

MYTHBUSTERS

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NEBRASKA DEPARTMENT OF EDUCATION

Agenda

Packets &
Application

Record
Keeping &
Regulations

Crediting
Handbook

Infant
Reminders



May Packets

- IEFs – Revised – use FY 2015 form
- Letters to Households
- Income Guidelines – effective July 1
- Enrollment Form
- Claim Worksheets
- Site Review Forms
- Permanent Agreements (Additional Signature Page Maybe Required.)



FY 2015 Applications

- New system training:

<https://nde.adobeconnect.com/nutrition>

- Dates:

– May 8

– June 9

- 10:00 a.m.

- 90 minutes



FY 2015 Applications

Identify what type of program do you offer:

- Child Care Program
- Head Start Program
- Outside School Hours (School-Age Only)
- At-Risk

All meals will need to be claimed separately according to the type of program(s) you offer.



FY 2015 Applications

- Must enter and submit application and all supporting documents by **June 13, 2014.**
- Remember to **mail** pages with **original signatures.**



MYTHBUSTERS

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myth *noun* \ˈmith\

: an idea or story that is believed by many people but that is not true

: a story that was told in an ancient culture to explain a practice, belief, or natural occurrence

: such stories as a group



Myth or Truth?

NDE can make changes to your application

Myth!



Application

- NDE cannot make any changes to the submitted application
- Errors on application will be returned to center by e-mail
- Center must correct application errors
- *Hint: Print out previous years (2014 & 2013) application to use as a guide and to keep on file*



Child and Adult Care Food Program



Applications | Claims | Compliance | Reports | Security | Search | Year | Help | Log Out

Applications > Application Packet - Centers >

Program Year: 2013 - 2014

Application Packet Sponsor of Affiliated Sites

000000 Status: Active
ABC Child Care
1234 Main Street
Your Town, NE

Packet Submitted Date: 02/06/2014
Packet Approved Date: 02/06/2014
Packet Original Approval Date: 07/01/2013
Packet Status: Approved

Action	Form Name	Latest Version	Status
View Revise	✓ Sponsor Application	Original	Approved
Details	Staff Profile		
View Revise	✓ Sponsor Budget Detail	Original	Approved
Details	Checklist Summary		

	Approved	Pending	Return for Correction	Denied	Withdrawn/ Closed	Error	Total Applications
Site Application(s)	3	0	0	0	0	0	3

[< Back](#) [Submit for Approval](#)

[Show Packet History](#)



Myth or Truth?

New responsible individual? Keep the same User ID & password.

Myth!



Responsible Individuals

New responsible individual or principal = must apply for a new User ID and password

New person with signing authority **must** attend full day CACFP training within 4 months.

Nebraska Department of Education Nutrition Services 301 Centennial Mall South P.O. Box 94967 Lincoln, NE 68509-4967		NDE 01-033 Revised March 2010 Page 2 of 2	
Authorized Representative/Responsible Individual Must Match the Online Program Application (Signatures must be kept current)			
1. Print Name of Authorized Representative/Responsible Individual	2. Signature of Authorized Representative/Responsible Individual		
3. Title of Authorized Representative/Responsible Individual	4. Date of Birth of Authorized Representative/Responsible Individual		
5. Sponsor/System Name	6. Agreement Number		
7. Email address	8. Telephone Number ()		
Sponsor/System Approval			
9. Printed Name of Board President/Owner/CEO	10. Signature of Board President/Owner/CEO		
11. Title of Board President/Owner/CEO	12. Date of Birth of Board President/Owner/CEO		
13. Telephone Number ()	14. Date Signed		
15. Check all Program agreements that apply			
<input type="checkbox"/> National School Lunch Program, School Breakfast Program and Special Milk Program			
<input type="checkbox"/> Child and Adult Care Food Program (Check One)			
___ Child Care Center ___ Adult Care Center ___ Family Day Care Home Sponsor			
<input type="checkbox"/> Summer Food Service Program			
NDE USE ONLY			
<input type="checkbox"/> Request Granted		<input type="checkbox"/> Request Denied	
Effective Date _____	Director, Nutrition Services _____		
URL: http://cnp.education.ne.gov			
User ID _____			
Password _____	Revocation Date _____		



Keep Your Email Current

Contacts

Program Contact

The Program Contact must be an individual who has been authorized to act on behalf of the Sponsor.

	Salutation	First Name	M.I.	Last Name
8. Name:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
9. Date of Birth:	<input type="text"/>	(mm/dd/yyyy)		
10. Email Address: 	<input type="text"/>			
11. Facility Phone:	<input type="text"/>	Ext:	<input type="text"/>	Fax: <input type="text"/>
12. Cell/Alt Phone:	<input type="text"/>			
13. Title:	<input type="text"/>			



Child and Adult Care Food Program



Applications | Claims | Compliance | Reports | **Security** | Search | Year | Help | Log Out

Security >

Item	Description
My Account	My account maintenance (name, contact, password)
User Manager	User Manager

Child and Adult Care Food Program



Applications | Claims | Compliance | Reports | Security | Search | Year | Help | Log Out

Security > My Account >

My Account

User Information

User Name:

First Name:

Middle Initial:

Last Name:

Title:

Email Address:

Phone Number: Ext:

Change Password (Optional)

Password Minimum Requirements
Length: 6

Enter your new password, then re-enter your new password to verify it.
Note: Passwords are case-sensitive and must meet the minimum requirements.

New Password:

Re-Enter New Password:

Password Hint (Optional)

Hint Question: Birth year:

Hint Answer:



Myth or Truth?

SAM/DUNS registration is good for a lifetime.

Myth!



DUNS Number

- DUNS number does not change year to year
- **MUST** re-register every year @ SAM.gov
- DUNS registration date must be submitted with application
- Centers receive reminder e-mail
- Registration is FREE



Annual Report & Verification Form Dun and Bradstreet (DUNS) and System for Award Management (SAM formerly CCR)

Instructions:

1. Please verify/correct the preprinted information:
 - a. DUNS number must be 9 digits and can contain a leading zero. If "None on File", please provide DUNS.
 - b. Zip code + four: Federal reporting requirements mandate a zip code + four. The four digits following the Zip code cannot contain "0000" or "1111." To verify zip code + four go to www.usps.com.
 - c. If multiple forms are received with different information, please return all forms with appropriate corrections to Nutrition Services
2. Enter date SAM registration/renewal completed: Sponsors participating in any Child Nutrition Program are required to register and/or renew registration annually in System for Award Management (SAM, formerly known as CCR)
3. Return to Nutrition Services by the appropriate deadline found in the footnote based on the Programs listed below

Sponsor Name:

Agreement Number:

Dunn and Bradstreet Number (DUNS):

These Child Nutrition Programs are associated with this Sponsor:
Child and Adult Care Food Program (CACFP)

Financial Service Address:

Nutrition Services' (CNP website) Mailing Address:

Address Line 1

Address Line 2

City

State

Zip + Four



Myth or Truth?

