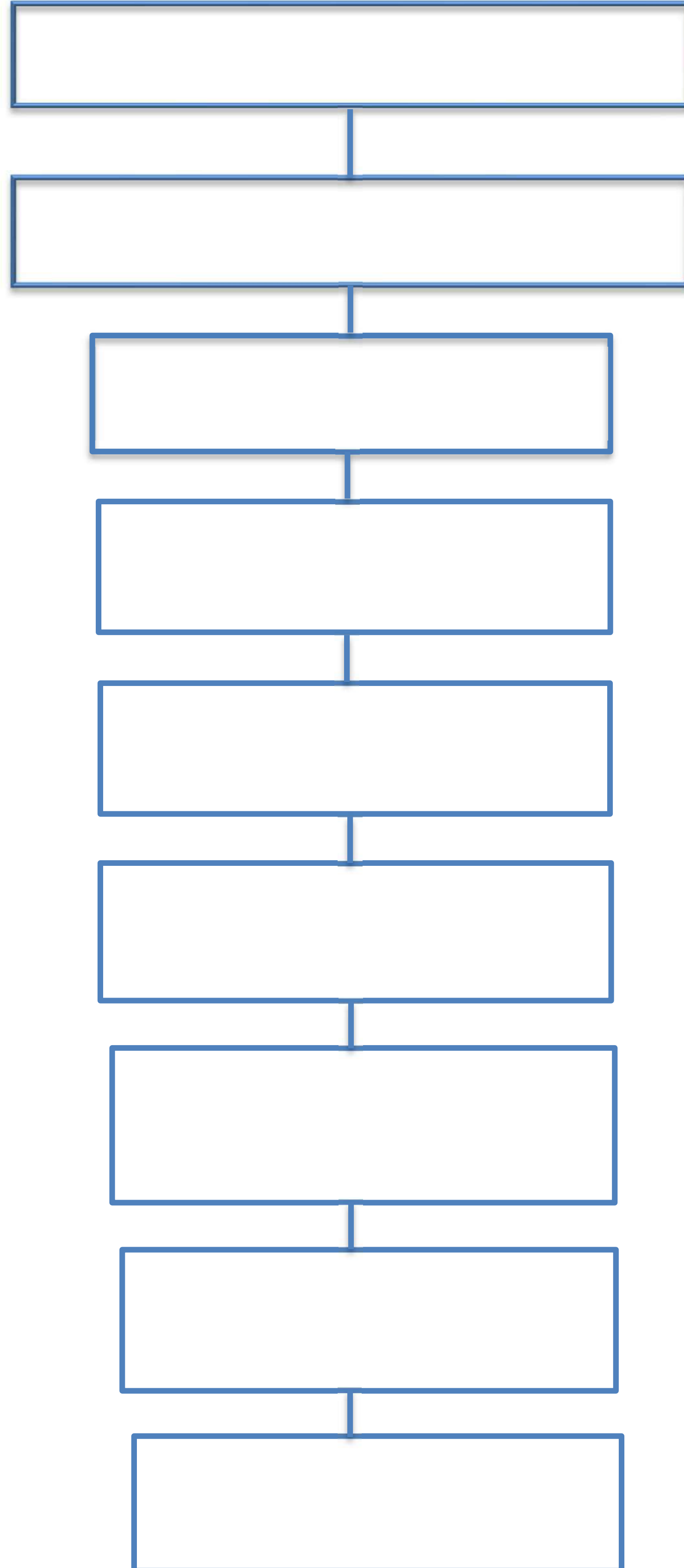
ADULT DAY CARE ORIGINALS

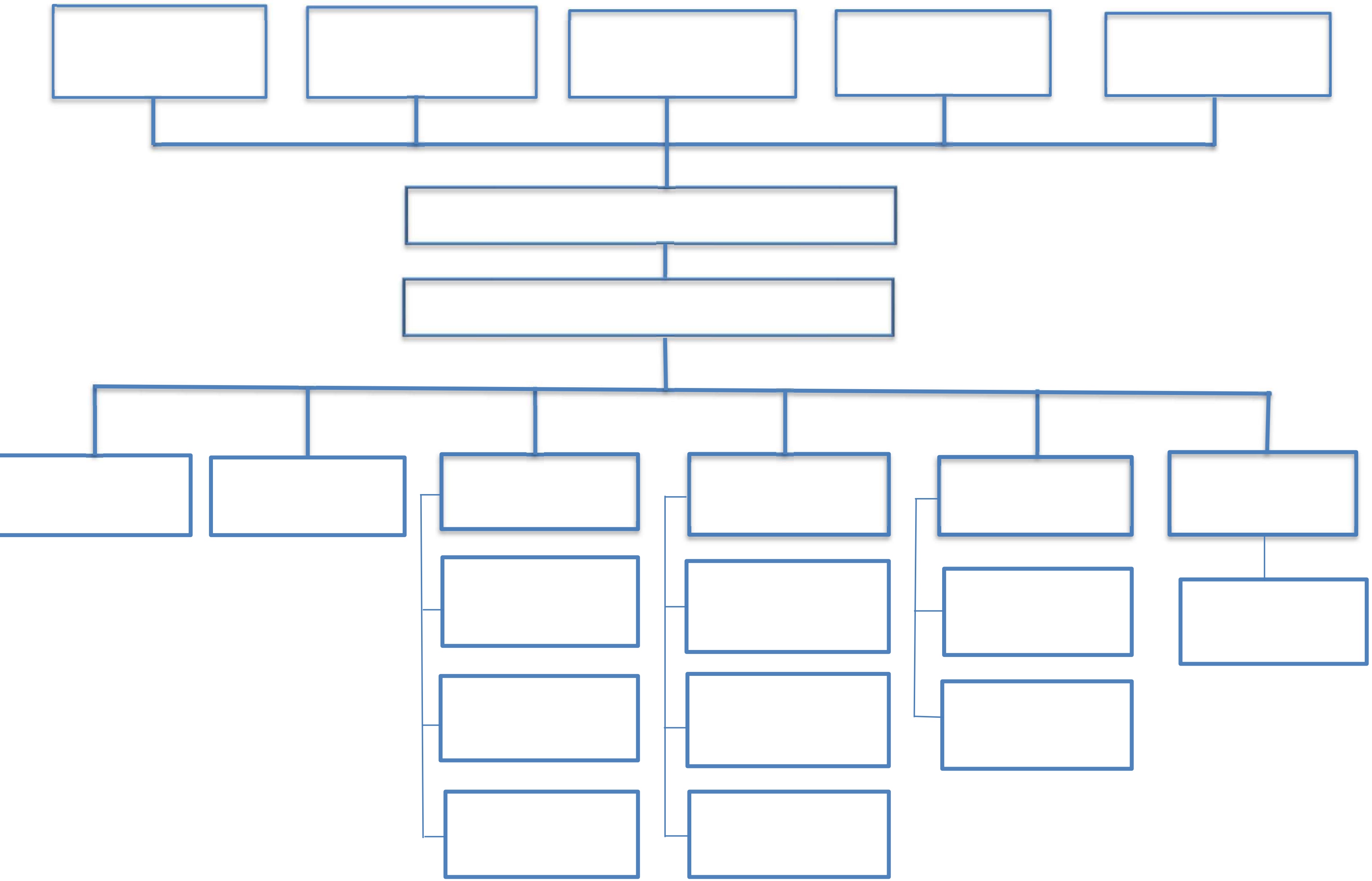
_____________________________ **Organizational Chart**

Name of Institution



Organizational Chart

Name of Institution



FOOD-PURCHASING FORM

(To Be Completed for Each Purchase)

Store Name/Vendor*: ______________________________ Center: __________________________ Date: ___________

Attach original receipt containing name of store and date of purchase. Check #: _________

FOOD AND MILK					**FOOD-RELATED SUPPLIES**				
# of Units	Unit Size	Items Used to Prepare Required CACFP Meals	Unit $ Cost	Total $ Cost	# of Units	Unit Size	Nonedible Items Used in Kitchen and Dining Areas: i.e., Paper Products, Cleaning Supplies	Unit $ Cost	Total $ Cost
							Food-Related Subtotal		
							Food-Related Tax		
							Total Food-Related Supplies		
					# of Units	Unit Size	**Nonreimbursable Items**	Unit $ Cost	Total $ Cost
		Food and Milk Subtotal			(Local Tax Rate =)		Nonreimbursable Subtotal		
		Food and Milk Tax					Nonreimbursable Tax		
		Total Food and Milk					Total Nonreimbursable Items		

* If you purchase from a food vendor or other delivery service, you may be provided with an itemized receipt and usage of this form may not be necessary. Check with your specialist.

