



OFFICE OF SUPERINTENDENT OF PUBLIC INSTRUCTION  
 Child Nutrition Services  
 Old Capitol Building, PO BOX 47200  
 Olympia, WA 98504-7200

**Child and Adult Care Food Program  
 SPONSOR INFORMATION**

**SPONSOR APPLICATION**

SPONSOR NAME	AGREEMENT NUMBER	FEDERAL ID NUMBER OR DUNS NUMBER	PROGRAM YEAR
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**ADDRESS INFORMATION**

Mailing Address		Street Address	
ADDRESS		ADDRESS	
ADDRESS (Cont.)		ADDRESS (Cont.)	
CITY		CITY	
STATE	ZIP CODE	STATE	ZIP CODE
COUNTY		COUNTY	
Out of State Mailing Address			
ADDRESS			
ADDRESS (Cont.)			
CITY			
STATE	ZIP CODE		
COUNTY			

The street address is the same as the mailing address.

**PAYMENT INFORMATION**

Payment Address	
ADDRESS	
ADDRESS (Cont.)	
CITY	
STATE	ZIP CODE
COUNTY	

The payment address is the same as the mailing address.

Program Information		
<b>Application Type</b>		
<input type="checkbox"/> Child Care Center	<input type="checkbox"/> Adult Care Center	<input type="checkbox"/> Day Care Home
<b>Organization Type</b>		
<input type="checkbox"/> Profit	<input type="checkbox"/> Nonprofit	
<b>Vendor Type</b>		
<input type="checkbox"/> Private business	<input type="checkbox"/> Public	
<input type="checkbox"/> Government	<input type="checkbox"/> Other	
<b>Ownership Code</b>		
<input type="checkbox"/> Sole Owner	<input type="checkbox"/> Partnership	
<input type="checkbox"/> Government	<input type="checkbox"/> Washington Corporation (LLC or Inc.)	
<input type="checkbox"/> Out-of-State Corporation		
<b>Sponsor Type</b>		
<input type="checkbox"/> Administrative Sponsor	<input type="checkbox"/> Independent Center	
<input type="checkbox"/> Center Sponsor	<input type="checkbox"/> Day Care Home Sponsor	
<b>For Centers Only:</b>		
Number of approved facilities	<input style="width: 100px; height: 20px;" type="text"/>	

### CONTACTS

CACFP Program Contact		
NAME (First, Middle, Last)		
PHONE (e.g., (555) 555-5555, extension)	EXT	TITLE
FAX		E-MAIL
ADDRESS		DATE OF BIRTH
CITY		COUNTY
STATE		ZIP CODE

Claim Contact		
NAME (First, Middle, Last)		
PHONE (e.g., (555) 555-5555, extension)	EXT	TITLE
FAX		E-MAIL
ADDRESS		DATE OF BIRTH
CITY		COUNTY
STATE		ZIP CODE

The claim contact is the same as the program contact.

Second Program Contact		
NAME (First, Middle, Last)		
PHONE (e.g., (555) 555-5555, extension)	EXT	TITLE
FAX	E-MAIL	
ADDRESS	DATE OF BIRTH	
CITY	COUNTY	
STATE	ZIP CODE	

<input type="checkbox"/> Business CEO/President/Owner Contact (For Profit Centers) or <input type="checkbox"/> Board Chairperson (Nonprofit Agency)		
NAME (First, Middle, Last)		
PHONE (e.g., (555) 555-5555, extension)	EXT	TITLE
FAX	E-MAIL	
ADDRESS	DATE OF BIRTH	
CITY	COUNTY	
STATE	ZIP CODE	

The owner, president, or CEO contact is the same as the program contact.

Day Care Home Sponsors Only		
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Requesting Advances? Amount Requested _____
<input type="checkbox"/>	<input type="checkbox"/>	Requesting Expansion Funds?
<input type="checkbox"/>	<input type="checkbox"/>	Requesting Start Up Funds?

Method of reimbursement for Tier II Mixed rate providers		
<input type="checkbox"/>	<input type="checkbox"/>	Actual
<input type="checkbox"/>	<input type="checkbox"/>	Blended
<input type="checkbox"/>	<input type="checkbox"/>	Percentage

	Tier 1	Tier II High	Tier II Low	Tier II Mixed	Total
Number of family day care home providers					
Number of children					

Miscellaneous Questions		
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do you charge separately for meals?
<input type="checkbox"/>	<input type="checkbox"/>	Does institution operate in other states? If so, under what names?
<input type="checkbox"/>	<input type="checkbox"/>	Has the institution, or any of its principals, been declared ineligible to participate in the CACFP for violating CACFP program requirements and is on the National Disqualified List? If yes, explain.
<input type="checkbox"/>	<input type="checkbox"/>	Has the institution, or any of its principals, been declared ineligible to participate in any other publicly-funded program? If yes, explain.
<input type="checkbox"/>	<input type="checkbox"/>	Institution attended annual training. Date: _____

Provide the breakdown of enrollment by ethnic and racial category.

Ethnic/Racial Data							
American Indian or Alaskan Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	Hispanic or Latino	White	Multi-Racial	Total

Civil Rights		
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Does the institution and all facilities/sites accept all participants regardless of race, color, age, gender, disability, or national origin?
<input type="checkbox"/>	<input type="checkbox"/>	Has the institution ever been found to be in noncompliance of the civil rights laws by any federal agency?

Claiming Months												
Oct <input type="checkbox"/>	Nov <input type="checkbox"/>	Dec <input type="checkbox"/>	Jan <input type="checkbox"/>	Feb <input type="checkbox"/>	Mar <input type="checkbox"/>	Apr <input type="checkbox"/>	May <input type="checkbox"/>	Jun <input type="checkbox"/>	Jul <input type="checkbox"/>	Aug <input type="checkbox"/>	Sept <input type="checkbox"/>	All Months <input type="checkbox"/>

**Audits**

Note: Public school districts, educational service districts, public universities and colleges, cities, counties, other municipalities, for-profits and federal government agencies are exempt from completing this section. Please indicate if this includes your organization by checking the box marked not applicable (n/a). Tribal organizations must complete this section.  n/a

Enter the institutions recently **completed** fiscal year-end (e.g., 7/01/2005 through 06/30/2006, enter 06/30/2006).

Month

Day

Year

Enter the total amount of federal funds **expended** during the most recently completed fiscal year, as stated above. **Include all federal funds regardless of the source. (e.g., HHS, USDA, HUD, etc.)**

\$

Federal regulations require that audits of nonprofit institutions including tribal organizations are to be conducted in accordance with Office of Management and Budget (OMB) Circular A-133.

If your total amount of federal funds expended is **\$500,000** or more:

You must submit a copy of your most recent OMB Circular A-133 audit report to:

**Office of Superintendent of Public Instruction  
Attn: Audit Management and Resolution  
PO Box 47200  
Olympia, WA 98504-7200**