Half of CACFP reimbursement must be spent on food.

Truth!



- At least 50% of CACFP income must be budgeted for food expenses
- NDE **CANNOT** make changes; only approve or disapprove

Budget Version: Original		
	Sponsor Complete This Column	FOR STATE USE ONLY Approved
A. ANTICIPATED ANNUAL CACFP REIMBURSEMENT		
1. Prior Year CACFP Reimbursement	\$61,598.46	\$0.00
B. OPERATING EXPENSES		
SALARIES AND BENEFITS		
1. Salaries, Benefits & Taxes (Total from Staff Profile)	\$78,257.13	\$0.00
FOOD SERVICE		
2. Other (Specify)	\$0.00	\$0.00
3. Food Purchases	\$75,000.00	\$0.00
4. Food Contracts (Vendor, school)	\$0.00	\$0.00
5. Nonfood Supplies (napkins, soap, disposable plates, gloves, etc.)	\$4,500.00	\$0.00
6. Equipment (freezer, stove, refrigerator, etc.)	\$0.00	\$0.00
Total Operating Costs	\$157,757.13	\$0.00
C. NET OPERATING AMOUNT		
1. Difference (F2 - Total Operating Costs)	\$-97,757.13	\$0.00
D. ADMINISTRATIVE EXPENSES		
1. Printing, Reproduction	\$0.00	\$0.00
2. Data Processing	\$0.00	\$0.00
3. Mileage	\$500.00	\$0.00
Total Administrative Costs	\$500.00	\$0.00



Myth or Truth?

Monthly profit/loss statements can be hand-written on notebook paper.

Myth!



Profit/Loss Statements

- Acceptable statements:
 - Accounting software
 - Year-end tax statement
 - Audit report
 - NDE's Summary of Income and Expenditures form

Balance sheets NOT acceptable

Handout

Summary of Income and Expenditures		
Center/organization name: _____		
CACFP sponsor number: _____		
Beginning month/year: _____		Ending month/year: _____
INCOME		
	Private Pay/Tuition	_____
	HHS/Title XX Payments	_____
	CACFP Reimbursement	_____
	Other (Specify) _____	_____
	Other (Specify) _____	_____
	Other (Specify) _____	_____
	Total	_____
EXPENSES		
	Payroll	_____
	Taxes	_____
	Rent/mortgage payment	_____
	Insurance	_____
	Utilities	_____
	Activities	_____
	Food and Food Service supplies	_____
	Food Service Contracts	_____
	Maintenance/Repairs	_____
	Auto Expenses/mileage	_____
	Other (Specify) _____	_____
	Total	_____
NET INCOME	Total income minus total expenses	_____ *

* All net losses must be accompanied by an explanation from the owner explaining how the organization/business remains financially viable while operating at a loss.
If operating at a net loss, list other sources of income used to support this business:



Financial Statements

- Not necessary to have an expense for every category
- MUST show financial viability
- If you didn't have a net profit, explain how the business remains financially viable

Handout

Summary of Income and Expenditures

Center/organization name: _____

CACFP sponsor number: _____

Beginning month/year: _____ Ending month/year: _____

INCOME	Private Pay/Tuition _____	_____
	HHS/Title XX Payments _____	_____
	CACFP Reimbursement _____	_____
	Other (Specify) _____	_____
	Other (Specify) _____	_____
	Other (Specify) _____	_____
	Other (Specify) _____	_____
	Total _____	_____
EXPENSES	Payroll _____	_____
	Taxes _____	_____
	Rent/mortgage payment _____	_____
	Insurance _____	_____
	Utilities _____	_____
	Activities _____	_____
	Food and Food Service supplies _____	_____
	Food Service Contracts _____	_____
	Maintenance/Repairs _____	_____
	Auto Expenses/mileage _____	_____
	Other (Specify) _____	_____
	Other (Specify) _____	_____
	Other (Specify) _____	_____
	Other (Specify) _____	_____
	Other (Specify) _____	_____
	Other (Specify) _____	_____
	Total _____	_____
NET INCOME	Total income minus total expenses _____	_____*

* All net losses must be accompanied by an explanation from the owner explaining how the organization/business remains financially viable while operating at a loss.
If operating at a net loss, list other sources of income used to support this business: _____



Financial Statements

Income & Expenses – most recent two months (or more) of entire business

- Income – private pay, title XX, grants, donations
- All expenses, including:
 - Rent, utilities
 - Salaries (all)
 - Food costs
 - General day care expenses

Handout

Summary of Income and Expenditures		
Center/organization name: _____		
CACFP sponsor number: _____		
Beginning month/year: _____		Ending month/year: _____
INCOME		
	Private Pay/Tuition	_____
	HHS/Title XX Payments	_____
	CACFP Reimbursement	_____
	Other (Specify) _____	_____
	Total	_____
EXPENSES		
	Payroll	_____
	Taxes	_____
	Rent/mortgage payment	_____
	Insurance	_____
	Utilities	_____
	Activities	_____
	Food and Food Service supplies	_____
	Food Service Contracts	_____
	Maintenance/Repairs	_____
	Auto Expenses/mileage	_____
	Other (Specify) _____	_____
	Total	_____
NET INCOME	Total income minus total expenses	_____ *
* All net losses must be accompanied by an explanation from the owner explaining how the organization/business remains financially viable while operating at a loss. If operating at a net loss, list other sources of income used to support this business: _____		



Financial Viability: Questions to answer

- Using savings to cover a deficit?
- Why the loss of income?
- How do you plan to cover losses if they continue?

- Additional profit/loss statements may be required
- Monitored by NDE, State Auditors and USDA



Myth or Truth?

Non-profit foodservice needs to be proven with receipts and staff time certification.

Truth!



