



Wisconsin Department of Public Instruction
 Child and Adult Care Food Program (CACFP)
CACFP HOME PROVIDER APPLICATION
 (Rev. 1/22)

Provider Number

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Instructions: This form must be completed by the sponsor and signed by both the new provider and sponsor. Once the sponsor has completed the provider's previsit and orientation, received the provider's regulation, and CACFP Sponsor-Home Provider Agreement has been signed, the sponsor must enter the provider's information online into their Provider List for DPI approval.

* **The Effective Date of Agreement is listed on the CACFP Sponsor-Home Provider Agreement and is the approved date the provider may start claiming meals. It is subject to DPI's approval in the sponsor's Provider List, which must be received prior to the sponsor submitting their claim to DPI.**

SPONSOR'S INFORMATION				MEAL SERVICE APPROVAL																																										
Sponsoring Organization's Name		Agency Code		<ul style="list-style-type: none"> Sponsors may only approve meal types served to enrolled children within the provider's regulation limits. Breakfast must be served during morning hours Shift Meals: Providers must be approved by the sponsor for shift meals and submit current meal shift information with each monthly claim. <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr style="background-color: #e0e0e0;"> <th rowspan="2" style="width: 15%;">Approved Meal Types</th> <th colspan="2" style="width: 15%;">First or Only Shift Serving Times</th> <th colspan="2" style="width: 15%;">Second Shift Serving Times</th> </tr> <tr style="background-color: #e0e0e0;"> <th>From</th> <th>To</th> <th>From</th> <th>To</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Breakfast</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> AM Snack</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Lunch</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> PM Snack</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Dinner</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Additional Snack</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>				Approved Meal Types	First or Only Shift Serving Times		Second Shift Serving Times		From	To	From	To	<input type="checkbox"/> Breakfast					<input type="checkbox"/> AM Snack					<input type="checkbox"/> Lunch					<input type="checkbox"/> PM Snack					<input type="checkbox"/> Dinner					<input type="checkbox"/> Additional Snack				
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Address (Street address/City/Zip)		Phone No.																																												
		Email:																																												
PROVIDER'S INFORMATION																																														
Provider's Name		Date of Birth (M/D/Y)																																												
Address (Street address/City/Zip)		Phone No.																																												
		Email:																																												
		County:																																												
REGULATION INFORMATION				Meals served to provider's own children may be reimbursable if the sponsor has determined the provider's current Household Size-Income Statement as eligible. <table style="width: 100%; text-align: center;"> <tr> <td style="width: 60%;">Provider's own children?</td> <td style="width: 20%;">Yes</td> <td style="width: 20%;">No</td> </tr> </table>				Provider's own children?	Yes	No																																				
Provider's own children?	Yes	No																																												
DWD Provider No.				Are children currently enrolled? Yes No • If no, anticipated start date of care?																																										
Regulation Type	Capacity	Effective Date	Expiration Date																																											
License	Certificate																																													
Days of Operation: Sunday Monday Tuesday Wednesday Thursday Friday Saturday				Orientation (M/D/Y):		Previsit (M/D/Y):																																								
Hours of Operation		Age Range of Children		*Effective Date of Agreement (M/D/Y):																																										
From	AM	To	AM					From	To																																					
	PM		PM																																											
CERTIFICATION																																														
I HEREBY CERTIFY that the information on this application is true and correct, and that I am not currently participating in the CACFP under any other sponsoring organization. I agree to only claim meals that meet the CACFP requirements for reimbursement and to offer the Program to all children regardless of age, sex, disability, race, color, or national origin. I understand that information on this application is being given in connection with the receipt of federal funds and deliberate misrepresentation may subject me to prosecution under applicable state and federal statutes.																																														
Provider's Signature			Signature date M/D/Y		Sponsor Representative's Signature		Signature date M/D/Y																																							