

ACFP New Provider Application

1. Application (Institution Information)

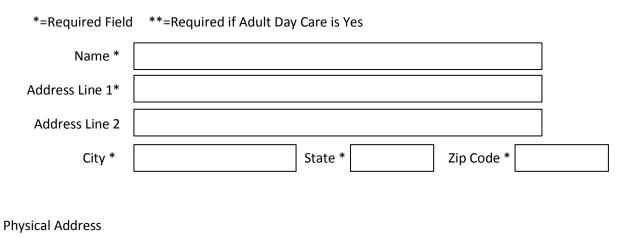
*= Required Field

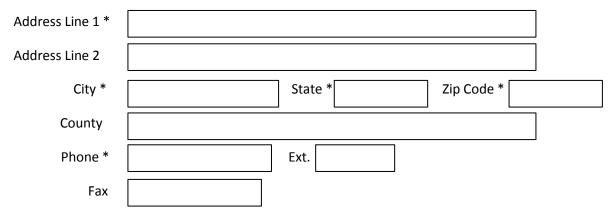
Institution Name *					
Federal Identification Number *					
Institution Mail Address *					
Institution Mail Address 2					
Institution Mail City *					
Institution Mail State *					
Institution Mail Zip Code *					
Institution County *					
Institution Street Address *					
Institution Street Address 2					
Institution Street State *		Ins	titution S	treet Zip Code *	
Institution Phone * [Instit	ution Phone Ext	
Institution Fax					
l					
Board President or Authorized Des	ignee Last Name *				
Board President or Authorized Des	gnee First Name *				
Board President or Authorized Des	gnee Salutation *			Mr. Mrs. Miss D	r. Ms. Hon. Rev.
Board President or Authorize	d Designee DOB *				
Board President or Authorize	d Designee Title *				
President or Authorized Designee E	usiness Address *				
Board President or Authoriz	ed Designee City *				
Board President or Authorized	Designee State *				
Board President or Authorized De	signee Zip Code *				
Board President or Authorized I	Designee Phone *			Phone Ext	
Board President or Authoriz	ed Designee Fax]	

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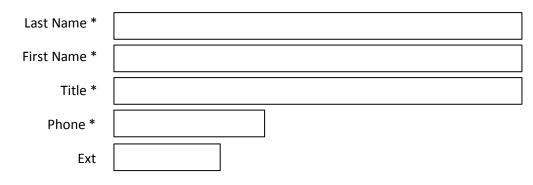
Contact Person Last Name *					
Contact Person First Name *					
Contact Person Salutation * Contact Person DOB *			Mr. Mi	rs. Miss	5 Dr. Ms. Hon. Rev.
Contact Person Business Address *					
Contact Person Business Address 2					
Contact Person Business City *			Stat	e *	Zip Code*
Contact Person Street Address *					
Contact Person Street Address 2					
Contact Person Street City *			Stat	e *	Zip Code*
Contact Person Phone *			Pho	ne Ext	
Contact Person Fax					
Contact Person Email					
Are all clients served over 18? (If no, contact State	e Agency) *		Yes	No	
Institution Fiscal Year	Ends on *				
Is your institution a faith-base	ed facility *		Yes	No	
Title III (i.e. congregate meal) Funding? (if yes, contact	t State Agency) *		Yes	No
Type of In	stitution *				
Method of Claims Sul	omission *				Fax or Electronic
List Federal Agency(s) that currently provide funding f	or your institu	Ition			
Does institution charge day participants separately	for meals *			Yes	No
Address ACFP Records Ma	aintained *			St	reet Address
	Γ				City, State

2. Schedule A (Site Information) Mailing Address





Person in Charge at Site



Schedule A (Site Information)

			_	-	
Adult Day Ca	are*	Yes	No		
Vocational Training Progr	ram*	Yes	No		
State Approved Day Prog	gram *	Yes	No]	
Mental Health Day Treatment (If yes, submit current DCF Conti	ract) *	Yes	No]	
License Capa	acity *				
License Expiration	Date *				
Days Per V	Veek *				
Weeks Per	Year *				
Staff Hours	From:				
	To:				
First Shift Hours	From:		٦		
(If Needed)					
	′ то: [
Second Shift Hours	From:		7		
(If Needed)	_				
	To:				
Title XIX Centers only	L				
Proprietary Adult Day Care Centers must submit documentation that they are currently providing nonresidential adult day care services for which they receive compensation under Title XIX or XX of the Social Security Act. Certification must be provided also indication that not less than 25 percent of enrolled participants in each center during the most recent calendar month were Title XIX or XX beneficiaries. Documentation of Title	Adults otal XIX			 	
Perce	ent XIX				
Methods by which meals will be provided (Choose one or more)					
A.On-Site/Se	lf Prep *	k			
B.Under Contract with Local School System (Send Memorandum of Agr	eement)			
C.Contract with Caterer (Send Food Service Contract and	nd MOA)			
D.Agency's Central Kitchen (Send Memorandum of Agree	eement)				
E.	Other				

