bars, bread, chips, etc.</p>
		<b>Documentation (Refer to Attachment A)</b>
Y	N	<p>The APP documentation is on letterhead of the manufacturer that actually makes the APP.</p> <p>Documentation should not be accepted on distributor letterhead or from the food company making your purchased product (except in the rare case that the food company making the finished product actually manufactures the APP itself).</p>
Y	N	a. The documentation states that the APP meets requirements found in 7 CFR Parts 210, 220, 225, and 226.
Y	N	b. The documentation indicates that nonprotein constituents have been removed.
Y	N	<p>c. The PDCAAS (Protein Corrected Amino Acid Score) is provided, and the score is greater than 0.80 (80).</p> <p>The PDCAAS score should be provided in decimal form (i.e., 0.92), but sometimes the PDCAAS is reported as a whole number (i.e., 92) instead. If the PDCAAS is less than 0.8 (80), then the product does not meet the protein quality requirements and cannot be used for credit even if the percent as-is protein is greater than 18 percent.</p>
Y	N	<p>d. The hydration ratio is provided in the documentation and was calculated correctly (percent protein as-is divided by 18) minus 1 part dry APP = parts water).</p> <p>Example: if the percent as-is protein is 64.8, the calculation is as follows: <math>[(64.8 \div 18) - 1 \text{ part dry APP}] = 2.6 \text{ parts water to hydrate the product down to 18 percent protein. The ratio of dry APP:water for this example will be 1:2.6.}</math></p>
Y	N	<p>e. The percent protein is provided on an as-is basis and is greater than 18 percent.</p> <p>If the documentation states MFB or moisture-free basis—you cannot use this protein value. The as-is protein value must be used in calculating the meat alternate credit for APP.</p>

<b>Circle Y or N</b>	<b>Steps for Evaluation Page 4</b>
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**ALTERNATE PROTEIN PRODUCT (APP) continued**

<b>Y</b>	<b>N</b>	APP documentation meeting all of the above requirements is provided for each separate APP listed on the product analysis form.
		<b>Check the Calculation for Each APP Ingredient Used</b>
<b>Y</b>	<b>N</b>	The whole number percent protein (not the decimal form of the percent) is used in the calculation.  Example: If the percent as-is protein is 64.8 percent, use 64.8 in the calculation, not 0.648.
<b>Y</b>	<b>N</b>	The answer for each separate APP calculation is correct and was not rounded up.
<b>Y</b>	<b>N</b>	The amount of credit from APP, Total B, is correct and was not rounded up.
		<b>TOTAL CREDITABLE AMOUNT</b>
<b>Y</b>	<b>N</b>	The sum of Total A (meat/meat alternate) plus Total B (APP credit) is correct and was not rounded up.
<b>Y</b>	<b>N</b>	The total weight per portion of the product is provided and matches portion information provided on the label.
<b>Y</b>	<b>N</b>	The total credit is rounded down to the nearest 0.25 ounce.
<b>Y</b>	<b>N</b>	The Total Creditable Amount is not greater than the total weight of the portion of the product. (The credit may be equal to or less than the portion weight served.)  When using APP with high concentrations of protein, sometimes the calculation provides an answer that is greater than the weight of the product served; in this case, you must reduce the credit so that it is equal or less than the weight of the product served.  Example: if a soy burger uses soy isolate and whey protein concentrate and the weight of the heated burger weighs 1.75 oz, but the calculations show a total of 2.3 oz meat alternate, you can only count a maximum of 1.75 oz meat alternate for the burger because that is the weight of the meat alternate food being served.
		<b>AUTHORIZATION INFORMATION</b>
<b>Y</b>	<b>N</b>	The phone number was called, and the number is valid for the company that manufactures the food product purchased; it is the correct contact number for the name of the person who signed the documentation.  Ask for clarifications if needed.
<b>Y</b>	<b>N</b>	Overall—the product formulation statement is acceptable without further information.  <i>Do not accept products that do not have acceptable documentation.</i>

(Place information on company letterhead with signature of a legally authorized representative of the company.)

