Reset

South Carolina Department of Social Services

APPLICATION FOR PARTICIPATION FOR CHILD CARE AND ADULT DAY CARE CENTERS IN THE CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

INSTRUCTIONS: Child Care Centers or Adult Day Care Centers must complete this form. A copy should be maintained for your file. If a sponsored facility, the original (and required attachments) must be submitted with "Application for Participation and Management Plan for Sponsoring Organizations." A copy of this form should be retained by the center and sponsor, if applicable. Type or print clearly in ink.

1. CACFP Agreement Number: _____ Federal Identification Number: _____

2. Name of Center: _____

Mailing Address: _____

_____

_____

City: _____ State: _____ Zip: _____

County: _____ Select County ...

3. Physical Address of Center: _____

_____

City: _____ State: _____ Zip: _____

County: _____ Select County ...

Center Telephone: ( ) _____ - _____

Center Fax: ( ) _____ - _____

4. Name and Physical Address of Sponsoring Organization: (Complete only if you operate and/or are applying for two or more centers.)

_____

_____

City: _____ State: _____ Zip: _____

County: _____ Select County ...

Sponsor Telephone: ( ) _____ - _____

Sponsor Fax: ( ) _____ - _____

5A. Name and Title of Person Responsible at Child Care or Adult Day Care Center:

_____

_____

5B. Name and Title of CACFP Representative: (Individual who SCDSS staff can contact for Program Information)

_____

_____

E-Mail: _____

6. Type of Facility: (Select one)

Child:

❑ Child Care Center ❑ Head Start Center

❑ Outside-School-Hours Care Center

Adult:

❑ Adult Care Center

To be completed by SCDSS staff only:

❑ Regular ❑ OSHC ❑ HS ❑ Title XIX

❑ Title XX ❑ F/RP

7. Type of Organization: (Select one and attach appropriate documentation)

❑ Private Nonprofit Secular

❑ Private Nonprofit Faith Based

❑ Private For-Profit (Title XX or Title XIX)

❑ Private For-Profit (F/RP)

❑ Public Organization (Governmental)

❑ Educational

8. Enter Age Range of Participants Accepted at the Center:

From: _____ To: _____

9. Is center a nonresidential facility?

❑ Yes ❑ No

Note: Only nonresidential facilities are eligible to participate in the CACFP.

10. Prior Participation in a Food and Nutrition Service Program

A. Has your center ever participated in any of the following programs? ❑ Yes ❑ No (If "yes," place a check mark in the appropriate box and indicate year.)

❑ CACFP (Center/DC Home) _____

❑ Emergency Shelter _____

❑ SFSP _____

❑ At-Risk After School Snack Program _____

❑ School Breakfast Program _____

❑ National Lunch Program _____

❑ Other _____

B. Has anyone at the center been a part of any of the programs listed under 10A that has been terminated as a result of being seriously deficient ? ❑ Yes ❑ No

C. If the answer to question 10B is "yes," give name(s) and title(s). (On a separate sheet, provide current responsibilities for the person who was on a program that was declared seriously deficient or terminated.)

_____

INSTRUCTIONS FOR DSS FORM 1633

Note: A DSS Form 1633 should be completed for **each** center.

All Sponsoring Organizations must complete the DSS Form 1613 and a DSS Form 1633 for each sponsored center.

1. The CACFP Agreement Number is assigned by the South Carolina Department of Social Services (SCDSS). If your organization has not participated in this program before, this number will be entered by SCDSS. If you are adding a center to your sponsorship, enter agreement number.

   Give the Federal Identification Number assigned to your organization by the IRS. This number should be taken from your tax documents and should agree with the information listed on the W-9 form, which is part of this application package. If your W-9 indicates that you are a sole proprietor (100% ownership), please include your Social Security number as well as your Federal Identification Number.

2. Give name and mailing address of the center, including the city, state, zip code and county.

3. Give the physical address of the child care or adult care center. Include the telephone number and fax number for the center location.

4. If this center is being sponsored by another organization to participate in the CACFP or if your organization is applying for more than one center to participate in the CACFP, give the name, physical address, telephone number and fax number of the sponsoring organization.

5. A. Give the name and title of the person in charge at the child care or adult day care center.

   B. Give the name and title of the person responsible for CACFP information at the child care or adult day care center. This is the individual who SCDSS staff can contact for program information. Updates on policy and other program requirements will normally be mailed to this person's attention. In addition, give e-mail address if applicable.