Non-profit Food Service

- Must keep ALL receipts for groceries, food service costs, vendor bills. *Remember to check that you are being billed correctly!*
- Must keep valid time certification – must complete bottom portion showing the cost allocated to CACFP.
- Must document how ALL CACFP funds were spent.



Myth or Truth?

CACFP reimbursement can be used to fund my payroll.

Myth!



Non-profit Food Service

- CACFP funds are not to be used to fund your payroll expenses.
- *AT LEAST* 50% of reimbursement is spent on food, groceries, or food service vendors.
- Your business should be paying for general administration, taxes, janitorial services, etc.



Financial Viability: Serious Deficiencies

- Failure to pay vendor or your commodity bill
- Failure to document a nonprofit food service



Myth or Truth?

I submit my staff profile for the year and forget it.

Myth!



Staff Profile

- Staff Profile must be current.
- Anyone who does work related to CACFP needs to be in the staff profile.
- If someone quits, enter their termination date.
- New hire? Enter the information for the new employee.

This information must be completed for all responsible individuals and principals including personnel who have any direct responsibility in the CACFP, e.g. Director, Assistant Director, Site Supervisor, Cook, etc. Sponsors of multiple sites must identify the person(s) responsible for site reviews.

Total CACFP Salaries (enter this total on line B.1 on CACFP Budget) \$24,934.62

Staff List

Action	Name	Job Description	Location	Employment Ended
View	Sam Smith	Direct Support Manager	Grand Island	March 2, 2014
View	Jason Smith	Direct Support Associate	Grand Island	



Staff Profile

Employees not listed:

Their wages are not an allowable expense to document a nonprofit food service operation.



Time Certification

Time certification must be completed monthly by employees if any portion of their wages come from CACFP. *

** If necessary to document a nonprofit food service operation*

Handout

CACFP Time Certification Documentation Worksheet
NS-405-G
Revised: April 2010

CACFP Time Certification Documentation Worksheet

INSTRUCTIONS: This worksheet must be completed for staff performing Child and Adult Care Food Program duties if any CACFP funds are used for salaries. Indicate the total number of hours per day spent on activities related to the CACFP. Examples of CACFP activities include, but are not limited to: menu planning, grocery shopping, cooking and serving meals, clean-up after meals, record keeping, attending inservices related to nutrition and food safety, maintaining commodity inventory, etc. **This entire form must be completed if you are using time certification to document a nonprofit food service operation.**

Employee Name (please print legibly) _____ Month/Year: _____

Date	Hours Worked on CACFP		Total Day Care Hours Worked	Date	Hours Worked on CACFP		Total Day Care Hours Worked
	Food Service	Record Keeping			Food Service	Record Keeping	
1				17			
2				18			
3				19			
4				20			
5				21			
6				22			
7				23			
8				24			
9				25			
10				26			
11				27			
12				28			
13				29			
14				30			
15				31			
16				TOTAL			

I certify that this is an accurate record of the number of hours worked on the Child and Adult Care Food Program.

Employee Name (please print legibly) _____ Employee's Signature _____ Date _____

TO BE COMPLETED BY CENTER DIRECTOR/CACFP AUTHORIZED REPRESENTATIVE.

A. (HOURLY PAID STAFF)
Total hours worked on CACFP _____ x \$ _____ (hourly wage) = \$ _____ (Total CACFP salary)

B. (SALARIED STAFF)
Total hours worked on CACFP _____ ÷ Total hours worked _____ = _____ %
Total Salary for month \$ _____ x _____ % = \$ _____ (Total CACFP salary)

I certify that payroll records are on file that verify the total wages as listed above.

Signature of Center Director/Authorized Representative _____ Date _____



Time Certification

Hours Worked on CACFP		Total Day Care Hours Worked
Food Service	Record Keeping	
7:00 – 3:00		7:00 – 4:00
11-12		9 - 5

Hours Worked on CACFP		Total Day Care Hours Worked
Food Service	Record Keeping	
3	0	7.5
5	1	7.5

Myth

CACFP Time Certification Documentation Worksheet
NS-405-G
Revised: April 2010

CACFP Time Certification Documentation Worksheet

INSTRUCTIONS: This worksheet must be completed for staff performing Child and Adult Care Food Program duties if any CACFP funds are used for salaries. Indicate the total number of hours per day spent on activities related to the CACFP. Examples of CACFP activities include, but are not limited to: menu planning, grocery shopping, cooking and serving meals, clean-up after meals, record keeping, attending inservices related to nutrition and food safety, maintaining commodity inventory, etc. **This entire form must be completed if you are using time certification to document a nonprofit food service operation.**

Employee Name (please print legibly) _____ Month/Year: _____

Date	Hours Worked on CACFP		Total Day Care Hours Worked	Date	Hours Worked on CACFP		Total Day Care Hours Worked
	Food Service	Record Keeping			Food Service	Record Keeping	
1				17			
2				18			
3				19			
4				20			
5				21			
6				22			
7				23			
8				24			
9				25			
10				26			
11				27			
12				28			
13				29			
14				30			
15				31			
16				TOTAL			

I certify that this is an accurate record of the number of hours worked on the Child and Adult Care Food Program.

Employee Name (please print legibly) _____ Employee's Signature _____ Date _____

MUST BE COMPLETED BY CENTER DIRECTOR/CACFP AUTHORIZED REPRESENTATIVE

A. (HOURLY PAID STAFF)

Total hours worked on CACFP _____ x \$ _____ (hourly wage) = \$ _____ (Total CACFP salary)

B. (SALARIED STAFF)

Total hours worked on CACFP _____ ÷ Total hours worked _____ = _____ %

Total Salary for month \$ _____ x _____ % = \$ _____ (Total CACFP salary)

I certify that payroll records are on file that verify the total wages as listed above.

Signature of Center Director/Authorized Representative _____ Date _____



Time Certification

Bottom portion must be completed and signed by the supervisor.

Employee **AND** employer must sign.

I certify that this is an accurate record of the number of hours worked on the Child and Adult Care Food Program.

Jane Doe Jane Doe 3/31/14
Employee Name (please print legibly) Employee's Signature Date

TO BE COMPLETED BY CENTER DIRECTOR/CACFP AUTHORIZED REPRESENTATIVE.