**PRODUCT FORMULATION STATEMENT  
FOR PREPARED GRAINS/BREADS**

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

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

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

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

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

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

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TELEPHONE NUMBER

\*For crediting as a Grains/Breads component, FNS Child Nutrition Programs require (1) all grains/breads items must be enriched or whole grain, made from enriched or whole-grain flour. If using a cereal, it must be whole grain, enriched, or fortified. Bran and germ are credited the same as enriched or whole-grain meal or flour; (2) the exact or minimum amount of creditable grains must be documented to assure that 14.75 grams of creditable grains equals one grains/breads serving. Grains/breads may be credited in 1/4-serving increments. See FNS Instruction 783-1, Rev. 2, to equal 1 serving Grains/Breads or FNS Food-Buying Guide, revised November 2001.

**PRODUCT FORMULATION STATEMENT  
FOR PREPARED FRUIT/VEGETABLE**

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

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

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

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

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

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TELEPHONE NUMBER

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

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

# 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  Evening 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

## **HOUSEHOLD CONTACT SYSTEM FOR SPONSORING ORGANIZATIONS**

Whenever fraud is suspected and cannot be proven otherwise, the sponsoring organization (SO) will implement the household contact system. If the SO or the monitor suspects at any time that the provider is cheating but records indicate compliance, the monitor will complete a household contact form on each household enrolled in the day care home.

Household contacts will consist of sending a form to **EVERY** household with a child attending the provider who is in question. The SO or the monitor will complete the forms using the records of the provider. The form will have an area for the SO or the monitor to enter the provider's name and number while the remaining requested information is to be completed by the parent/guardian of the enrolled child. The form will explain to the parents that the provider where their child is in attendance is being reviewed and their response would be appreciated.

Once the SO or the monitor completes the forms with the provider's information, the forms will be submitted to the SO for follow-through. The SO will make envelope labels for each form and mail the envelopes to the parents. Each envelope will contain a self-addressed, stamped envelope to the SO to encourage the parents to respond. The SO will log when the household contacts were sent out and log the responses when any are returned. The parents will be able to call the SO should there be any questions. The SO must receive at least **two negative** responses before further action is taken against the provider.

If the SO receives two or more negative responses, the SO will prepare a letter that will declare the provider seriously deficient. The only sufficient corrective action would be documentation that proved the household contact was invalid. The sponsor will allow only 48 hours for corrective action. At the end of 48 hours, if the provider did not present sufficient corrective action, the sponsor will propose the provider for termination and disqualification from the Child and Adult Care Food Program (CACFP). The appeal procedures will be enclosed. The SO will log the seriously deficient status. If the provider does not appeal, the SO will send a termination/disqualification letter to the provider, logging the dates of the termination/disqualification. The State Department of Education (the *State Agency*) will receive copies of all letters when the termination/disqualification is complete. The State Agency, in turn, will send the Report of Disqualification From Participation form to the United States Department of Agriculture (USDA).



**TIER I PROVIDERS BASED ON SNAP ELIGIBILITY  
INSTRUCTIONS**

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

**CHILD AND ADULT CARE FOOD PROGRAM (CACFP)  
REPORT OF DISQUALIFICATION FROM PARTICIPATION  
FAMILY DAY CARE HOME (FDCH) PROVIDER**

State Agency Imposing Disqualification: Oklahoma State Department of Education

Name of Provider: Last Name: \_\_\_\_\_ First Name/M.I.: \_\_\_\_\_

Also Known As (AKA): \_\_\_\_\_

Address of Provider: \_\_\_\_\_

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

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

Has the PROVIDER failed to repay debts owed under the Program? Yes  No

Sponsoring Organization (SO) Name: \_\_\_\_\_

Sponsoring Organization Address: \_\_\_\_\_

Reason(s) for Disqualification: (Check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Submission of false information on application    | <input type="checkbox"/> Failure to keep required records  |
| <input type="checkbox"/> Submission of false claims for reimbursement      | <input type="checkbox"/> Conduct or conditions that threaten the health or safety of children in care or the public health or safety   |
| <input type="checkbox"/> Simultaneous participation under more than one SO | <input type="checkbox"/> A determination that the family day care home (FDCH) has been convicted of any activity that occurred during the past 7 years and that indicated a lack of business integrity |
| <input type="checkbox"/> Noncompliance with the program meal pattern       | <input type="checkbox"/> Any other circumstance related to nonperformance under the SO-FDCH agreement, as specified by the SO or the State Agency  |

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

\_\_\_\_\_

\_\_\_\_\_