Summary of Costs	
Total Food and Milk	$
Total Food-Related Supplies	
Total Nonreimbursable Items	
Grand Total (Must Agree With Receipt)	$

Form completed by: ____________________________

Maintain in institution records.

EXPENDITURE/REIMBURSEMENT WORKSHEET

INDEPENDENT CENTERS OR SITES UNDER A SPONSOR

Month: ____________________ Year: ________________

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

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

(15) Reimbursement Received $ ____________________

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

Form completed by: ______________________________

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

END OF THE YEAR REPORT

Institution Name: ______________________ Year: ________ Fiscal Months: ______________

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

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

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

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

MILK SUBSTITUTION REQUEST

Participant's Name:	Age:

The enrolled participant cannot consume milk for the following reason(s):

Signature of Parent/Guardian:	Date:

INSTITUTION APPROVAL: Signature:	Date:

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

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

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

MEDICAL STATEMENT

Part I (to be filled out by *institution or parent/guardian)*	
Name of Participant:	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):
List food(s) to be omitted from diet:
List food(s) that may be substituted (diet plan):
Additional information:

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

Date	Signature of State-Recognized Medical Authority
	Telephone Number

LETTER TO THE HOUSEHOLD

Dear Guardian:

The Child and Adult Care Food Program (CACFP) offers meal reimbursements to adult day care facilities that provide structured comprehensive services to nonresidential adults who are functionally impaired or aged 60 and older. By completing the attached Family-Size and Income Application (FSIA), the centers will be able to receive reimbursement that is based on the number of enrolled participants who are eligible for free or reduced-price meals.

1. **Do I need to fill out an FSIA for each adult in day care?** You may complete and submit one FSIA for the adults enrolled in day care in your household ***ONLY*** if they are enrolled in the same center. We cannot approve an FSIA that is not complete, so be sure to read the instructions carefully and fill out all required information. ***Return the completed FSIA to: (Name of Center)*** ________________________________, ***(Address)*** ___________________________________ , ***(Phone Number)*** _____________________ .

2. **Who can get free meals?** Adults in households getting Supplemental Nutrition Assistance Program (SNAP), Food Distribution Program on Indian Reservations (FDPIR), Social Security Income (SSI), or Medicaid can get free meals. Adults in households participating in Women Infants and Children (WIC) ***MAY*** be eligible for free meals.

3. **Who can get reduced-price meals?** Adults can get low-cost meals if your household income is within the reduced-price limits on the Income-Eligibility Guidelines, shown on this application. Adults in households participating in WIC ***MAY*** be eligible for reduced-price meals.

4. **May I fill out an FSIA if someone in my household is not a United States (U.S.) citizen?** Yes. You or the adult in your care do not have to be U.S. citizens to qualify for meal benefits offered at the center.

5. **Who should I include as members of my household?** You must only include your spouse and your dependents who share income and expenses.

6. **How do I report income information and changes in employment status?** The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income-Eligibility Guidelines, the adult day care center will receive a higher level of reimbursement. Once properly approved for free or reduced-price benefits, whether through income or by providing a current SNAP or FDPIR case number or an SSI or Medicaid assistance number, you will remain eligible for those benefits for the current fiscal year. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income during the period of unemployment causes your household income to be within the eligibility standards.

7. **What if my income is not always the same?** List the amount that you normally get. For example, if you normally get $1000 each month but you missed some work last month and only got $900, put down that you get $1000 per month. If you normally get overtime, include it, but not if you only get it sometimes. If you have lost a job or had your hours or wages reduced, use your current income.