A. (HOURLY PAID STAFF)
Total hours worked on CACFP 44 x \$ 7.50 (hourly wage) = \$ 330 (Total CACFP salary)

B. (SALARIED STAFF)
Total hours worked on CACFP _____ ÷ Total hours worked _____ = _____ %
↓
Total Salary for month \$ _____ x _____ % = \$ _____ (Total CACFP salary)

I certify that payroll records are on file that verify the total wages as listed above.

Signature of Center Director/Authorized Representative Jane's Boss Date 3/31/14



Application Renewal

- Submit application, including:
 - Site application
 - Sponsor application
 - Staff profile
 - Food service budget
 - Checklist summary (a.k.a. supporting documents)
- Re-registration of DUNS



Submit for Approval

Child and Adult Care Food Program

NEBRASKA DEPARTMENT OF EDUCATION 

Applications | Claims | Compliance | Reports | Security | Search | Year | Help | Log Out

Applications > Application Packet - Centers > Program Year: 2013 - 2014

Application Packet Sponsor of Affiliated Sites

000000 Status: Active Packet Submitted Date: 02/06/2014
ABC Child Care Packet Approved Date: 02/06/2014
1234 Main Street Packet Original Approval Date: 07/01/2013
Your Town, NE Packet Status: Approved

Action	Form Name	Latest Version	Status
View Revise	✓ Sponsor Application	Original	Approved
Details	Staff Profile		
View Revise	✓ Sponsor Budget Detail	Original	Approved
Details	Checklist Summary		

	Approved	Pending	Return for Correction	Denied	Withdrawn/ Closed	Error	Total Applications
Site Application(s)	3	0	0	0	0	0	3

[Show Packet History](#)





Child and Adult Care Food Program



Applications | Claims | Compliance | Reports | Security | Search | Year | Help | Log Out

Applications > Application Packet - Centers >> Program Year: 2014 - 2015

VIEW | MODIFY

CACFP Checklist

000000 Status: Active
 ABC Child Care
 1234 Main Street
 Your Town, NE

Required Forms/Documents to submit to NDE	Document Submitted to NDE	Date Submitted to NDE	Document on File w/NDE	Status	Status Date	Last Updated By
CACFP Certificate of Authority	<input checked="" type="checkbox"/>	02/18/2014	<input checked="" type="checkbox"/>	Approved	02/18/2014	Kaytende
CACFP Organization Representatives Authorization Statement	<input checked="" type="checkbox"/>	02/18/2014	<input checked="" type="checkbox"/>	Approved	02/18/2014	Kaytende
Copy of Financial Statement	<input checked="" type="checkbox"/>	02/18/2014	<input checked="" type="checkbox"/>			

Action	Checklist Item	Comment
There are no attachments		
<input type="button" value="Save"/>	<input type="button" value="Cancel"/>	

- 2 original signature pages
- Financial Statement

Child and Adult Care Food Program



Applications | Claims | Compliance | Reports | Security | Search | Year | Help | Log Out

Applications > Application Packet - Centers >> Program Year: 2014 - 2015

VIEW | MODIFY

CACFP Checklist

000000 Status: Active
 ABC Child Care
 1234 Main Street
 Your Town, NE

000000 Status: Active
 ABC Child Care
 1234 Main Street
 Your Town, NE

Required Forms/Documents to submit to NDE	Document Submitted to NDE	Date Submitted to NDE	Document on File w/NDE	Status	Status Date	Last Updated By
Copy of License	<input checked="" type="checkbox"/>	02/18/2014	<input checked="" type="checkbox"/>	Approved	02/18/2014	Kaytende

Action	Checklist Item	Comment	Attachment Date/Time
There are no attachments			
<input type="button" value="Save"/>	<input type="button" value="Cancel"/>		

- Copy of License
- Copy of Title XX Agreement





DOOR PRIZE



NEBRASKA DEPARTMENT OF EDUCATION

Agenda

Packets &
Application

Record
Keeping &
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Crediting
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Myth or Truth?

I can claim meals for anyone,
anytime, anywhere.

Myth!



Claiming Meals

- Meals may be claimed only for enrolled participants.
- Over claims are assessed for meals claimed with no enrollment form on file.
- Meals may be claimed only for those served at approved sites and ON SITE.



Myth or Truth?

Once I have an enrollment form, I don't have to look at it ever again!

Myth!



CACFP Enrollment Forms

Child care centers must have new or updated enrollment forms signed and dated by the parent/guardian on file every 12 months.

Handout

Child and Adult Care Food Program Annual Child Enrollment Form
NS-105-C
Revised: April 2009

CACFP Annual Child Enrollment Form

Annual enrollment in the Child and Adult Care Food Program is required by federal regulation for all children who receive program meals. Complete the following information for each child enrolled at the center. Provide your signature and contact information at the bottom of this form. The U.S. Department of Agriculture (USDA) prohibits discrimination in its programs and activities 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 Avenue, S.W., Washington, D.C. 20250-9410, or call (800) 795-3272 (voice) or (202) 720-6362 (TTY). USDA is an equal opportunity provider and employer.

INFANT FORMULA SELECTION: Complete this section if any child listed is an infant under one year of age.

This center provides _____ (brand) iron fortified infant formula to all infants under one year of age.

I Accept the formula
 I Decline the formula
 I Accept the CACFP meal pattern (4 - 11 months)

If declined formula, check one:
 Parent will provide breast milk
 Parent will provide formula (list brand): _____

Complete a separate section for each child in the household. Attach additional pages if necessary.

