

## ACFP New Provider Application

### 1. Application (Institution Information)

\*= Required Field

Institution Name *	<input type="text"/>		
Federal Identification Number *	<input type="text"/>		
Institution Mail Address *	<input type="text"/>		
Institution Mail Address 2	<input type="text"/>		
Institution Mail City *	<input type="text"/>		
Institution Mail State *	<input type="text"/>		
Institution Mail Zip Code *	<input type="text"/>		
Institution County *	<input type="text"/>		
Institution Street Address *	<input type="text"/>		
Institution Street Address 2	<input type="text"/>		
Institution Street State *	<input type="text"/>	Institution Street Zip Code *	<input type="text"/>
Institution Phone *	<input type="text"/>	Institution Phone Ext	<input type="text"/>
Institution Fax	<input type="text"/>		

  

Board President or Authorized Designee Last Name *	<input type="text"/>		
Board President or Authorized Designee First Name *	<input type="text"/>		
Board President or Authorized Designee Salutation *	<input type="text"/>	Mr. Mrs. Miss Dr. Ms. Hon. Rev.	
Board President or Authorized Designee DOB *	<input type="text"/>		
Board President or Authorized Designee Title *	<input type="text"/>		
President or Authorized Designee Business Address *	<input type="text"/>		
Board President or Authorized Designee City *	<input type="text"/>		
Board President or Authorized Designee State *	<input type="text"/>		
Board President or Authorized Designee Zip Code *	<input type="text"/>		
Board President or Authorized Designee Phone *	<input type="text"/>	Phone Ext	<input type="text"/>
Board President or Authorized Designee Fax	<input type="text"/>		

**Application (Institution Information)**

Contact Person Last Name \*

Contact Person First Name \*

Contact Person Salutation \*

Mr. Mrs. Miss Dr. Ms. Hon. Rev.

Contact Person DOB \*

Contact Person Business Address \*

Contact Person Business Address 2

Contact Person Business City \*

State \*

Zip Code\*

Contact Person Street Address \*

Contact Person Street Address 2

Contact Person Street City \*

State \*

Zip Code\*

Contact Person Phone \*

Phone Ext

Contact Person Fax

Contact Person Email

Are all clients served over 18? (If no, contact State Agency) \*

Yes No

Institution Fiscal Year Ends on \*

Is your institution a faith-based facility \*

Yes No

Title III (i.e. congregate meal) Funding? (if yes, contact State Agency) \*

Yes No

Type of Institution \*

Method of Claims Submission \*

Fax or Electronic

List Federal Agency(s) that currently provide funding for your institution

Does institution charge day participants separately for meals \*

Yes No

Address ACFP Records Maintained \*

Street Address

City, State

2. Schedule A (Site Information)

Mailing Address

\*=Required Field    \*\*=Required if Adult Day Care is Yes

Name \*

Address Line 1\*

Address Line 2

City \* State \* Zip Code \*

Physical Address

Address Line 1 \*

Address Line 2

City \* State \* Zip Code \*

County

Phone \* Ext.

Fax

Person in Charge at Site

Last Name \*

First Name \*

Title \*

Phone \*

Ext

## Schedule A (Site Information)

Adult Day Care*	Yes	No	<input type="text"/>
Vocational Training Program*	Yes	No	<input type="text"/>
State Approved Day Program *	Yes	No	<input type="text"/>
Mental Health Day Treatment (If yes, submit current DCF Contract) *	Yes	No	<input type="text"/>
License Capacity *	<input type="text"/>		
License Expiration Date *	<input type="text"/>		
Days Per Week *	<input type="text"/>		
Weeks Per Year *	<input type="text"/>		
Staff Hours From:	<input type="text"/>		
To:	<input type="text"/>		
First Shift Hours From:	<input type="text"/>		
(If Needed)	To:	<input type="text"/>	
Second Shift Hours From:	<input type="text"/>		
(If Needed)	To:	<input type="text"/>	

## Title XIX Centers only

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 XIX or XX benefits must be provided by for-profit institutions at the time of application and also at renewal.

Total Adults	<input type="text"/>
Total XIX	<input type="text"/>
Percent XIX	<input type="text"/>

## Methods by which meals will be provided (Choose one or more)

A. On-Site/Self Prep *	<input type="text"/>
B. Under Contract with Local School System (Send Memorandum of Agreement)	<input type="text"/>
C. Contract with Caterer (Send Food Service Contract and MOA)	<input type="text"/>
D. Agency's Central Kitchen (Send Memorandum of Agreement)	<input type="text"/>
E. Other	<input type="text"/>

### 3.Site Yearly Estimate

Adult Food Program – Add Site Estimate

Provider Number	
Schedule A: Site 1	
Fiscal Year Begins	<input type="text"/>
Daily Meals Breakfast Estimate	<input type="text"/>
Meals Breakfast Begin Time	<input type="text"/>
Meals Breakfast End Time	<input type="text"/>
Daily Meals AM Supplement Estimate	<input type="text"/>
Meals AM Supplement Begin Time	<input type="text"/>
Meals AM Supplement End Time	<input type="text"/>
Daily Meals Lunch Estimate	<input type="text"/>
Meals Lunch Begin Time	<input type="text"/>
Meals Lunch End Time	<input type="text"/>
Daily Meals PM Supplement Estimate	<input type="text"/>
Meals PM Supplement Begin Time	<input type="text"/>
Meals PM Supplement End Time	<input type="text"/>
Daily Meals Dinner/ Supper Estimate	<input type="text"/>
Meals Dinner/ Supper Begin Time	<input type="text"/>
Meals Dinner/ Supper End Time	<input type="text"/>
Total Enrollment Free	<input type="text"/>
Total Enrollment Reduced	<input type="text"/>
Total Enrollment Non-Needy	<input type="text"/>

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, <input type="text"/>
Budget Food Purchases	<input type="text"/>
Budget Non-Food Supplies	<input type="text"/>
Supplemental Budget Expenses	<input type="text"/>
Does your institution prefer cash in lieu of donations	<input type="text" value="YES"/>
Did your institution expend \$750,000.00 or more in federal funds	<input type="text"/>
during your fiscal year, if YES enter last agency wide audit date.	
Federal Funds Audit Date	<input type="text"/>
Media Release Sent	<input type="text"/> 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

#### Budget Food Purchases:

Estimate of yearly expense for food items: groceries, caterer, etc.

#### Budget Non-Food Supplies:

Estimate of yearly expense for non-food items, such as plates, napkins, etc.

#### Budget Other Expenses:

Any additional yearly expenses (not including labor)

**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

**Food service Operations review – Scheduled Site Monitoring**

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.

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	<div></div>
Duties	<div></div>
Employee Count	<div></div>
Hours Per Day	<div></div>
Hourly Rate	<div></div>
Days Per Year	<div></div>
Position Type	<div></div>
Duties	<div></div>
Employee Count	<div></div>
Hours Per Day	<div></div>
Hourly Rate	<div></div>
Days Per Year	<div></div>



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	<div></div>
Duties	<div></div>
Employee Count	<div></div>
Hours Per Day	<div></div>
Hourly Rate	<div></div>
Days Per Year	<div></div>

  

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