6. Check the appropriate item that identifies the facility type.

   "Outside-School-Hours Care" (OSHC) center means a public or private nonprofit facility licensed or approved to provide organized nonresidential child care services to enrolled children, primarily of school age, outside of regular school hours.

7. Check the appropriate item that identifies the type of institution.

   Private Nonprofit centers – must have federal tax exempt status and must have an appropriate Board of Directors providing oversight to the organization. Churches can provide a copy of their certificate of Nonprofit Status issued by the Secretary of State's office.

   Private For-Profit Title XX or Title XIX organization – must provide documentation that at least 25% of the enrollees, or licensed capacity, whichever is less, are either Title XX recipients (adult or child care), or Title XIX recipients (adult care) for the month prior to submission of application.

   Private F/RP (child care) – must provide documentation that at least 25% of the children enrolled in your center, or licensed capacity, whichever is less, are eligible for free or reduced-price meals.

   Public organizations are a part of local, state or federal government.

   Educational organizations are colleges, universities, schools, etc.

8. Enter age range of participants accepted at the center.

9. To be eligible for participation, all centers must be nonresidential and have federal, state or local licensing to operate as a child care, adult care, head start or OSHC center.

10. A. If you check "yes," please make sure you place a check mark in the appropriate box. If you are renewing your contract with SCDSS, you should check "yes."

    B. and C. Organizations that 1) have been declared seriously deficient and terminated from program participation or 2) that employ individuals that have been a part of a program that was declared seriously deficient and terminated may not be approved to participate in the CACFP.

11. Operating Data	
11A. Hours of Operation: From: _____ To: _____	11B. Number of Staff at this Facility: (Include Director/Owner) _____
11C. Place a Check Mark by the Days of Operation: ❑ M ❑ T ❑ W ❑ T ❑ F ❑ S ❑ S	11D. Number of Operating Weeks Per Year: _____
11E. Does center receive Title III meal funding or commodities? If yes, please explain on a separate sheet. ❑ Yes ❑ No	11F. List any months or period during which the Child and Adult Care Food Program will not operate: (Include dates of closing and reopening.) _____

12. Meal Service (Complete only for meals you are requesting reimbursement)						
	Breakfast	AM Supplement	Lunch	PM Supplement	Supper	Evening Supplement
12A. Time of Meal Service						
12B. No. of Meals Expected to be Served Per Day						

13. Does the center provide care in shifts? ❑ Yes ❑ No If yes, complete question 15.

14. Is the center requesting reimbursement for more than two meals and one snack or two snacks and one meal? ❑ Yes ❑ No If yes, complete question 15.

15. If you responded yes to question 13 or 14, identify the times of each shift at this center and the meals that will be served at each shift.

	Shift Times	Meals to be claimed for reimbursement
First Shift		
Second Shift		
Third Shift		

16. Total Enrollment for this Center: _____

17. Provide the License Capacity for this Center: _____ License Expiration Date: _____

License No.: _____

18. Method by which meals will be provided. Identify the meal type for each method used by this center. (For example, Breakfast, Lunch, PM Snack, for each method used.)

A. Meals Prepared at the Service Location: _____

B. Meals Prepared at the Central Kitchen: _____

Provide Physical Address of Central Kitchen: _____

C. Meals Provided by a Local School System*: _____

D. Meals Prepared by a Food Service Management Co.*: _____

*** Attach Copy of Contract**

19. Method of Reimbursement: (Check one) ❑ Actual ❑ Claiming Percentage **Note**: Record keeping requirements are different for each method. If you selected the actual method of reimbursement, you must maintain the actual meal count record (DSS Form 1642).	20. Do you charge a separate fee for meals? (Check one) ❑ Yes (Pricing Program) ❑ No (Non-Pricing Program)

INSTRUCTIONS FOR DSS FORM 1633, CONTINUED

11. A. - F. Enter operating data as requested.

    Title III funding refers to funds associated with the Older Americans Act.

12. A. Indicate the start time for each meal type for which you are requesting reimbursement. A maximum of two meals and one snack or two snacks and one meal served will be reimbursed per participant.

    B. For each meal type you are requesting reimbursement, indicate the number of meals that you anticipate serving per day. This number should not be greater than the center's total enrollment.

13. Self-explanatory.

14. Self-explanatory.

16. List center's current total enrollment.

17. Indicate the center's license capacity, license expiration date and license number. Adult day care centers must submit a copy of the license with this application.

