ILLINOIS STATE BOARD OF EDUCATION

100 North First Street, W-270
Springfield, Illinois 62777-0001

CHILD AND ADULT CARE FOOD PROGRAM SITE APPLICATION

NUTRITION DEPARTMENT

INSTRUCTIONS: *Complete this form for each location and return to the above address.*

1. OFFICIAL NAME OF SITE (If applicable, use name on DCFS license.)

2. NAME OF SPONSOR (Provide RCDT/Agreement # if one has been assigned)

3. CONTACT PERSON (First, Last)

4. BUSINESS TELEPHONE (Include area code)

5. BUSINESS FAX (Include Area Code)

6. EMAIL

7. COUNTY

8. ADDRESS OF SITE (Provide complete official street address, city, state, and ZIP.)

9. MAILING ADDRESS (If mailing address is the same as street address, leave blank.)

10. LEGAL ENTITY QUESTIONS (Selection one option only)

☐ A. Your institution operates other programs for children at this facility, including CACFP, and is responsible for hiring and paying staff who work at the facility. Skip to Question 11.

☐ B. Your institution provides ONLY CACFP services and no other programs for children at this facility, and is not responsible for hiring and paying staff who work at the facility. If yes, complete information below

SEPARATE LEGAL ENTITY

If you marked **B** above, please answer the following:

1) Provide the name and FEIN of the organization that is legally responsible for programs at this facility.
Name: _____ FEIN: _____
☐ **Yes** ☐ **No**
Is this organization federally tax-exempt? If ***Yes***, submit a copy of the facility's 501(c)(3).

2) Mark the appropriate box below:
☐ Our institution charges this facility a fee for CACFP services and the remaining reimbursement is disbursed to the facility within five working days of receipt of the funds.
☐ Our institution provides CACFP meals to this facility. CACFP reimbursement is used by our institution for CACFP expenses and is not disbursed to the facility.

11. ELIGIBILITY

☐ Public Entity ☐ Not-for-Profit, Federal Tax-Exempt ☐ Private for-Profit

12. NUMBER OF CHILDREN ENROLLED

☐ a) _____*12 Years and Younger* ☐ b) _____13 to 18 Years

13. AGE RANGE OF CHILDREN AT FACILITY
Fill in the blanks
to designate ages: _____ to _____

14. DCFS LICENSE EXPIRATION DATE

DCFS LICENSE NUMBER

DCFS LICENSE CAPACITY
Day _____ **Night** _____

15. Unlicensed Programs: Unlicensed programs must include a copy of their most recent fire and health inspections, dated within the past 12 months and with no violations. Programs located in a public school building are exempt from this requirement.

☐ **Yes** ☐ **No** Does this facility meet State or local public health inspections?
☐ **Yes** ☐ **No** Does this facility meet State or local fire inspections?

16. DAYS OF WEEK SITE OPERATES

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

17. HOURS OF OPERATION
Open _____ Close _____

18. MEAL PREPARATION

☐ On-Site ☐ Central Kitchen ☐ School Agreement
☐ Formal Bid Contract Annual purchases over $250,000 ☐ Small Purchase Agreement Annual purchases **under** $250,000

19. OUTSIDE SCHOOL HOURS AND AT-RISK AFTERSCHOOL MEALS PROGRAMS REQUIREMENTS ONLY

☐ **Yes** ☐ **No** The Outside School Hours Program and At-Risk Afterschool Meals Program offers regularly scheduled and supervised education and/or enrichment activities for the students.
List enrichment activities: _____ Organization providing activities: _____

20. FOR AT-RISK AFTERSCHOOL PROGRAMS ONLY (Provide the name and address of the elementary, middle, or high school that serves the area where this site is located.)

Full Name of School: _____

Address (Street Address, City, State, and Zip): _____

☐ **Yes** ☐ **No** Is this a year-round school?

ISBE USE ONLY

Site Number: _____

Percentage eligible: _____

Date of Eligibility Data: _____

21. SERVICES

INSTRUCTIONS:

A. **Program(s)** – Select the program-type your facility wishes to participate as to receive CACFP claims for reimbursement. NOTE: If you provide Head Start programming for children at your center, you must claim those children under Head Start. Read the CACFP Program Fact Sheets online http://www.isbe.net/Pages/Child-Adult-Care-Food-Program-Documents.aspx to review the differences between programs.

B. **Days of Operation** – Enter your anticipated beginning and end dates for the CACFP fiscal year (the CACFP fiscal year runs October 1 – September 30).

C. **Break in Service** – If your program will have a break in service for more than one month during the CACFP fiscal year, enter the beginning and end dates for when the program will restart. An example of a break in service would be summer break during the school year.

A. Program(s)	B. Days of Operation		C. Break in Service Dates	
	Begin Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Begin Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
☐ Child Care Center				
☐ Head Start				
☐ Outside School Hours				
☐ School Pre-K				
☐ At-Risk				
☐ Emergency Shelter				

D. **Meal Service** – For each Program selection made in Section A, write in the program-type and check the box for each Meal Service you want to claim for CACFP reimbursement. Then, enter begin and end times for each meal service.

E. **Two Sessions** – Check this box only when the same meal service is offered to two different groups of children, causing the meal count for that meal service to go over the DCFS license capacity. Then, enter the meal service times for the second session.

NOTE: Most institutions would only need to claim under one or two different Program types, but if your organization would require more than two program types (as selected in Section A), please submit additional information for Sections D and E as an attachment.

D. Meal Service				E. Two Sessions		
Program (from Section A above): _____			Approx. # of meals served	☐ Check if you serve any meal(s) in two sessions, then enter meal service times below:		Approx. # of meals served
Meal Services	Begin Time	End Time		2nd Begin Time	2nd End Time	
☐ Early Snack						
☐ Breakfast						
☐ AM Snack						
☐ Lunch						
☐ PM Snack						
☐ Supper						
☐ Evening Snack						

Program (complete if you had a 2nd selection in Section A above): _____			Approx. # of meals served	☐ Check if you serve any meal(s) in two sessions, then enter meal service times below:		Approx. # of meals served
Meal Services	Begin Time	End Time		2nd Begin Time	2nd End Time	
☐ Early Snack						
☐ Breakfast						
☐ AM Snack						
☐ Lunch						
☐ PM Snack						
☐ Supper						
☐ Evening Snack						

ISBE USE ONLY				
Approved ..... _____ Received ..... _____ Reviewed ..... _____	VENDOR NAME	DATE RENEWAL YEAR	CACFP OPERATING APPROVAL DATES Beginning Date: _____ Ending Date: _____	Fiscal Year: _____ Agreement #: _____ Site #: _____