Last Name	First Name	Date of Birth	Date Enrolled
Usual Days in Care	Usual Hours in Care	Usual Meals Received While in Care	Optional: Ethnic Identity
<input type="checkbox"/> Monday	_____ to _____	<input type="checkbox"/> Breakfast	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> Tuesday	_____ to _____	<input type="checkbox"/> AM Snack	<input type="checkbox"/> Not Hispanic or Latino
<input type="checkbox"/> Wednesday	_____ to _____	<input type="checkbox"/> Lunch	Racial Identity
<input type="checkbox"/> Thursday	_____ to _____	<input type="checkbox"/> PM Snack	<input type="checkbox"/> American Indian or Alaska Native
<input type="checkbox"/> Friday	_____ to _____	<input type="checkbox"/> Supper	<input type="checkbox"/> Asian
<input type="checkbox"/> Saturday	_____ to _____	<input type="checkbox"/> Evening Snack	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Sunday	_____ to _____		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> Non-school days/holidays	_____ to _____		<input type="checkbox"/> White
<input type="checkbox"/> Check if Head Start eligible	<input type="checkbox"/> Check if infant under one year of age		

Last Name	First Name	Date of Birth	Date Enrolled
Usual Days in Care	Usual Hours in Care	Usual Meals Received While in Care	Optional: Ethnic Identity
<input type="checkbox"/> Monday	_____ to _____	<input type="checkbox"/> Breakfast	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> Tuesday	_____ to _____	<input type="checkbox"/> AM Snack	<input type="checkbox"/> Not Hispanic or Latino
<input type="checkbox"/> Wednesday	_____ to _____	<input type="checkbox"/> Lunch	Racial Identity
<input type="checkbox"/> Thursday	_____ to _____	<input type="checkbox"/> PM Snack	<input type="checkbox"/> American Indian or Alaska Native
<input type="checkbox"/> Friday	_____ to _____	<input type="checkbox"/> Supper	<input type="checkbox"/> Asian
<input type="checkbox"/> Saturday	_____ to _____	<input type="checkbox"/> Evening Snack	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Sunday	_____ to _____		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> Non-school days/holidays	_____ to _____		<input type="checkbox"/> White
<input type="checkbox"/> Check if Head Start eligible	<input type="checkbox"/> Check if infant under one year of age		

Annual Update

Signature of Parent or Legal Guardian _____ Parent may sign & date if the enrollment information is correct.

Printed Name _____ Signature _____ Date _____

Street Address _____

City, State, Zip _____

Telephone (include area code) _____

Date signed: ____/____/____
 Month Day Year

Nebraska Department of Education Nutrition Services



CACFP Enrollment Forms

Child and Adult Care Food Program Annual Child Enrollment Form
 NS-105-C
 Revised: April 2009

CACFP Annual Child Enrollment Form

Annual enrollment in the Child and Adult Care Food Program is required by federal regulation for all children who receive program meals. Complete the following information for each child enrolled at the center. Provide your signature and contact information at the bottom of this form. The U.S. Department of Agriculture (USDA) prohibits discrimination in its programs and activities 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 Avenue, S.W., Washington, D.C. 20250-9410, or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

INFANT FORMULA SELECTION: Complete this section if any child listed is an infant under one year of age.

This center provides _____ (brand) iron fortified infant formula to all infants under one year of age.

- | | |
|---|--|
| <input type="checkbox"/> I Accept the formula | If declined formula, check one: |
| <input type="checkbox"/> I Decline the formula | <input type="checkbox"/> Parent will provide breast milk |
| <input type="checkbox"/> I Accept the CACFP meal pattern
(4 - 11 months) | <input type="checkbox"/> Parent will provide formula (list brand): _____ |

Last Name	First Name	Date of Birth	Date Enrolled
-----------	------------	---------------	---------------

INFANT FORMULA SELECTION: Complete this section if any child listed is an infant under one year of age.

This center provides _____ (brand) iron fortified infant formula to all infants under one year of age.

- I Accept the formula
- I Decline the formula
- I Accept the CACFP meal pattern
(4 - 11 months)

- If declined formula, check one:
- Parent will provide breast milk
- Parent will provide formula (list brand): _____

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Saturday | to | <input type="checkbox"/> PM Snack | <input type="checkbox"/> Black or African American |
| <input type="checkbox"/> Sunday | to | <input type="checkbox"/> Supper | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> Non-school days/holidays | to | <input type="checkbox"/> Evening Snack | <input type="checkbox"/> White |
| <input type="checkbox"/> Check if Head Start eligible | <input type="checkbox"/> Check if infant under one year of age | | |

Annual Update

Signature of Parent or Legal Guardian _____	Parent may sign & date if the enrollment information is correct.
Printed Name _____	Signature _____ Date _____
Street Address _____	_____
City, State, Zip _____	_____
Telephone (include area code) _____	_____
Date signed: ____/____/____ Month Day Year	_____

Nebraska Department of Education Nutrition Services



NEBRASKA DEPARTMENT OF EDUCATION

CACFP Enrollment Forms

Child and Adult Care Food Program Annual Child Enrollment Form
 NS-105-C
 Revised: April 2009

CACFP Annual Child Enrollment Form

Annual enrollment in the Child and Adult Care Food Program is required by federal regulation for all children who receive program meals. Complete the following information for each child enrolled at the center. Provide your signature and contact information at the bottom of this form. The U.S. Department of Agriculture (USDA) prohibits discrimination in its programs and activities 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 Avenue, S.W., Washington, D.C. 20250-9410, or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

INFANT FORMULA SELECTION: Complete this section if any child listed is an infant under one year of age.

- This center provides _____ (brand) iron fortified infant formula to all infants under one year of age.
- Accept the formula
 Decline the formula
 Accept the CACFP meal pattern (4 - 11 months)
- If declined formula, check one:
 Parent will provide breast milk
 Parent will provide formula (list brand): _____

Complete a separate section for each child in the household. Attach additional pages if necessary.

Last Name	First Name	Date of Birth	Date Enrolled

Usual Days in Care	Usual Hours in Care	Usual Meals Received While in Care	Optional: Ethnic Identity
<input type="checkbox"/> Monday	_____ to _____	<input type="checkbox"/> Breakfast	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> Tuesday	_____ to _____	<input type="checkbox"/> AM Snack	<input type="checkbox"/> Not Hispanic or Latino
<input type="checkbox"/> Wednesday	_____ to _____	<input type="checkbox"/> Lunch	<input type="checkbox"/> Racial Identity
<input type="checkbox"/> Thursday	_____ to _____	<input type="checkbox"/> PM Snack	<input type="checkbox"/> American Indian or Alaska Native
<input type="checkbox"/> Friday	_____ to _____	<input type="checkbox"/> Support	<input type="checkbox"/> Asian
<input type="checkbox"/> Saturday	_____ to _____	<input type="checkbox"/> Evening Snack	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Sunday	_____ to _____		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> Non-school days/holidays	_____ to _____		<input type="checkbox"/> White

Complete a separate section for each child in the household. Attach additional pages if necessary.