18. Identify how each meal and snack that will be claimed for reimbursement will be provided for this center. For example, if breakfast, lunch and PM snacks are prepared at the center, list these meal service types (breakfast, lunch and PM snack) on the line beside "Preparation at Meal Service Location".

    Include a copy of the current contract with the school of Food Service Management Company if this function is contracted. It may be necessary to complete more than one item.

19. Select a method of reimbursement. Actual means that each meal served to each participant will be counted individually and the category of eligibility will need to be documented by meal. Claiming Percentage means that a "general" meal count will be taken at the time of meal service. The reimbursement for Claiming Percentage is based upon the percentage of free, reduced and paid participants enrolled during a given month. This percentage is then calculated against the total number of meals claimed and the reimbursement calculated accordingly. The main difference between the two is the way meals are counted. With Claiming Percentage, there is only a generalized meal count; with Actual, every participant's meals and category must be tabulated.

20. Indicate if your center is structured as a pricing or non-pricing center. Pricing means you charge a separate fee for meals; non-pricing means you charge one price that includes meals.

21. Indicate your preference. Currently, donated foods are not available in South Carolina. Therefore, you must check the box for USDA-Donated Food.

22./23. Federal regulations require that an organization include as part of its CACFP application the name and date of birth of Principals and/or responsible individuals. Principals of an organization include, but are not limited to the Chairperson, Executive Director, Owner or individuals with the equivalent title within an organization. Responsible individuals are individuals who have oversight of the program. If more space is needed, attach a separate sheet of paper.

21. Applicant organization would prefer to receive: ❑ USDA-DONATED FOOD ❑ CASH PAYMENTS
(Approved applicants which prefer cash payments instead of donated foods will receive such payments. However, those who choose foods may be required to accept cash instead.)

22. Responsible Individuals of the Organization: Responsible individuals are individuals who have oversight of the program.

Name	Title	Date of Birth

23. Principals of the Organization: These include but are not limited to the Chairperson, Executive Director, Owner or individuals with the equivalent title within an organization.

Name	Title	Date of Birth	Name and Date(s) of Publicly Funded Programs Individual Participated in During Past Seven Years

24. List the name and date(s) of the publicly funded programs this center has participated in during the past seven years.

Name of Program/Dates of Participation	Name of Program/Dates of Participation

CERTIFICATION STATEMENT

25. I CERTIFY that during the past seven years the applicant center has not been disqualified from participation in any other publicly-funded program for violating program's requirements. I understand that "publicly-funded program" means any program or grant funded by federal, state or local government. Initial:_____ Date:_____

26. I CERTIFY that the information on this application, including all attachments, is true to the best of my knowledge; that I will accept final administrative and financial responsibility for total Child and Adult Care Food Program operations at this facility and that reimbursement will be claimed only for meals served to enrolled participants; that the CACFP will be available to all eligible participants without regard to race, color, sex, national origin, age or disability at this food service facility and that this facility has the capability for the meal service planned for the number of participants anticipated to be served. I understand that this information is being given in connection with the receipt of federal funds and that deliberate misrepresentation may subject me to prosecution under applicable state and federal criminal statutes. Initial:_____ Date:_____

Note: The individual completing number 25 and number 26 must be the same as the signature below, and the individual's name must be listed on item number 1 on the Statement of Authority.

Date:	Name and Title of Center Representative:	Signature of Center Representative:
Date:	Name and Title of Administrator: (Authorized sponsoring organization representative; print or type)	Signature of Administrator: (Authorized sponsoring organization representative)

INSTRUCTIONS FOR DSS FORM 1633, CONTINUED

22./23. Federal regulations require that an organization include as part of its CACFP application the name and date of birth of Principals and/or responsible individuals. Principals of an organization include, but are not limited to the Chairperson, Executive Director, Owner or individuals with the equivalent title within an organization. Responsible individuals are individuals who have oversight of the program. If more space is needed, attach a separate sheet of paper.

24. Self-explanatory. If more space is needed, attach a separate sheet of paper.

25. Please read the certification statement, initial and date in the space provided. (An individual authorized by the Statement of Authority to sign the agreement and all supporting documentation must initial this section.)

26. Please read the certification statement, initial and date in the space provided. (An individual authorized by the Statement of Authority to sign the agreement and all supporting documentation must initial this section.)

Note: Please make sure that the DSS Form 1633 is signed and dated by the individual authorized by the Statement of Authority to sign the agreement and all supporting documentation.