APPLICATION FOR PARTICIPATION OF NON-PRICING ADULT CARE CENTER IN CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

NOTE: THIS FORM IS TO ONLY BE COMPLETED IF ADULT CARE CENTER IS TO PARTICIPATE IN THE CACFP AS A NON-PRICING ADULT CARE CENTER.

1A. **NAME OF CENTER:**

1B. **CACFP AGREEMENT NO.:**

03-47- _____*

***If applying for first time, CACFP Agreement No. will be assigned by Department of Human Services.**

1C. **FEDERAL EMPLOYER IDENTIFICATION NUMBER FOR CENTER:**

_____

2. **MAILING ADDRESS:**

_____

Street City State Zip Code

FEEDING SITE ADDRESS:

_____

Street City State Zip Code

COUNTY LOCATION OF CENTRAL OFFICE: _____

3. **CONTACT INFORMATION:**

Telephone Number:	Fax Number:	E-Mail Address:
Area Code: ( ) _____	Area Code: ( ) _____	_____

4. **NAME AND TITLE OF PERSON RESPONSIBLE AT CENTER FOR THE CACFP:**

5A. **FOR PRIVATE NON-PROFIT, PUBLIC OR CHURCH CENTER ONLY:**

Name of Executive Director:	Home Address of Executive Director:	Date of Birth of Executive Director:
Name of Board Chairperson:	Home Address of Board Chairperson:	Date of Birth of Board Chairperson:

6. **TYPE OF PARTICIPATION** (Check only one):

____ Independent Center (only one licensed adult care facility to participate)

____ Sponsored Affiliated Center (center is legally affiliated with sponsoring agency and is participating with one or more other licensed adult or child care facilities under the same sponsoring agency)

____ Sponsored Unaffiliated Center (center is **not** legally affiliated with sponsoring agency)

7. **TYPE OF CENTER ELIGIBLITY** (Check only one):

____ Private Non-Profit (center is not legally affiliated with any governmental unit and has federal income tax exemption

____ Public (center is legally affiliated with a governmental unit.)

____ Church sponsored

____ Proprietary (For Profit)

8. **FOR PRIVATE NON-PROFIT CENTER ONLY:**

Please attach photocopy of letter of federal income tax exemption from the Internal Revenue Service.

9. **FOR CHURCH AFFILIATED CENTER ONLY:**

Please attach a letter from the Chairman of the Governing Board or Pastor which authorizes this application. In addition, please attach a copy of letter from Tennessee Department of Revenue which documents state sales tax exemption for the church.

10. **FOR PUBLIC OR PRIVATE NON-PROFIT CENTER WITH GOVERNING BOARD OF DIRECTORS ONLY:**

Attach a copy of minutes of Board meeting in which CACFP application was approved.

11. **FOR ALL CENTERS:**

Attach a copy of current license to provide adult care.

12. **RECEIPT OF FEDERAL FUNDS BY INDEPENDENT CENTER ONLY:**

Did the total federal funds received by the center through the State of Tennessee and expended during the center's prior fiscal year, **and** the total federal funds received by the center directly from the federal government and expended during the center's prior fiscal year exceed $500,000: ____ Yes ____ No If the total federal funds exceeded $500,000, the center is required to have an audit of the funds to participate in the CACFP.

13. **FOR INDEPENDENT CENTER ONLY:**

Complete the attached budget **only** if your center is to participate as an independent center. If your center is to participate under a a sponsoring agency, do **not** complete the attached budget.

14A. **FOR ALL CENTERS:**

Is your center claiming any meals under part C of title III of the Older Americans Act of 1965: ____ Yes ____ No

If yes, please provide additional information: _____

_____

14B. **PARTICIPATION OF ENROLLED ADULTS IN OTHER PROGRAMS:**

Does any adult who is enrolled and under care at the center now participate or expect to participate in any of the following programs which may be administered by the center:

1. Programs which provide care or socialization/recreation opportunities only for persons 60 years of age or older who are not functionally impaired: ___ Yes ___ No

2. Sheltered workshops and other vocational rehabilitation programs whose overriding purpose is to provide employment and development opportunities: ___ Yes ___ No

3. Programs whose overriding purpose is to provide treatment and rehabilitation for substance abuse: ___ Yes ___ No

15. **ADULT CARE SERVICES:** Answer the following questions below. (Attach additional sheets if necessary.)