Last Name	First Name	Date of Birth	Date Enrolled

Usual Days in Care	Usual Hours in Care	Usual Meals Received While in Care	Optional: Ethnic Identity
<input type="checkbox"/> Monday	_____ to _____	<input type="checkbox"/> Breakfast	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> Tuesday	_____ to _____	<input type="checkbox"/> AM Snack	<input type="checkbox"/> Not Hispanic or Latino
<input type="checkbox"/> Wednesday	_____ to _____	<input type="checkbox"/> Lunch	<input type="checkbox"/> Racial Identity
<input type="checkbox"/> Thursday	_____ to _____	<input type="checkbox"/> PM Snack	<input type="checkbox"/> American Indian or Alaska Native
<input type="checkbox"/> Friday	_____ to _____	<input type="checkbox"/> Support	<input type="checkbox"/> Asian
<input type="checkbox"/> Saturday	_____ to _____	<input type="checkbox"/> Evening Snack	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Sunday	_____ to _____		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> Non-school days/holidays	_____ to _____		<input type="checkbox"/> White

Signature of Parent or Legal Guardian _____

Printed Name _____

Street Address _____

City, State, Zip _____

Telephone (include area code) _____

Date signed: ____/____/____
 Month Day Year

Annual Update

Parent may sign & date if the enrollment information is correct.

Signature _____ Date _____

Nebraska Department of Education Nutrition Services



NEBRASKA DEPARTMENT OF EDUCATION

CACFP Enrollment Forms

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This center provides _____ (brand) iron fortified infant formula to all infants under one year of age.

I Accept the formula
 I Decline the formula
 I Accept the CACFP meal pattern (4 - 11 months)

If declined formula, check one:
 Parent will provide breast milk
 Parent will provide formula (list brand): _____

Complete a separate section for each child in the household. Attach additional pages if necessary.

Last Name	First Name	Date of Birth	Date Enrolled
Usual Days in Care		Usual Hours in Care	Usual Meals Received While in Care
<input type="checkbox"/> Monday	_____ to _____	_____ to _____	<input type="checkbox"/> Breakfast
<input type="checkbox"/> Tuesday	_____ to _____	_____ to _____	<input type="checkbox"/> AM Snack
<input type="checkbox"/> Wednesday	_____ to _____	_____ to _____	<input type="checkbox"/> Lunch
<input type="checkbox"/> Thursday	_____ to _____	_____ to _____	<input type="checkbox"/> PM Snack
<input type="checkbox"/> Friday	_____ to _____	_____ to _____	<input type="checkbox"/> Supper
<input type="checkbox"/> Saturday	_____ to _____	_____ to _____	<input type="checkbox"/> Evening Snack
<input type="checkbox"/> Sunday	_____ to _____	_____ to _____	
<input type="checkbox"/> Non-school days/holidays	_____ to _____	_____ to _____	
<input type="checkbox"/> Check if Head Start eligible	<input type="checkbox"/> Check if infant under one year of age		

Last Name	First Name	Date of Birth	Date Enrolled
Usual Days in Care		Usual Hours in Care	Usual Meals Received While in Care
<input type="checkbox"/> Monday	_____ to _____	_____ to _____	<input type="checkbox"/> Breakfast
<input type="checkbox"/> Tuesday	_____ to _____	_____ to _____	<input type="checkbox"/> AM Snack
<input type="checkbox"/> Wednesday	_____ to _____	_____ to _____	<input type="checkbox"/> Lunch
<input type="checkbox"/> Thursday	_____ to _____	_____ to _____	<input type="checkbox"/> PM Snack
<input type="checkbox"/> Friday	_____ to _____	_____ to _____	<input type="checkbox"/> Supper
<input type="checkbox"/> Saturday	_____ to _____	_____ to _____	<input type="checkbox"/> Evening Snack
<input type="checkbox"/> Sunday	_____ to _____	_____ to _____	
<input type="checkbox"/> Non-school days/holidays	_____ to _____	_____ to _____	
<input type="checkbox"/> Check if Head Start eligible	<input type="checkbox"/> Check if infant under one year of age		

Signature of Parent or Legal Guardian _____

Printed Name _____

Street Address _____

City, State, Zip _____

Telephone (include area code) _____

Date signed: ____/____/____
 Month Day Year

Annual Update
 Parent may sign & date if the enrollment information is correct.

Signature _____ Date _____

Annual Update
 Parent may sign & date if the enrollment information is correct.

Signature _____ Date _____

Every year!



CACFP Enrollment Forms

- Don't assume the parent has completed the enrollment form
- Provider's responsibility to ensure all info is collected:
 - Name
 - Date of birth
 - Date enrolled
 - Signature of parent/guardian
 - Days and times in care (child care only)
 - Usual meals served in care (child care only)



CACFP Enrollment Forms

- Recommend updating enrollments during June-July
- Don't forget families on vacation.
- Must update child enrollment forms annually for all children.
- Good for one year.
Example: July 1, 2014 – July 31, 2015



Myth or Truth?

You need a new Income Eligibility Form (IEF) for EACH household EVERY year.

Truth!



Income Eligibility Forms

Fiscal Year 2013 Income Eligibility Form - Page 1 of 2
 Child Care Centers NS-100-C
 Revised 4/2012

Application for Free and Reduced Price Meals in the Child and Adult Care Food Program

