

South Carolina Department of Social Services
**AT-RISK AFTERSCHOOL CARE PROGRAM/OUTSIDE SCHOOL HOURS PROGRAM
APPLICATION FOR PARTICIPATION**

CACFP Agreement No.: _____ FEIN No.: _____

1. Name and Mailing Address of Organization:

City: _____ State: _____ Zip: _____ County: _____

2. Physical Address of Organization: _____

City: _____ State: _____ Zip: _____ County: _____

Office Hours: _____ to _____ Telephone: _____ Fax: _____

List specific dates when this office will be closed: _____

Note: All organizations that wish to participate in the CACFP in South Carolina as a sponsoring institution must have an administrative office located in South Carolina. All required records pertaining to South Carolina CACFP must be maintained in this office.

If institution home office is located in another state, has your organization registered to operate in South Carolina with the Secretary of State Office? Yes No N/A

3. Name and Title of Administrator: _____

(Authorized sponsoring organization representative who will sign the Agreement)

E-Mail Address: _____

4. Type of Institution: (Choose one)

Private Nonprofit-Secular (Attach a copy of the letter from IRS documenting Federal tax-exempt status)

Private Nonprofit-Faith Based

Are you a church? Yes No (Churches may submit a copy of the Certificate of Nonprofit Status from the Secretary of State's office. All others must submit documentation of Federal tax exempt status from the IRS. Reference the instructions for this form for definition of a church.)

Private For-Profit

Educational Institution

Public Institution (Governmental)

Other: (Specify) _____

5. Does your organization operate the CACFP in any other state(s)? Yes No

If yes, please identify which state(s): _____

6. Does your organization now participate or have you participated in programs funded through the USDA Food and Nutrition Service in the past three years? (If yes, give name of Program and dates of participation.) Yes No

7. Does your organization participate in any other federally funded programs? (If yes, give name of Program and dates of participation.) Yes No

8. Has your organization been terminated from participating in any publicly funded programs within the past seven years? (If yes, give name of Program, dates of Participation and reason(s) for termination.) Yes No

9. Which program are you applying for? At-Risk Afterschool Care Program Outside School Hours Care Program

10. Number of sites included with this application: _____

11. Do any of the sites charge a separate fee for meals or snacks? Yes No

12. Identify the meals being applied for in the chart below:

At-Risk Afterschool Care Program	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Identify Number of Sites Serving Each Meal						
Estimated Number of Meals Each Day						
Outside School Hours Care Program	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Identify Number of Sites Serving Each Meal						
Estimated Number of Meals Each Day						

13. Applicant organization would prefer to receive: (Check one box only. Approved applicants who prefer cash payments instead of donated foods will receive such payments. However, those which choose foods may be required to accept cash instead.)

- USDA-Donated Food Cash Payments

14. Identify the type of accounting system used by your organization. (Please check one. If you check paper ledger, skip to number 4.)

- Paper Ledger Accounting Software No Formal Accounting System

Other: (Provide description) _____

15. If accounting software is used, please provide the following information:

A. Type of software used: _____

B. What system do you have in place to ensure the availability of records that support CACFP costs in the event of theft, property damage, fire, system crash, etc.?

16. If you use a paper ledger system, how do you ensure that all CACFP records are safeguarded from theft, property damage, fire, etc.?

17. Will the organization use a separate bank account for CACFP monies? Yes No

18. How will CACFP funds (expenses and income) be tracked separately from other institutional funds? (Please check the method which applies to your organization.)

- Summary of Expense Form (Provided by DSS)
 Formal Accounting System (If a formal accounting system is used, the organization must establish a CACFP fund account within the system. A monthly report that summarizes the CACFP expenses and income and any other income that is specifically used for the food service must be prepared. In addition, a detailed transaction report of expenditures and income must also be available. Please attach a sample of each of these reports from your accounting system to this form.)
 Other: (Specify) _____

19. Who is responsible for purchasing food, nonfood supplies, etc. for the organization?

20. Has this person received training on allowable costs for CACFP? Yes No

If yes, when was training provided? _____

21. Who is responsible for maintaining the accounting records for the organization?

22. Is this person aware of the requirements for allowable and unallowable costs for using CACFP funds?
 Yes No

23. Who is responsible for the development of the menu for the meals/snacks?

24. Has this person received training on the required meal components for each meal service? Yes No
If yes, when was training provided and by whom? _____

25. Will all sponsored facilities use the same menu? Yes No

26. Can substitution be made to the menus? Yes No
If yes, how is this done and when is it approved? _____

27. Describe your procedures for determining free and reduced-price eligibility and reporting this information on the claim for reimbursement. (This question applies to organizations applying for the Outside School Hours Care Program only.)

28. Describe your organization's system for submitting timely and accurate claims for reimbursement.

29. Do you have an annual audit? Yes No
If yes, provide a copy of the most recent audit report. If the audit has not been completed, specify the anticipated completion date in the space provided:

Specify type of audit: Organization Wide Program Specific N/A

Name of firm to conduct audit: _____

Audit Firm Mailing Address: _____

Audit Period: _____

30. Indicate your annual dates of operation: Starting: _____ Ending: _____
MM/YY MM/YY

31. Indicate your fiscal (tax year) year: Starting: _____ Ending: _____
MM/YY MM/YY

32. CACFP reimbursement may not cover all costs incurred due to operating the Program. Please indicate below other sources of funds available to the center that will be used.

A. _____ D. _____

B. _____ E. _____

C. _____ F. _____

33. Responsible individuals of the organization: Responsible individuals have oversight of the program.

Name	Title	Date of Birth

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

Name: _____ Title: _____ Date of Birth: _____

Name of publicly funded programs individual participated in during the past seven years and dates of participation:
(If the organization participates in the program, the principal does as well.)

Program Name	Dates of Participation
_____	_____
_____	_____
_____	_____

Name: _____ Title: _____ Date of Birth: _____

Name of publicly funded programs individual participated in during the past seven years and dates of participation:
(If the organization participates in the program, the principal does as well.)

Program Name	Dates of Participation
_____	_____
_____	_____
_____	_____

Name: _____ Title: _____ Date of Birth: _____

Name of publicly funded programs individual participated in during the past seven years and dates of participation:
(If the organization participates in the program, the principal does as well.)

Program Name	Dates of Participation
_____	_____
_____	_____
_____	_____

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

Program Name	Dates of Participation
_____	_____
_____	_____
_____	_____

CERTIFICATION STATEMENT

I CERTIFY that this organization has not been disqualified from participation in any other publicly funded program for violating that program's requirements. I understand that "Publicly-funded program" means any program or grant funded by Federal, State, or local government.

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. I certify that this organization is capable of monitoring and managing the program as required by the Child and Adult Care Food Program. 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.

Date

Name and Title of Authorized Representative

Signature of Authorized Representative