

**CHILDREN FIRST
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
CHILD CARE HOME PROVIDER APPLICATION**

FY 2012

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| Provider's Name: _____ Physical Address: _____ Mailing Address: _____ City: _____ AZ, Zip Code: _____ Last 4 digits of SSN: _____ DOB: _____ School District: _____ Assigned Elementary School: _____ | Phone: (____) _____ Cell: (____) _____ Fax: (____) _____ Email: _____ County: _____ |
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Is there anything that restricts home monitors access to the property (i.e. gated community, locked entry, loose dogs, etc.) _____

Major cross roads to home: _____

Any gas utilities? Yes No *If yes, home must maintain working carbon monoxide detector.*

(When Applicable) Name of Substitute Care Giver _____ Requires CPR/First Aid and Fingerprint Clearance card copy to be on file with Children First. Substitute care giver cannot replace approved child care provider on a regular basis.

Application Type: New Provider Renewing/Continuing Provider Change of Address Provider Transfer
 If previous participated in the CACFP, list name of sponsoring organization and dates: _____

Provider Information:

Home is: Alternately Approved (Private) DES Certified DHS Licensed Military Certified Tribal Certified

CACFP child care days, hours and meal times listed will assist in home monitoring schedule for meal observation. Be advised home monitoring visits and allowable meal claims will be based on the information listed below. Update when necessary.

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| Days and hours CACFP child care will regularly be provided: <input type="checkbox"/> Mon _____ AM / PM to _____ AM / PM <input type="checkbox"/> Tues _____ AM / PM to _____ AM / PM <input type="checkbox"/> Wed _____ AM / PM to _____ AM / PM <input type="checkbox"/> Thurs _____ AM / PM to _____ AM / PM <input type="checkbox"/> Fri _____ AM / PM to _____ AM / PM <input type="checkbox"/> Sat _____ AM / PM to _____ AM / PM <input type="checkbox"/> Sun _____ AM / PM to _____ AM / PM | Explain any variations in days or hours of care: _____ _____ _____ _____ _____ _____ |
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Will holiday care be provided? *Holidays include Federal, State, and Local School District holidays or breaks.* Yes No

Provider claims own children (residential) ? Yes No NA NE If Yes, How many: _____

Below, list meals that will be **regularly** claimed and times meals will be served:

| Meals Claimed | Meal Times | Meals Claimed | Shift 2* (if applicable) | Allowable Time Frame and Limit Guidance |
|--|-----------------------|--------------------------------------|--------------------------|--|
| <input type="checkbox"/> Breakfast | Time: _____ to: _____ | <input type="checkbox"/> Breakfast | Time: _____ to: _____ | Breakfast = 6 - 9 a.m., may not exceed 1 ½ hours. AM snack = 9 - 11 a.m., may not exceed 1 hour. Lunch = 11 a.m. - 1 p.m., may not exceed 2 hours. PM snack = 1 - 5 p.m., may not exceed 1 hour. Dinner = 5 - 7 p.m., may not exceed 2 hours. Night snack = 7 - 9 p.m., may not exceed 1 hour. There must be at least 2 hours between the start of one meal/snack and the start of the next meal/snack. Last meal served must end 15 minutes before child care hours end. |
| <input type="checkbox"/> AM Snack | Time: _____ to: _____ | <input type="checkbox"/> AM Snack | Time: _____ to: _____ | |
| <input type="checkbox"/> Lunch | Time: _____ to: _____ | <input type="checkbox"/> Lunch | Time: _____ to: _____ | |
| <input type="checkbox"/> PM Snack | Time: _____ to: _____ | <input type="checkbox"/> PM Snack | Time: _____ to: _____ | |
| <input type="checkbox"/> Dinner | Time: _____ to: _____ | <input type="checkbox"/> Dinner | Time: _____ to: _____ | |
| <input type="checkbox"/> Night Snack | Time: _____ to: _____ | <input type="checkbox"/> Night Snack | Time: _____ to: _____ | |
| *Shift change is when more than one meal service is offered for the same meal. When claiming shift care meals, there must be a minimum of 30 minutes in between shift servings. In addition, the total meal and shift meal cannot exceed the allowable meal time for the applicable meal. | | | | |
| Will meals claimed or meal times vary? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please explain: _____ | | | | |

I hereby certify that all of the above information is true and correct as of this date. I understand that this information is being given in connection with the receipt of federal funds; that ADE officials may, for cause verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal criminal statutes.

Provider's Signature _____ **Date** _____

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| Official Use Only - Reimbursement Rate Notification School District _____ Assigned School _____ Rates: _____ Tier I _____ Tier II _____ Mixed _____ |
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This institution is an equal opportunity provider.

According to 7 CFR 226.19(d), "Each day care home participating in the program shall serve the meal types specified in its approved application in accordance with the meal pattern requirements specified in 226.20.