Part 1. Enrolled children's information. Attach NS-100-C.a. to list more children.			Part 2. Enter Master Case Number if household qualifies for SNAP, TANF or FDIPIR. <i>Note: Social Security numbers, Medicaid numbers and EBT numbers are not accepted.</i> Master Case Number: _____		
Child's Last Name, First Name	Date of Birth M/D/Y	Date Enrolled M/D/Y			
Part 3. Foster Children			Foster child's personal use income		
			\$ _____		
			\$ _____		
Part 4. Total Household Income from Last Month – Complete Part 4 if you did not complete Part 2.					
Names of all household members not listed above unless they have income			LAST MONTH'S HOUSEHOLD INCOME Do not list hourly wage.		Check if NO income
Last Name, First Name	Gross Income (before taxes)	Welfare, child support, alimony	Pensions, retirement, Social Security	Other	
	\$ _____	\$ _____	\$ _____	\$ _____	<input type="checkbox"/>
	\$ _____	\$ _____	\$ _____	\$ _____	<input type="checkbox"/>
	\$ _____	\$ _____	\$ _____	\$ _____	<input type="checkbox"/>
	\$ _____	\$ _____	\$ _____	\$ _____	<input type="checkbox"/>
Part 5. Signature - The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page). If you have given a case number in Part 2 or if this application is for a foster child, a social security number is not needed. I certify that all information on this application is true and that all income is reported. I understand that the center will get Federal funds based on the information I give. I understand that state officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.					
Sign here: Social Security Number (Last 4 digits): _____ <input type="checkbox"/> I do not have a Social Security Number		Print Name _____ Street Address _____ City/State/Zip _____ Telephone _____			
Date Signed _____					
Part 6: (Optional) Racial/Ethnic Identity of children listed above					
Mark one ethnic identity:		Mark one or more racial identities:			
<input type="checkbox"/> Hispanic or Latino		<input type="checkbox"/> American Indian or Alaska Native			
<input type="checkbox"/> Not Hispanic or Latino		<input type="checkbox"/> Asian			
		<input type="checkbox"/> Black or African American			
		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander			
		<input type="checkbox"/> White			
FOR CENTER USE ONLY					
Totals from Part 4, if applicable:		<input type="checkbox"/> Free <input type="checkbox"/> Foster <input type="checkbox"/> Free - Zero Income			
Total Household Size _____		<input type="checkbox"/> Reduced <input type="checkbox"/> Paid <input type="checkbox"/> Incomplete			
Total Monthly Income \$ _____		Temporary approval for 45 days Expires: _____			
Signature of Center Official _____		Today's Date _____		Effective Date (no earlier than first of current month; expires in 1 year) _____	

- IEFs **REQUIRED** to be new EACH year
- No updating

DO NOT update!
DO NOT update!
DO NOT update!



Myth or Truth?

I can use white-out to cover old dates and write new ones in.

Myth!



Income Eligibility Forms

NEVER OKAY to use white out

OK to strike out and initial corrections to errors.



Myth or Truth?

I can complete and sign IEFs for parents/guardians.

Myth!



Income Eligibility Forms

- NEVER OKAY to forge a parent's/guardian's signature or household income
- Do not assume household categorical benefits apply based on Title XX



Myth or Truth?

Title XX participants automatically qualify to received Free meals.

Myth!



Income Eligibility Forms:

Parts 1 and 2

Name and Case Number

Part 1. Enrolled children's information. Attach NS-100-C.a. to list more children.			Part 2. Enter Master Case Number if household qualifies for SNAP, TANF or FDPIR <i>Note: Social Security numbers, Medicaid numbers and EBT numbers are not accepted.</i>
Child's Last Name, First Name	Date of Birth M/D/Y	Date Enrolled M/D/Y	
Rodriguez , Daniel (D.J.)			Master Case Number: 00112233
Part 3. Foster Children			Foster child's personal use income
			\$
			\$

Parents/guardians need to indicate which benefit they receive.

Make no assumptions!



IEF: Case Numbers

- Circle the qualifying benefit: SNAP, TANF, FDPIR
- Social Security Numbers NOT valid so don't use them
 - Social Security Numbers are associated only with adult centers' Medicaid recipients



Income Eligibility Forms

- Full names of participants
- Do not pre-sign or pre-date IEFs
- Title XX authorization does not equal Free status.
- Do not make assumptions or alter information provided; NO WHITE OUT



Myth or Truth?

Foster children need their own separate IEF.

Myth!



Foster Children

- Foster children do not need their own IEF – Part 3
- MUST list personal use income (or \$0 if none)
- Part 2 if appropriate

Part 1. Enrolled children's information. Attach NS-100-C.a. to list more children.			Part 2. Enter Master Case Number if household qualifies for SNAP, TANF or FDPIR <i>Note: Social Security numbers, Medicaid numbers and EBT numbers are not accepted.</i>
Child's Last Name, First Name	Date of Birth M/D/Y	Date Enrolled M/D/Y	
Rodriguez , Daniel (D.J.)	4/6/09		Master Case Number: 00112233
Part 3. Foster Children			Foster child's personal use income
Garber, Cyrus			\$ \$0
			\$



IEF: Foster Children

- Households may include foster children on IEF to increase household size.
- Other children in household classified based on total household size, including foster children, and all household income received.
- Money received for caring for foster child(ren) is not counted as income.



Income Eligibility Forms:

Parts 4 & 5

Household members, income & signature

- Zero Income forms are good for one year
- An IEF without income documented is incomplete and qualifies for PAID meals



Income Eligibility Forms:

Parts 4 & 5

Household members, income & signature

Names of all household members not listed above unless they have income	LAST MONTH'S HOUSEHOLD INCOME Do not list hourly wage.				Check if NO income
Last Name, First Name	Gross Income (before taxes)	Welfare, child support, alimony	Pensions, retirement, Social Security	Other	
<i>Jane Doe</i>	\$	\$	\$	\$	<input type="checkbox"/>
<i>Jethro Doe</i>	\$	\$	\$	\$	<input type="checkbox"/>
	\$	\$	\$	\$	<input type="checkbox"/>
	\$	\$	\$	\$	<input type="checkbox"/>

Names of all household members not listed above unless they have income	LAST MONTH'S HOUSEHOLD INCOME Do not list hourly wage.				Check if NO income
Last Name, First Name	Gross Income (before taxes)	Welfare, child support, alimony	Pensions, retirement, Social Security	Other	
<i>Jane Doe</i>	\$ <i>0</i>	\$	\$	\$	<input type="checkbox"/>
<i>Jethro Doe</i>	\$	\$	\$	\$	<input checked="" type="checkbox"/>
	\$	\$	\$	\$	<input type="checkbox"/>
	\$	\$	\$	\$	<input type="checkbox"/>



Myth or Truth?

IEFs need FULL social security numbers.

Myth!



IEFs: Social Security Numbers

- Last 4 digits required only on IEFs based on Household Size and Income
 - Includes ZERO income households
- Remember, no Social Security number necessary for household with Master Case number



Myth or Truth?

Income eligibility forms are good for as long as a child attends a daycare.

Myth!



Income Eligibility Forms

- Need a NEW IEF every 12 months
 - expire on a calendar year basis
- Effective through the end of the month of determination
- Example:
 - IEF effective April 1, 2013
 - Expires April 30, 2014

Must get new IEF each year!



Income Eligibility Forms

- Effective date cannot be backdated to a previous month
- Change your meal count sheets to reflect any changes to the child's category (A,B,C)



Myth or Truth?

It is okay to complete meal count records from attendance records.

