Application Update
Child and Adult Care Food Program

MANAGEMENT PLAN FOR SPONSOR OF DAY CARE HOMES

For FY 2017 beginning October 1, 2016 through September 30, 2017

1. Sponsoring Organization: _____

Street Address: _____

Mailing Address: _____City, State, Zip: _____

Telephone Number: _____Fax Number: _____

Sponsor's Federal Tax ID Number: _____

Director: _____Date of Birth: _____E-mail: _____

CACFP Contact: _____ E-mail: _____

Board Chairman: _____ Date of Birth: _____

Board Chairman Mailing Address: _____

Business Hours of Operation: _____am to _____pm Circle operating days of week: S M T W T F S

2. Providers currently participating in the CACFP under this sponsor:
_____ Number of providers with current agreements with this sponsor. (Attach a list of all Providers)

3. Funding sources; List all publicly funded programs in which this sponsoring organization and its principals have participated in the past seven (7) years. Attach a separate sheet if necessary.

Program name	Funding Program

4. _____**Yes** _____ **No** The Sponsor is requesting an **advance payment** for administrative expenses.
*(If **yes**, must complete **Attachment N Advance Payment Request.)***

111 North Jackson St., PO Box 202925
Helena, MT 59620-2925
Phone (406) 444-4347; Toll-Free (888) 307-9333; Fax (406) 444-2547

5. Acknowledgements and certifications:

A. I certify that neither this Sponsor nor any of its Responsible Principals or Responsible Individuals or any Provider this Sponsor has an agreement with, are on the National Disqualified List for the CACFP.

B. I certify that during the past seven years, neither this Sponsor nor any of its Responsible Principals or Responsible Individuals; have been declared ineligible to participate in any other publicly funded program for violating that program's requirements. I understand that anyone providing false information will be placed on the National Disqualified List for the CACFP and may be subject to other applicable civil or criminal penalties.

C. I certify that during the past seven years, that neither this Sponsor nor any of its Responsible Principals or Responsible Individuals has had any criminal convictions that indicated a lack of business integrity. I understand that anyone providing false information will be placed on the National Disqualified List for the CACFP and may be subject to other applicable civil or criminal penalties.

D. I certify that the information on this application and attached forms is true and correct to the best of my knowledge; I will accept final administrative and financial responsibility for total Child and Adult Care Food Program operations under this sponsorship; reimbursement will be claimed only for meals served to registered and enrolled participants; and the CACFP will be available at no additional cost and served without discrimination to all eligible participants regardless of race, color, national origin, sex, age, or disability.

E. I understand that the Montana Department of Public Health and Human Services, the Montana CACFP, and other State or Federal officials may make announced or unannounced reviews of this sponsorship during the normal business hours of operation. Additionally, I understand that state or federal monitors and/or any other authorized review personnel for the CACFP must show photo identification demonstrating employment with one of the above entities.

F. I understand that employees of this Sponsor must show photo identification which demonstrates employment with this organization when performing monitoring or when involved in personal contact with day care home providers at their place of business.

G. I certify that the current Montana CACFP Meal Benefit Income Eligibility Form is being used in determining the Provider's income for purposes of tiering by income.

H. I certify that Providers who claim their own children for reimbursement have completed and submitted the Montana CACFP Meal Benefit Income Eligibility Form and qualify by income for Tier I classification. All documents that verify Provider income and Tier I classification are located in their Provider file.

I. I certify that this Sponsor is a private, non-profit organization with tax exempt status from the IRS.

J. I certify that this Sponsor is financially viable, administratively capable, and has internal accountability controls in its administration of the CACFP.

K. I understand that this information is being given in conjunction with the receipt of federal funds, and that a deliberate misrepresentation may subject me to prosecution under applicable State and Federal statutes.

_____

Printed Name and Title of Sponsoring Organization Representative

_____

Signature of Sponsoring Organization Representative Date Signed

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write: USDA Director, Office of Civil Rights, 1400 Independence Ave. SW, Washington, DC 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY).