## **ILLINOIS STATE BOARD OF EDUCATION** FISCAL YEAR AGREEMENT NUMBER Nutrition and Wellness Programs Division 100 North First Street, W-270 SITE NUMBER ISBE Springfield, Illinois 62777-0001 **USE ONLY** Child and Adult Care Food Program SITE INFORMATION - DAY CARE HOME NAME OF SPONSORING ORGANIZATION NAME OF SPONSOR PROVIDER HAS TRANSFERRED FROM DAY CARE HOME PROVIDER TRANSFER AT END OF FISCAL YEAR ONLY 2. MAILING ADDRESS (Street, City, State, Zip Code) 1. NAME (First, Middle, Last) AND ADDRESS (Street, City, State, Zip Code) (If mailing address is the same as in 1., leave blank) SITE INFORMATION 3. COUNTY 5. FAX NUMBER 4. TELEPHONE NUMBER (Include Area Code) 6 F-MAIL ADDRESS 10. LICENSE CAPACITY 11. ISBE/IDHS DATA ID. 7 PERIOD OF OPERATION 8.DCFS/MILITARY INFORMATION 9 TYPE OF HOME **APPLICATION BEGINNING DATE** LICENSE EXPIRATION DATE DAY CARE HOME DAY IDHS CHILD CARE SUBSIDY NUMBER EXTENDED DAY LICENSE NUMBER **EXTENDED** CARE HOME CLOSING DATE **GROUP DAY CARE** $\equiv$ / NIGHT Check box for license HOME exempt by military. 12. OPERATING DAYS PER WEEK 13. DAYS OF SERVICE: Provide the exact number of days food service is offered each month Sun Mon Wed. Thu. Fri. Sat Oct Nov. Feb Marc. May July PROGRAM DETAILS 14. CURRENT ENROLLMENT 16. HOURS OF OPERATION 15 FOOD SERVICE DATA (Cannot exceed DCFS license Own children SERVING TIME (Two hours required between meals.) hours of operation.) (residing in home OPEN under the age SHIFT A.M. P.M. Evening **Breakfast** of 13) Lunch Dinner Snack Snack Snack DAY Foster children CLOSE (residing in home Begin: under the age of 13) First Serving Ē End: **OPEN** Outside Children Begin **NIGHT** Second TOTAL CLOSE Serving End: **ENROLLMENT** 17. TIER INFORMATION - Select only one Tier II All Lower Tier II Mixed Tier I School \_ Tier I Census \_\_\_ Tier I Household Income \_\_ Tier II All Higher TIER INFORMATION **SCHOOL DISTRICT DATA** To determine if your day care home will receive Tier I or Tier II reimbursement by school data, the following must be completed. A. NAME AND ADDRESS OF THE PUBLIC SCHOOL DISTRICT YOUR CHILD ATTENDS (Street, City, State, Zip Code)\* (MUST COMPLETE) B.NAME AND ADDRESS OF THE PUBLIC ELEMENTARY SCHOOL WITHIN THAT DISTRICT YOUR CHILD ATTENDS (Street, City, State, Zip Code)\* (MUST COMPLETE) ≥ TELEPHONE (Include Area Code) TELEPHONE (Include Area Code) **VERIFICATION OF SCHOOL ATTENDANCE AREA** APPROVED: Yes Date of Contact Name of Contact Person If your child attends a nonpublic school or if you do not have children, state the name and address of the public school district and elementary school that your child would have been assigned. **CERTIFICATION BY PROVIDER** I certify the above is true and correct and I understand this information is provided in connection with the receipt of federal funds and deliberate misrepresentation may result in state or federal prosecution. I will follow all rules and regulations governing participation in the Child and Adult Care Food Program for which application is made. The Sponsor/Provider also acknowledges the contents of the attached agreement [ISBE 68-49A] and accepts all conditions and obligations as contained therein. Signature of Provider Date Signature of Sponsoring Organization Representative

Date