8. **We are in the military; do we include our housing and supplemental allowance as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

This institution is an equal opportunity provider.

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

Sincerely,

(Signature) ______________________

INSTRUCTIONS FOR COMPLETING THE ADULT FAMILY-SIZE AND INCOME APPLICATION

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

Part 1: a. List all enrolled participants.
b. List all household members, including enrolled adult participant(s). For each enrolled participant, include his/her age.

Part 2: List the case number for any household member receiving ***SNAP, FDPIR, SSI,*** or ***Medicaid*** benefits.

Part 3: Skip this part.

Part 4: Sign the form. The last four digits of a social security number are ***NOT*** necessary.

Part 5: Answer this question if you choose to.

ALL OTHER HOUSEHOLDS, FOLLOW THESE INSTRUCTIONS:

Part 1: a. List all enrolled adult participants.
b. List all household members, including enrolled adult participant(s) in care. For each enrolled participant, include his/her age. For any person with no income, you must check the ***No Income*** box.

Part 2: Skip this part.

Part 3: Follow these instructions to report total household income from this month or last month.

- **Column A—Name:** List only the first and last name of ***EACH*** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.
- **Column B—Gross income and How Often It Was Received:** For each household member who is a spouse or dependent of the participant, 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, or 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 4: 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 5: Answer this question if you choose to.

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

ADULT FAMILY-SIZE AND INCOME APPLICATION (FSIA)
FY 2023-2024

PART 1. ALL HOUSEHOLD MEMBERS		
a. Name(s) of Adult Participant(s)		
b. Names of All Household Members (First, Middle Initial, Last)	**Age of Adult Participant(s)**	**Check If *NO* Income**
		☐
		☐
		☐

PART 2. BENEFITS

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

NAME: ______________________________ CASE NUMBER: ______________________________

PART 3. TOTAL HOUSEHOLD GROSS INCOME. You must tell us how much and how often.				
A. NAME (List only household members with income)	**B. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED**			
	Earnings From Work Before Deductions	**Welfare, Child Support, Alimony**	**Pensions, Retirement, Social Security, SSI, VA Benefits**	**All Other Income**
Example: Jane Smith	$ *200 /weekly*	$ *150 /twice a month*	$ *100 /monthly*	$ ________/________
	$ ________/________	$ ________/________	$ ________/________	$ ________/________
	$ ________/________	$ ________/________	$ ________/________	$ ________/________
	$ ________/________	$ ________/________	$ ________/________	$ ________/________
	$ ________/________	$ ________/________	$ ________/________	$ ________/________
	$ ________/________	$ ________/________	$ ________/________	$ ________/________

PART 4. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN).

An adult household member must sign this form. ***If Part 3 is completed, the adult signing the form also must list the last four digits of his or her social security number or mark the*** **I do not have a social security number** ***box.***

I certify (promise) that all information on this form is true and that all income is reported. I understand that the center or day care home will get federal funds based on the information that I give. I understand that CACFP officials may verify (check) 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 5. PARTICIPANT'S ETHNIC AND RACIAL IDENTITIES (Optional)			
Choose one ethnicity:	*Choose one or more (regardless of ethnicity):*		
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaskan Native	☐ Black or African American
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander	

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	Eligibility: Reduced	Eligibility: Denied
Reason:					
Determining Official's Signature:				Date:	

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

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

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

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

mail:
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or

fax: (833) 256-1665 or (202) 690-7442; or

email: program.intake@usda.gov

This institution is an equal opportunity provider.

