Reset

South Carolina Department of Social Services
Child and Adult Care Food Program

APPLICATION FOR PARTICIPATION FOR CHILD CARE HOMES

❑ Check if revised and enter the "effective" date: _____

1. Sponsor Agreement Number: _____ Sponsor Name: _____
2. Name of Provider: _____ 2a. Date of Birth: _____

3A. Street Address: (If mailing address is different, please indicate both. Also include zip code.)

_____

_____

3B. Is this your private residence? ❑ Yes ❑ No

4. Telephone: _____ County: _____
5. Name of Person Responsible at Child Care Home: _____
6. **Type of Facility:** ❑ Group Child Care Home ❑ Licensed Family Child Care Home ❑ Registered Family Child Care Home ❑ Military Child Care Home
7. License or Registration Capacity: _____ Expiration Date: _____
   Attach a copy of license or registration.
8. Provider's Social Security Number: (Last four digits only) XXX-XX- _____
9. **Operating Data:**

   A. Hours of Operation: From: _____ To: _____ B. Do you care for participants in shifts? ❑ Yes ❑ No

   C. List Operating Days Per Week: _____ D. Number of Operating Weeks Per Year: _____

   E. List any holidays, weeks and/or months during which the Child and Adult Care Food Program **will not** operate:

   _____

   F. Age Range of Enrolled Children: From: _____ To: _____

10. **Meal Service:**

A. Meals Claimed for Reimbursement:	❑ Breakfast	❑ AM Supplement	❑ Lunch	❑ PM Supplement	❑ Supper	❑ Evening Supplement
B. Time of Meal Service:						

11. Number of Children 12 and Under that Provider Takes Care of Daily:

    A. Provider's Own Children: (Include all Residential Children) _____ B. Other Than Provider's Own Children: _____

12. Are provider's children eligible to be claimed for reimbursement according to the family size and income information available at the sponsoring organization? ❑ Yes ❑ No ❑ NA
13. Has provider ever participated in the CACFP under another sponsor? ❑ Yes ❑ No

    If yes, list sponsor name and dates of participation: _____

    _____

I certify that to the best of my knowledge, this home is not participating in the Child and Adult Care Food Program under any other sponsor organization. I further certify that all of the above information is true and correct. I understand that this information is being given in connection with the receipt of federal funds, that department officials may, for cause, verify information; and that deliberate misrepresentation may subject me to prosecution under applicable state and criminal statutes. The program must be made available to all eligible children regardless of age, sex, disability, race, color or national origin.

14. Provider's Signature: _____ Date: _____
15. Sponsoring Organization Representative's Signature: _____ Date: _____

INSTRUCTIONS FOR DSS FORM 1606

1. Enter sponsor agreement number and name.
2. Enter provider name.

2A. Date of Birth of the Provider

3A. Enter street address of child care home including the zip code. If mailing address is different, please indicate this also.

3B. Indicate whether or not this is your private residence.

4. Enter provider's telephone number and county of residence.
5. Enter name of person responsible at child care home.
6. Mark the appropriate type of home child care.
7. Enter the license or registration capacity and expiration date. Also, attach a copy of the license or registration.
8. Enter the last four digits of the provider's Social Security number. To participate in the CACFP in South Carolina it is mandatory to disclose your Social Security number. Your SSN is used to prevent participation under more than one sponsor. The legal authority for collecting your SSN for the CACFP is Section 1211(b) of the Tax Reform Act of 1976 and 42 USCA § 1766 AND 7 CFR § 226 et. seq.
9. A. Enter the hours the home is open for child care.

   B. If the provider cares for more children than their regulatory permit capacity or they want to be approved for more than three meals, then this must be marked yes.

   C. List the week days that the child care is open.

   D. Enter the number of weeks the child care operates per year.

   E. List any holidays, weeks and/or months which the home will not be open.

   F. Enter the age range of children that the provider cares for.

10. A. Check the meals the provider will serve and claim reimbursement for. **If more than three are checked, 9B must be answered yes.**

    B. Enter the time each meal will be served on a normal basis.

    C. Enter the number of children expected to be served at each meal.

11. A. Enter the number of children 12 and under that the provider takes care of daily that are the provider's own children and/or residential children.

    B. Enter the number of all other children the provider takes care of.

    Note: If 11A and 11B total to more than the allowable capacity, 9B must be answered yes.

12. Indicate whether or not the provider's children and other residential children are eligible to be claimed for reimbursement. If the provider has no children 12 or under, mark NA (Not Applicable).
13. Indicate whether or not the provider has participated on the CACFP under another sponsor. If yes, indicate the sponsor name and dates of participation.
14. Provider must sign and date the form here.
15. Sponsor representative must sign and date the form here.

DISTRIBUTION: Sponsor should submit white copy to SCDSS Child and Adult Care Food Program, canary copy to provider and should retain the pink copy for their file.