A. Describe the population your center serves:

B. How does your center determine if an adult is "functionally impaired":

C. Describe your center's program(s) for health, social and related support services to impaired participants:

D. Describe your center's program(s) for health, social and related support services to impaired participants:

E. How are individual plans of care developed and implemented for each participant in your center:

F. What is the overriding purpose of the adult care service your center provides:

G. Are any participants in your center a resident of an institution: ___ Yes ___ No

If YES, please explain:

16. **TOTAL ENROLLMENT BY ELIGIBILITY CATEGORY:**

Identify the total enrollment by eligibility category for all participants enrolled at your center.

ELIGIBILITY CATEGORY	NUMBER OF PARTICIPANTS
Free (For renewing centers only)	
Reduced-Price (For renewing centers only)	
Paid (For renewing centers only)	
TOTAL NUMBER OF CURRENTLY ENROLLED PARTICIPANTS (FOR ALL CENTERS):	

17. **POTENTIAL ELIGIBLE BENEFICIARIES BY ETHNIC/RACIAL CATEGORIES:**

Provide the number of potential eligible adults in your service area by the **ethnic** categories below:

Hispanic or Latino: _____ Not Hispanic or Latino: _____

Provide the number of potential eligible adults in your service area by the **racial** categories below:

American Indian or Alaskan Native: _____ Asian: _____ Black or African American: _____

Native Hawaiian or Other Pacific Islander: _____ White: _____

18A. **FOR ALL CENTERS:**	18B. **FOR ALL CENTERS:**
What are days of operation: _____ THROUGH _____	What are hours of operation? FROM: _____ TO: _____

18C. **FOR ALL CENTERS:**	18D. **FOR ALL CENTERS:**	18E. **FOR ALL CENTERS:**	18F. **FOR ALL CENTERS:**
Number of operating days per week?	Number of operating Weeks per year?	Annual dates of operation? Starting: _____ Ending: _____	List any months during which the CACFP will not operate:

19. **FOR ALL CENTERS:** What are the age ranges of your center's enrolled participants? From: _____ To: _____

20. **FOR ALL CENTERS:** Identify method by which meals will be provided:

____ Preparation at center location ____ Preparation at central kitchen for multiple sites

____ Under contract with local school system ____ Under contract with food service management company **(Attach copy of food service contract)**

21. **FOR ALL CENTERS:** Identify the meal services to participate in the CACFP. There must be at least two (2) hours between the end of each type of meal service and the beginning of the next type of meal service.

MEAL	TIME MEAL BEGINS	TIME MEAL ENDS	CHECK THE DAYS OF THE WEEK MEALS TO BE SERVED	AGES OF PARTICIPANTS TO BE SERVED	ESTIMATED NO. OF MEALS TO BE SERVED
BREAKFAST			__M __T __W __T __F __S __S		
AM SUPPLEMENT			__M __T __W __T __F __S __S		
LUNCH			__M __T __W __T __F __S __S		
PM SUPPLEMENT			__M __T __W __T __F __S __S		
SUPPER			__M __T __W __T __F __S __S		
EVENING SUPPLEMENT			__M __T __W __T __F __S __S		

NOTE: IF CENTER IS TO PARTICIPATE AS A "SPONSORED AFFILIATED CENTER", DO NOT ENTER ANY DATA FOR SECTIONS 22 THROUGH 29 BELOW. PLEASE READ THE "CERTIFICATION STATEMENT" AT THE END OF THE APPLICATION AND SIGN AND DATE THE FORM.

IF CENTER IS TO PARTICIPATE AS AN "INDEPENDENT CENTER" OR "SPONSORED UNAFFILIATED CENTER", PLEASE COMPLETE SECTIONS 22 THROUGH 29 BELOW, AS APPROPRIATE, AND READ THE "CERTIFICATION STATEMENT" AT THE END OF THE APPLICATION, AND SIGN AND DATE THE FORM.

22. **NEWS RELEASES (FOR ALL CENTERS):**

Each center approved for CACFP participation must distribute news releases announcing its participation in the program. Identify below the names of the local news media, minority or other grassroots organizations to receive these news releases. The news releases are to be distributed after approval for CACFP participation is received from the Tennessee Department of Human Services. Your center is **not** required to have the news releases published in newspapers as a legal notice. A sample form for the news release is attached.

IDENTIFY LOCAL NEWS MEDIA, MINORITY AND GRASSROOTS ORGANIZATIONS TO RECEIVE NEWS RELEASES:

1.

2.

3.

4.

5.

23. **BOARD OF DIRECTORS:**

Identify name, address and telephone number of each member of your center's Board of Directors. Attach additional sheets if necessary. (**Not** required for state colleges and universities, and proprietary centers.)