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

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

(The Free Scale Should Not Be Distributed to Families)

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

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

FREE CACFP ROSTER

Center: ________________________________ **Fiscal Year:** ____________

Form completed by: ____________________________

NAME	DATE APPROVED	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	DROP DATE
1.														
2.														
3.														
4.														
5.														
6.														
7.														
8.														
9.														
10.														
11.														
12.														
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25.														
26.														
27.														
28.														
29.														
30.														
31.														
32.														
33.														
34.														
35.														
TOTAL														

*EF = Enrollment Form obtained

REDUCED-PRICED CACFP ROSTER

Center: ________________________________ **Fiscal Year:** ____________

Form completed by:

NAME	DATE APPROVED	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	DROP DATE
1.														
2.														
3.														
4.														
5.														
6.														
7.														
8.														
9.														
10.														
11.														
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25.														
26.														
27.														
28.														
29.														
30.														
31.														
32.														
33.														
34.														
35.														
TOTAL														

*EF = Enrollment Form obtained

NOT ELIGIBLE CACFP ROSTER

Center: ________________________________ **Fiscal Year:** ____________

Form completed by:

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

*EF = Enrollment Form obtained

PARTICIPANT MEAL WAIVER

A new waiver from must be obtain every fiscal year

I wish to decline the enrolled participant to participate in the Child and Adult Care Food Program (CACFP). I understand that the facility will not be claiming meals for CACFP reimbursement for the participant listed below.

Name of Participant: ____

Birthdate or Age: ____

Signature of Parent/Guardian: ______________________________________

Date: ____

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

Agreement Number: AD- ____________ Month: _____________ 20 _______

Form Completed By: ___________________________________

(To be maintained at institutions with CACFP records.)

DATE	NUMBER MEALS SERVED PROGRAM PARTICIPANTS				NUMBER NONCLAIMABLE MEALS SERVED*			
	Breakfast	Lunch	Supper	Supplement	Breakfast	Lunch	Supper	Supplement
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
TOTALS								

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

DAILY ATTENDANCE RECORD

Name of Day Care Center: ____________________ **Month:** __________ **Year:** ______

Form Completed By: ____________________

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

DAILY RECORD OF MEALS SERVED

Center: ______________________________ Month and Year: ______________________

Total Reimbursable Meals

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

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

Form completed by: ______________________

INDIVIDUAL PLAN OF CARE

Adult Day Care Center: ______________________ **Fiscal Year:** __________

Participant's Name: __________ Current Date: __________

Medical Diagnosis: ______________________

Orders: ______________________

Caregiver's/Participant's Expectations: ______________________

Needs/Goals:

1. Physical: ______________________
2. Cognitive: ______________________
3. Social: ______________________
4. Other: ______________________

GOAL	RESPONSIBLE STAFF/ DISCIPLINE	STRATEGY	MEASURE	OUTCOME

GROUP PROGRAM

Adult Day Care Center: ________________________________

Month: ________________________________ **Year:** ______

DAY/DATE	MONDAY, ______	TUESDAY, ______	WEDNESDAY, ______	THURSDAY, ______	FRIDAY, ______

DAY/DATE	MONDAY, ______	TUESDAY, ______	WEDNESDAY, ______	THURSDAY, ______	FRIDAY, ______

END OF THE MONTH INVENTORY FOR UNOPENED PRODUCTS

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

Center Name: ______________________ Inventory Month/Year: ______________

Date Conducted: ______________ Form Completed By: ____________________

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

END OF THE MONTH INVENTORY FOR UNOPENED PRODUCTS

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

Milk	Purchase Unit	# of Units	Extra Items *(optional)*	Purchase Unit	# of Units
Condiments *(optional)*	**Purchase Unit**	**# of Units**	**Food-Related Supplies** *(optional)*	**Purchase Unit**	**# of Units**

CACFP Claim Revision

Agreement #:____

Institution/Site Name: ____

Please provide the revised counts

Claim Month/Year:______________

Number of days in operations: ________

Total enrollment: ________

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

At-Risk total enrollment, if applicable: ________

<u>Participation Data:</u>

Title XX/XIX, if applicable: ________

Number free eligible: ________

Number reduced eligible: ________

Number not eligible: ________

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

Reason for revision: ____

____

____

____

CACFP Notification of Meal Service Change

Agreement Number: ___________ Institution/Site Name: ____

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

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

Please list currently approved mealtimes here:

Breakfast		AM Snack		Lunch		PM Snack		Supper		Late PM Snack	
1st shift		1st shift		1st shift		1st shift		1st shift		1st shift	
Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending
2nd shift		2nd shift		2nd shift		2nd shift		2nd shift		2nd shift	
Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending

Please list currently approved maximum number of meals:

Breakfast		AM Snack		Lunch		PM Snack		Supper		Late PM Snack	
1st	2nd	1st	2nd	1st	2nd	1st	2nd	1st	2nd	1st	2nd

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

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Open	Close

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

If applicable, list NEW mealtimes here: ☐ No change to mealtimes

Breakfast		AM Snack		Lunch		PM Snack		Supper		Late PM Snack	
1st shift		1st shift		1st shift		1st shift		1st shift		1st shift	
Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending
2nd shift		2nd shift		2nd shift		2nd shift		2nd shift		2nd shift	
Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending	Beginning	Ending

Please list NEW maximum number of meals: ☐ No change to max number

Breakfast		AM Snack		Lunch		PM Snack		Supper		Late PM Snack	
1st	2nd	1st	2nd	1st	2nd	1st	2nd	1st	2nd	1st	2nd

If serving shift or weekend meals, please provide justification:

If applicable, check the box for each day you wish to serve meals: ☐ No change to days of the week

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

If applicable, list your NEW hours of operation:

Open	Close

☐ No change to hours of operation

I further certify that all the information is true and correct. I understand that this information is being given in connection with the receipt of federal funds; that Department officials may, for cause, verify information; and that deliberate misrepresentation may subject me to prosecution under applicable state and criminal statutes. The program must be made available to all eligible children regardless of race, color, national origin, disability, age, reprisal, and retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Authorized Representative Signature: ____ Date:_________________

SDE Signature: ____ Date:_________________

Budget Revision Justification Form

Date:___________________

Institution Name: ___________________________________
Agreement Number:_______________

Budget Amendment Justification Month and Year:__________________________

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

Budget Line-Item Number/Type of Expense: ____

Original projected amount: ___________________________

Adjusted projected amount: ___________________________

Justification Explanation:

Budget Line-Item Number/Type of Expense: ____

Original projected amount: ___________________________

Adjusted projected amount: ___________________________

Justification Explanation:

Budget Line-Item Number/Type of Expense: ____

Original projected amount: ___________________________

Adjusted projected amount: ___________________________

Justification Explanation:

MONTHLY RECORD-KEEPING CHECKLIST

Month: ____ **Year:** __________________________________

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

( ) Meal Count Worksheet

( ) Expenditure/Reimbursement Worksheet (Summary of All Allowable Operating and Administrative Costs)

( ) Financial Documentation - Any bank and credit card statement(s) where CACFP funds were deposited, spent, or transferred to or from, Year to date report, Profit/Loss statement, canceled checks, etc.

( ) Food-Purchasing Forms/Itemized Receipts

( ) End of the Month Inventory for Food and Milk

( ) Title XIX Documentation

( ) Canceled Checks (Documentation of CACFP Expenditures)

( ) Daily Attendance Records

( ) Daily Attendance Records—Arrival and Departure Times, if applicable

( ) Daily Record of Meals Served, if applicable

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

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

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

ANNUAL REQUIRED DOCUMENTATION
( ) Procurement Documentation

( ) Training Records

WEEKLY MENU PLANNER

BREAKFAST	AM SNACK	LUNCH

This institution is an equal opportunity provider.

WEEKLY MENU PLANNER

PM SNACK	SUPPER	LATE PM SNACK

This institution is an equal opportunity provider.

BREAKFAST
HOW TO CALCULATE NUMBER OF ADULT SERVINGS NEEDED

Adults Present: _____

Number of Adults Served					
MILK					
Adults		X	8 fluid ounces	=	
					Total Number of Fluid Ounces Needed
There are 128 ounces of milk in one gallon.					

FRUIT/VEGETABLE/JUICE					
Adults		X	2 (1/4 cup)	=	
					Total Number of 1/4 Cups Needed

MEAT/MEAT ALTERNATE (Optional)					
Adults		X	2.0 ounces	=	
					Total Ounces Needed

GRAINS					
Adults		X	2 oz eq	=	
					Total Ounce Eq Needed

LUNCH AND SUPPER*
HOW TO CALCULATE NUMBER OF ADULT SERVINGS NEEDED

Number of Adults Served: _____

Number of Adults Served

MILK*					
Adults		X	8 fluid ounces	=	
					Total Number of Fluid Ounces Needed
There are 128 ounces of milk in one gallon.					