3.Site Yearly Estimate

Adult Food Program – Add Site Estimate

Provider Number

Schedule A: Sit	e 1
Fiscal Year Begins	
Daily Meals Breakfast Estimate	
Meals Breakfast Begin Time	
Meals Breakfast End Time	
Daily Meals AM Supplement Estimate	
Meals AM Supplement Begin Time	
Meals AM Supplement End Time	
Daily Meals Lunch Estimate	
Meals Lunch Begin Time	
Meals Lunch End Time	
Daily Meals PM Supplement Estimate	
Meals PM Supplement Begin Time	
Meals PM Supplement End Time	
Daily Meals Dinner/ Supper Estimate	
Meals Dinner/ Supper Begin Time	
Meals Dinner/ Supper End Time	

Total Enrollment Free	
Total Enrollment Reduced	
Total Enrollment Non-Needy	

Meal/Snack

Estimates:

How many clients you think you will serve meals to each day.

You need at least two hours between any two meal/snack times.

Example:

A.M. Snack ends at 10 a.m.

Lunch cannot begin before 12 p.m.

Enrollment

How many clients are enrolled in each category

Meals/Snacks not served

You must put "0".

There are three categories of eligibility associated with the ACFP: Free, Reduced, and Non-needy. Each participant is individually assessed to determine her/his eligibility category.

4. Management Plan (Institution Fiscal Year Records)

Fiscal Year Begins	October 1,
Budget Food Purchases	
Budget Non-Food Supplies	
Supplemental Budget Expenses	
Does your institution prefer cash in lieu of donations	YES
Did your institution expend \$750,000.00 or more in federal funds	
during your fiscal year, if YES enter last agency wide audit date.	
Federal Funds Audit Date	
Media Release Sent	Yes No
	Yes No

Please describe how you reach diverse groups in your area? Please Explain in the box what tools (brochures, fliers, outreach programs Etc.) you use to ensure that minority populations have equal opportunity to participate in the food program.

Provide the ethnic and racial population makeup

of the area from which each institution draws its

attendance. Information needs to be reported in

whole numbers.

See **Census Data**

http://factfinder2.census.gov/faces/nav /jsf/Pages/index.

Ethnicity:	
Hispanic or Latino	
Not Hispanic or Latino	
Race:	
American Indian or Alaskan Native	
Asian	
Black or African American	
Native Hawaiian or Other Pacific Islander	~
White	

Answers required only of institutions with more than one site

(Sponsoring Organizations)

If monthly claim reimbursement is not deposited

into a central institutional account,

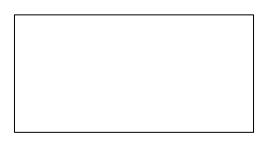
then outline systems used for disbursing reimbursements

to facilities under your administration within five days.

Outline Procedures for Training



Outline methods of collection records from each facility regarding the daily point of service meal counts and daily attendance



Describe your system for calculating your ACFP food service and administrative costs claim



Describe your system for collecting Family size and income information from each client



Describe your time frame for collecting monthly records from each site



1st Operation Review

2nd Operation Review

3rd Operation Review



You MUST submit the dates you plan to visit your sites. You're required to monitor them three times during the fiscal year.

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4. Management Plan (Institution Fiscal Year Records)

Labor Expenses (make copies as needed)

This is required for you to claim labor expenses.

Food Service includes: Planning menus, checking menus, grocery shopping, cooking, serving, clean up, etc. All boxes must be filled. Hourly rate must be included. Include only time working with ACFP duties.

Position Type	
Duties	
Employee Count	
Hours Per Day	
Hourly Rate	
Days Per Year	
Position Type	
Duties	
Employee Count	
Hours Per Day	
Hourly Rate	
Days Per Year	

4. Management Plan (Institution Fiscal Year Records)

Labor Expenses (make copies as needed)

Administrative Includes: Overseeing the program, applications, rosters, determining eligibility, checking the menu, etc. All boxes must be filled. Hourly rate must be included. Include only time working with ACFP duties.

Position Type	
Duties	
Employee Count	
Hours Per Day	
Hourly Rate	
Days Per Year	

Position Type	
Duties	
Employee Count	
Hours Per Day	
Hourly Rate	
Days Per Year	