NAME:	ADDRESS:	TELEPHONE NUMBER:

24. **EMPLOYEES TO SIGN REIMBURSEMENT CLAIMS:**

Enter the name, title, and signature of the employees authorized to sign claims:

1. _____ _____
Name and Title Signature

2. _____ _____
Name and Title Signature

3. _____ _____
Name and Title Signature

4. _____ _____
Name and Title Signature

25. **TRAINING OF EMPLOYEES PERFORMING CACFP DUTIES** (Training for each employee performing CACFP duties must be provided at least once per program year):

Identify your center's anticipated date(s) for in-house training for the program year beginning October 1 and ending September 30.

_____ _____ _____
Month Day Year

_____ _____ _____
Month Day Year

_____ _____ _____
Month Day Year

26. **BOOKKEEPING/ACCOUNTING SERVICE:**

Identify the name and address of any bookkeeping or CPA firm used to perform accounting functions for the CACFP:

27. **FINANCIAL VIABILITY (FOR NON-GOVERNMENTAL, INDEPENDENT CENTER ONLY):**

Please include one of the following documents with your application:

A. A copy of a "Letter of Credit" from your banking institution that identifies available credit that is equal to (or greater than) the reimbursement received by your agency for an average two-month period during the last twelve months; or

B. A copy of the letter entitled "Independent Auditor's Report" that is contained in an audit report for your center that is not more than two years old; or

C. A copy of your center's most recent checking accounting statement; or

D. A copy of a financial statement for your center's last business year which is signed and dated by an authorized representative and which identifies the following:

(1) Assets (cash, securities, real estate, etc.),

(2) Liabilities (notes payable, mortgages, other liabilities, etc.),

(3) Total annual expenditures for all programs and activities of the center, and

(4) Total annual income from all sources received by the center.

28. **MANAGEMENT CONTROLS FOR PROGRAM ACCOUNTABILITY (FOR NON-GOVERNMENTAL, INDEPENDENT CENTER ONLY):**

Please complete, sign and date the attached **Sample Form to Document Required Management Controls** and return it with your application.

29. **CIVIL RIGHTS COMPLIANCE:**

Answer each question for your center's Civil Rights Compliance:

Does your center provide care regardless of race, color, national origin, sex, age, or disability? ____ Yes ____ No

Is membership in any organization a prerequisite for the adult care? ____ Yes ____ No If yes, what is organization's name?

_____

Does your center have procedures for handling discrimination complaints? ____ Yes ____ No

Has your center received any discrimination complaint(s)? ____ Yes ____ No

If discrimination complaint(s) have been received, attach information describing what action has been taken.

CERTIFICATION STATEMENT

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE ; AND THAT I AM AUTHORIZED BY THE CENTER TO APPLY FOR PARTICIPATION IN THE CACFP. I ALSO CERTIFY THAT THE CENTER WILL ACCEPT FINAL ADMINISTRATIVE AND FINANCIAL RESPONSIBILITY FOR THE CACFP OPERATED AT THE CENTER IDENTIFIED HEREIN; THAT THE CENTER WILL ADMINISTER THE CACFP IN FULL COMPLIANCE WITH THE FEDERAL GOVERNING REGULATIONS FOUND IN 7 CFR PART 226, AND THE STATE POLICIES CONTAINED IN OPERATIONAL MANUALS AND POLICY MEMORANDA ISSUED BY THE TENNESSEE DEPARTMENT OF HUMAN SERVICES. I FURTHER ASSURE THE TENNESSEE DEPARTMENT OF HUMAN SERVICES THAT THE FOLLOWING ACTIONS SHALL BE TAKEN:

1. REIMBURSEMENT WILL ONLY BE CLAIMED FOR THOSE MEALS AND SUPPLEMENTS SERVED TO ELIGIBLE PARTICIPANTS; AND THAT THE MEAL SERVICE WILL BE AVAILABLE TO ALL ELIGIBLE PARTICIPANTS REGARDLESS OF RACE, COLOR, NATIONAL ORIGIN, SEX, AGE OR DISABILITY;

2. ALL ELIGIBLE PARTICIPANTS IN THE CACFP MEAL SERVICES WILL BE SERVED THE SAME MEAL(S) AT NO SEPARATE CHARGE REGARDLESS OF RACE, COLOR, NATIONAL ORIGIN, SEX, AGE OR DISABILITY; AND THAT THERE SHALL BE NO DISCRIMINATION IN THE COURSE OF THE MEAL SERVICES;

3. ONLY THOSE MEALS THAT ARE APPROVED IN THIS APPLICATION BY THE TENNESSEE DEPARTMENT OF HUMAN SERVICES AND THAT MEET FEDERAL AND STATE REQUIEMENTS FOR FOOD COMPONENTS AND PORTION SIZES SHALL BE CLAIMED FOR REIMBURSEMENT;