VEGETABLE					
Adults		X	2 (1/4 cup)	=	
					Total Number of 1/4 Cups Needed

FRUIT					
Adults		X	2 (1/4 cup)	=	
					Total Number of 1/4 Cups Needed

MEAT/MEAT ALTERNATE					
Adults		X	2.0 ounces	=	
					Total Ounces Needed

GRAINS					
Adults		X	2 oz eq	=	
					Total Ounce Eq Needed

*Milk is not a required component at supper.

SNACK

HOW TO CALCULATE NUMBER OF ADULT SERVINGS NEEDED

(Choose two of the five food components)

Number of Adults Served: _____

Number of Adults Served

MILK					
Adults		X	8 fluid ounces	=	
					Total Number of Fluid Ounces Needed
There are 128 ounces of milk in one gallon.					

VEGETABLE					
Adults		X	2 (1/4 cup)	=	
					Total Number of 1/4 Cups Needed

FRUIT					
Adults		X	2 (1/4 cup)	=	
					Total Number of 1/4 Cups Needed

MEAT/MEAT ALTERNATE					
Adults		X	1.0 ounce	=	
					Total Ounces Needed

GRAINS					
Adults		X	1 oz eq	=	
					Total Ounce Eq Needed

CONTRACT MEAL SERVICE DELIVERY RECEIPT

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

DATE: ______________________________

MEAL TYPE: Breakfast ______ Lunch ______ AM/PM/LATE PM Snack ______ Supper _____
(Circle One)

SITE PREPARING MEAL: ____

SITE RECEIVING MEAL: ____

DELIVERY TIME: ________________________ NUMBER OF MEALS ORDERED/DELIVERED: _______

FOOD ITEMS AND QUANTITIES DELIVERED

Menu	**Quantity Delivered:** **Number of Participants** ______ **Bulk Delivery:** ______ **Preportioned:** ______	***Crediting/Portioning Information**	**Temperature at Delivery**
Milk	**Milk provided by:** **SITE VENDOR** **(Circle One)** **Record Quantity:** _______		
Vegetable/Juice			
Fruit/Juice			
Grains/Breads			
Meat/Meat Alternate			
Extras			

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

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

____

Signature From Preparation Kitchen

I acknowledge that the above items and quantities were delivered to this contract site.

INSPECTION DELIVERY: Was the food delivered in a safe/sanitary method? Yes or No

Were food temperatures proper? Yes or No

Comments: ____

____

Signature From Site Receiving Food

FOR INSTITUTION TO USE WHEN CONTRACTING MEALS FROM OUTSIDE VENDOR OR WITHIN OWN INSTITUTION; KEPT IN INSTITUTION'S MONTHLY FOLDER.

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

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

Product Name: ____ Code Number: ____________________

Manufacturer: ____________________________________ Case/Pack/Count/Portion Size: ____________

I. Meat/Meat Alternate (M/MA)

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

Description of Creditable Ingredients Per *Food-Buying Guide*	Ounces Per Raw Portion of Creditable Ingredient	Multiply	*Food-Buying Guide* Yield	Creditable Amount*
		X		
		X		
		X		
A. Total Creditable Amount[1]				

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

II. Alternate Protein Product (APP)

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

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

* 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.

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

Total weight (per portion) of product as purchased: ____

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

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

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

Signature: ____ Title: ____________________________

Printed Name: ____________________________ Date: ______________ Phone Number: ______________________

PRODUCT FORMULATION STATEMENT FOR PREPARED GRAINS/BREADS

Product Name: ________________________________ Code Number: ________________

Case/Pack/Count/Portion Size: ____

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

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

____

____

____

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

______________________________ ______________________________

Signature Title

____________________ ____________________ ____________________

Printed Name Date Telephone Number

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

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

ATTACHMENT A

Company Name: ____________________

APP Product: _____________________

A. _______________ certifies that ___________________ meets all requirements for APP intended for use in foods manufactured for Child Nutrition Programs as described in Appendix A of 7 CFR 210, 220, 225, and 226.