4. THAT THE NUMBER OF MEALS CLAIMED FOR REIMBURSEMENT SHALL NOT EXCEED THE MAXIMUM ALLOWED UNDER THE CACFP; AND THAT APPROPRIATE AND ADEQUATE RECORDS, INCLUDING MENUS, ATTENDANCE AND MEAL COUNT RECORDS SHALL BE MAINTAINED TO SUPPORT THE NUMBER AND TYPE OF MEALS REPORTED TO THE TENNESSEE DEPARTMENT OF HUMAN SERVICES FOR CACFP REIMBURSEMENT;

5. THAT A PUBLIC RELEASE SHALL BE PROVIDED TO THE INFORMATIONAL MEDIA SERVING THE AREA(S) FROM WHICH PARTICIPANTS LIVE; AND THAT MINORITY AND GRASSROOTS ORGANIZATIONS IN THE SERVICE AREA(S) OF THE CENTER ARE INFORMED OF THE CHILD OR ADULT CARE SERVCIES AVAILABLE FROM THE CENTER;

6. ALL REQUIRED ELIGIBLITY APPLICATIONS ARE CURRENT; AND THAT FAMILY SIZE AND INCOME DOCUMENTATION SHALL BE MAINTAINED ON AN ANNUAL BASIS, AND WHENEVER THERE IS A CHANGE IN ELIGIBLITY CRITERIA;

7. ALL DOCUMENTATION CONCERNED WITH ELIGIBLITY APPLICATIONS SHALL BE MAINTAINED FOR AT LEAST THREE YEARS AFTER THE END OF THE CACFP FISCAL YEAR TO WHICH THE DOCUMENTATION PERTAINS, UNLESS IT MUST BE HELD PENDING FOR A LONGER TIME FOR AN AUDIT RESOLUTION PURPOSE.

8. NOT SHARE ANY INCOME INFORMATION CONCERNING PARTIPANTS WITHOUT THE WRITTEN CONSENT OF THE PARENTS OR GUARDIANS; AND LIMIT ACCESS TO AND USE OF THIS DOCUMENTATION BY THOSE PERSONS EMPLOYED BY THE CENTER;

9. DESIGNATE THE FOLLOWING EMPLOYEE(S) TO REVIEW FAMILY SIZE AND INCOME DOCUMENTATION AND MAKE DETERMINATIONS OF FREE AND REDUCED PRICE ELIGIBILITY AND REPORT ANY CHANGES IN THE ELIGIBILITY OF PARTICIPANTS:

_____ _____

Name and Title **Name and Title**

I ALSO CERTIFY THAT THE CENTER HAS PARTICIPATED IN THE FOLLOWING PUBLICLY FUNDED PROGRAMS DURING THE PAST SEVEN YEARS AND THAT NEITHER THE CENTER NOR ANY OF ITS PRINCIPALS ARE INELIGIBLE TO PARTICIPATE IN THESE PROGRAMS BY REASON OF VIOLATION OF THE REQUIREMENTS OF THESE PROGRAMS DURING THAT PERIOD:

LIST OF PUBLICLY FUNDED PROGRAMS: _____

_____

_____

I FURTHER CERTIFY THAT NEITHER THE CENTER OR ANY OF ITS PRINCIPALS HAVE BEEN CONVICTED OF ANY ACTIVITY THAT OCCURRED DURING THE PAST SEVEN YEARS AND THAT INDICATED A LACK OF BUSINESS INTEGRITY. CONVICTIONS INDICATING A LACK OF BUSINESS INTEGRITY INCLUDE FRAUD, ANTITRUST VIOLATIONS, EMBEZZLEMENT, THEFT, FORGERY, BRIBERY, FALSIFICATION OR DESTRUCTION OF RECORDS, MAKING FALSE STATEMENTS, RECEIVING STOLEN PROPERTY, MAKING FALSE CLAIMS, AND OBSTRUCTION OF JUSTICE.

I UNDERSTAND THAT THIS INFORMATION IS BEING GIVEN IN CONNECTION WITH THE RECEIPT OF FEDERAL FUNDS, AND THAT A DELIBERATE MISREPRESENTATION MAY SUBJECT ME TO PROSECUTION UNDER APPLICABLE STATE AND FEDERAL CRIMINAL STATUES. I ALSO UNDERSTAND THAT ANY CENTERS AND INDIVIDUALS PROVIDING FALSE CERTIFICATIONS WILL BE PLACED ON THE USDA NATIONAL DISQUALIFIED LIST AND WILL BE SUBJECT TO ANY OTHER APPLICABLE CIVIL OR CRIMINAL PENALTIES.

NAME, TITLE AND SIGNATURE OF AGENCY BOARD CHAIRPERSON, CHIEF EXECUTIVE OFFICER, OWNER OR OTHER AUTHORIZED REPRESENTATIVE:

Name (Please Print)	Title
Signature (Do Not Print)	Date

SAMPLE FORM TO DOCUMENT REQUIRED MANAGEMENT CONTROLS

As mandated by the federal regulation at 7 CFR Part 226.6 (b) (18), each new or renewing institution must have a financial system with written management controls. To document the management controls utilized by your institution, please provide the following information:

1. What is the frequency for depositing all cash receipts (including checks) at your banking institution:

   _____

2. Who is authorized to perform the following:

   a. Receive all adult care fees:

      Name: _____ Position Title: _____

      Name: _____ Position Title: _____

   b. Deposit all cash receipts (including checks) at your banking institution:

      Name: _____ Position Title: _____

      Name: _____ Position Title: _____

   c. Open the mail:

      Name: _____ Position Title: _____

      Name: _____ Position Title: _____

   d. Review the CACFP budget (approved by the Tennessee Department of Human Services) before incurring costs that are charged to the program:

      Name: _____ Position Title: _____

      Name: _____ Position Title: _____

   e. Review vendor invoices for correctness of the quantities received and prices charged before payment is made:

      Name: _____ Position Title: _____

      Name: _____ Position Title: _____

f. Ensure that pre-numbered checks are utilized for the payment of all costs:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

g. Record all checks when issued:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

h. Safeguard all unused checks:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

i. Retaining all voided checks:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

j. Ensure that no checks are issued payable to cash:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

k. Mail checks:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

l. Receive statements and cancelled checks from your banking institution:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

m. Reconcile monthly bank statements:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

n. Review reconciled bank statements:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

o. Review monthly statements for outstanding balances owed:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

p. Approve, sign, and distribute payroll checks:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

q. Prepare monthly CACFP claims for reimbursement:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

r. Contact the Tennessee Department of Human Services on all CACFP claims that are <u>not</u> paid within 30 days of submission;

Name: _____ Position Title: _____

Name: _____ Position Title: _____

3. Who is responsible for ensuring that all labor costs charged to the CACFP are supported by Time and Attendance Records which identify the starting time, ending time, and absences for each working day in each pay period:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

4. Who is responsible for ensuring that Time Distribution Records are maintained for all employees who perform both CACFP operational and administrative duties, or duties for the CACFP and other programs.

Name: _____ Position Title: _____

Name: _____ Position Title: _____

5. Who is responsible for ensuring that payroll records are maintained for each employee charged to the CACFP:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

The payroll records must include the following information:

a. Employee name;

b. Rate of pay;

c. Hours worked;

d. Benefits earned;

e. Any reductions or increases to the employee's base compensation, such as overtime pay;

f. Gross pay;

g. Net pay;

h. Date of payment;

j. Method of payment, such as check or electronic funds transfer; and

k. Verification that employee has been paid, such as canceled checks or electronic funds transfer deposit verification.

6. Describe the procedures for employees to request and receive approval for annual and sick leave;

_____

_____

_____

7. Who has access to the personnel files of employees:

   Name: _____ Position Title: _____

   Name: _____ Position Title: _____

8. Who is responsible for maintaining an inventory of all equipment purchased with CACFP funds:

   Name: _____ Position Title: _____

   Name: _____ Position Title: _____

   The CACFP defines equipment as an item of non-expendable personal property with a useful life of more than 1 year and an acquisition cost of $5,000 or more per unit.

NAME AND TITLE OF AUTHORIZED INSTITUTION OFFICIAL:

_____ _____

NAME TITLE

SIGNATURE OF AUTHORIZED INSTITUTION OFFICIAL:

_____ _____

SIGNATURE DATE

PUBLIC RELEASE FOR
CHILD AND ADULT CARE FOOD PROGRAM

_____ announces participation in
(NAME OF ADULT CARE CENTER)

the Child and Adult Care Food Program. Meals will be provided at no separate charge to eligible children served at the following site(s):

NAME:	ADDRESS:

All meals will be provided in accordance with the U.S. Department of Agriculture non-discrimination policy which prohibits discrimination based on race, color, national origin, sex, age and disability. (Not all prohibited bases apply to all programs.)

The income eligibility guidelines for free and reduced price meals are attached.