B. _______________ certifies that ___________________ has been processed so that some portion of the nonprotein constitutes have been removed by fractionating. This product is produced from ____ _____________________________________ .

C. The Protein Digestibility Corrected Amino Acid Score (PDCAAS) for __________________ is ____________ . It was calculated by multiplying the lowest uncorrected amino acid score by true protein digestibility as described in the Protein Quality Evaluation Report from the Joint Expert Consultation of the Food and Agriculture Organization/World Health Organization of the United Nations, presented December 4-8, 1989, in Rome, Italy. The PDCAAS is required to be greater than 0.8 (80 percent of casein).

D. The protein level of ____________________ is at least 18 percent by weight when fully hydrated at a ratio of ____________ parts water to one part product.

E. The protein level of _____________________ is certified to be at least ___________ on an As-Is basis for the As-Purchased product. ***NOTE: Protein is often provided on a moisture-free basis (MFB), which is not the information Food and Nutrition Service (FNS) requires.***

All of the above information is required for APP.

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

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

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

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

  The only exceptions are:
  — Tomato paste and tomato puree are credited based on their whole food equivalency using the percent natural tomato soluble solids in the past or puree. See FBG for additional information on calculated volume.
  — Dried fruits credit as double the volume served in school meals only (e.g., 1/4 cup raisins credit as 1/2 cup fruit). All other CN programs credit dried fruit on the volume served.
  — Raw leafy vegetables credit as half the volume served in school meals only (e.g., 1 cup raw spinach credits as 1/2 cup dark-green vegetable). All other CN programs credit as volume served.

- A PFS may include crediting information for more than one meal component. For instance, a cheese pizza may credit toward the meat/meat alternate, grains, and the red/orange vegetable subgroup. The crediting information for each meal component may be documented on the same PFS.

PFS templates for each meal component are available on the CN labeling Web site at ***http://www.fns.usda.gov/cnlabeling/food-manufacturersindustry***. Manufacturers may use PFS templates as a guide to help develop a PFS; however, they are not required to use the same format as the USDA's template, but they must present the same information on their company letterhead.

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

MENUS AS SERVED

Comments/Special Dietary Needs:

Date: ______________________

Form completed by: ________________________

MEAL TYPE	QTY SERVED: MEAT/MEAT ALTERNATE	QTY SERVED: GRAINS	QTY SERVED: VEGETABLE/ JUICE	QTY SERVED: FRUIT/JUICE	QTY SERVED: MILK
BREAKFAST Total participants served: ______ Program Adults: ______		WG ☐			
AM SNACK Total participants served: ______ Program Adults: ______		WG ☐			
LUNCH Total participants served: ______ Program Adults: ______		WG ☐			
PM SNACK Total participants served: ______ Program Adults: ______		WG ☐			
SUPPER Total participants served: ______ Program Adults: ______		WG ☐			
LATE SNACK Total participants served: ______ Program Adults: ______		WG ☐			

MENUS AS SERVED

(For Institutions who only serve these 3 meals per day)

Comments/Special Dietary Needs: Form completed by: ______________________

MEAL TYPE	QTY SERVED: MEAT/MEAT ALTERNATE	QTY SERVED: GRAINS	QTY SERVED: VEGETABLE/ JUICE	QTY SERVED: FRUIT/JUICE	QTY SERVED: MILK
BREAKFAST Date:__________ Total participants served: ____ Program Adults: ____		WG ☐			
LUNCH Date: _________ Total participants served: ____ Program Adults: ____		WG ☐			
PM SNACK Date:________ Total participants served: ____ Program Adults: ____		WG ☐			
BREAKFAST Date:_________ Total participants served: _____ Program Adults: _____		WG ☐			
LUNCH Date:_________ Total participants served: _____ Program Adults: _____		WG ☐			
PM SNACK Date: ________ Total participants served: _____ Program Adults: _____		WG ☐			