Myth!



Meal Counts

- Meal count done **ONLY** while children seated **AT THE TABLE** to eat
- Maximum 3 meals/child each day
 - 2 main meals + 1 snack
 - 1 main meal + 2 snacks
- 4th meals must **NOT BE CLAIMED**

Meal counts MUST BE DONE at the time of meal service.



Myth or Truth?

I can take records home and it doesn't really matter how long I keep them.

Double Myth!



Record Retention

- All records must be **COMPLETE** and on site for the current year.
 - Hard copy or electronic
- Off-site storage? Must be stated on the application.
- Deductions will be made if the last 12 months of records are not on-site.
- Keep for 3 years after submission of the final claim for the fiscal year.



Record Maintenance: Q & A

- Q: Fiscal Year ending June 30, 2014 must be kept until _____.
- A: August 31, 2017



Records to Keep

- Claims
- Claim worksheets
- Enrollment forms
- Income eligibility forms
- Meal count sheets
- Meal production records (regular & infant)
- Receipts for expenditures
- Attendance records (times in/out)



Myth or Truth?

At-risk sites must keep records.

Truth!



At-Risk Afterschool Meals

- Track at-risk meals/snacks separately from regular meals/snacks – different Blue & White sheets
- Meal counts must be completed **DAILY** for each meal service
- **DAILY** attendance or **DAILY** roster
- Daily production records

****At-risk guidance booklet**



At-Risk Afterschool

- After-school snacks & suppers in low-income areas for school-age children
- Approved site
 - Determination by NDE staff only
- At-risk meals/snacks claimed ONLY during school year AFTER school and on non-school days
- Facility must provide an enrichment/educational activity for all children in attendance



At-Risk Afterschool Meals

- Do not enter “regular” meals in the At-risk section of the claim

Regular Meals Served Only (Do not include At-Risk Meals)				
Meal Type	Free Meals (A)	Reduced Meals (B)	Paid Meals (C)	Total Meals (A+B+C)
Regular Breakfasts	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="0"/>
Regular A.M. Snacks	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="0"/>
Regular Lunches	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="0"/>
Regular P.M. Snacks	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="0"/>
Regular Supper	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="0"/>
Regular Evening Snack	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="0"/>

At-Risk Meals Only (Meals claimed At-Risk cannot be claimed above in Regular Meals)				
Do not include any meals that are claimed above. Breakfasts and Lunches may be claimed only on school's out days, vacation days (e.g., winter and springs break) and weekends during the school year.				
Meal Type	Number Days Served	Number of At-Risk Participants	Average Daily Attendance	Meals Served
At-Risk Breakfasts	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
At-Risk A.M. Snacks	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
At-Risk Lunches	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
At-Risk P.M. Snacks	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
At-Risk Supper	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
At-Risk Evening Snack	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>





DOOR PRIZE



NEBRASKA DEPARTMENT OF EDUCATION

NDE's typical drop-in visits

- Meal production records completed through most current meal OR delivery tickets from vendor
- Meal count records that are up-to-date
- Time in/Time out attendance records
- Infant production records through most current meal
none done in advance
- Income Eligibility Forms are in secure location
- View how and where old records are stored
- Complaint visits may require more in-depth investigation



Corrective Action Plans

- When corrective action is required:
 - Written documentation
 - What: identify the finding(s)
 - When: provide timeline for implementing procedure for correction
 - Where will the CAP be retained?
 - How will staff and facilities be informed of new policies, procedures?
 - Handbooks, trainings, etc.
 - Who: personnel responsible for correcting the findings



Corrective Action Plans

- Reasons for CAP
 - 10% finding error (production records, IEFs, enrollments, infant records)
 - Failing to meet non-profit food service status
 - Purchasing poor-quality foods; non-compliant meals
 - Not following management plan/application (staff training, site visits)
 - Failure to meet deadlines
 - Etc.

Not an all-inclusive list!



Corrective Action Plans

- Fail to comply with CAP?
 - May be declared *Seriously Deficient*
- Records are STILL not in compliance after serious deficiency determination?
 - *Termination*
 - *Placement on the National Disqualified List*
 - *Pay back reimbursement* for period of missing records



Consequences

- May be declared seriously deficient if findings recurring, not being fixed
- Frequency and severity
- Corrective Action Plans: who, what, when & how problems will be fixed
- MUST demonstrate problems have been fixed permanently



Myth or Truth?

My center purchases foods from local grocers so I do not have to compare prices.

Myth!



Food Purchases

- MUST get three bids from more than one vendor/grocer
- Includes small purchases from local grocers
 - E.g. Bakers, Walmart, Sam's, Hiland Dairy, Sysco etc.
- Documentation includes:
 - Date
 - Who was contacted
 - Amount quoted – street price in local ads

This is for ALL programs, BIG and small



Handout

INFORMAL PROCUREMENT LOG

Items to be Purchased	Quantity Expected to Buy	Vendor:		Vendor:		Vendor:	
		Unit Price	Extended Price (Quantity x Unit Price)	Unit Price	Extended Price (Quantity x Unit Price)	Unit Price	Extended Price (Quantity x Unit Price)
TOTAL			\$		\$		\$
Vendor Selected	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		
Date and Method of Contact							
Additional Notes:							
Signature of person completing this form:						Date:	



Food Service Contracts

- Documentation: complete and submit Attachment A
 - Type of procurement
 - Name all vendors contacted, the amount of each bid & the date of each bid
 - Can renew contract 4 times (after 5 years must receive new bids)



Food Service Contracts

- Pay your vendor!
- Failure to pay your vendor can result in being declared *Seriously Deficient*
- CACFP funds may be used ONLY for food service.



Myth or Truth?

I want to switch from a food vendor and begin preparing my own meals;
I need to document that with NDE.

Truth!



Self-Prep Meals

- Must notify NDE
 - Revise your online application
 - Notify in writing (fax, email, letter)
- Must submit copies of meal production records to demonstrate compliance with requirements
- You may need to attend NDE's Meal Requirements Training



Civil Rights

- Centers are required to collect racial and ethnic information.
- Centers are required to submit racial and ethnic data.
- Centers are required to report aggregate data on their application each year.



Civil Rights

- If a participant is biracial or multi-racial, they may mark all applicable categories.
- When compiling data, these participants are counted in each of the categories.
- Aggregate totals may be more than your total enrollment.



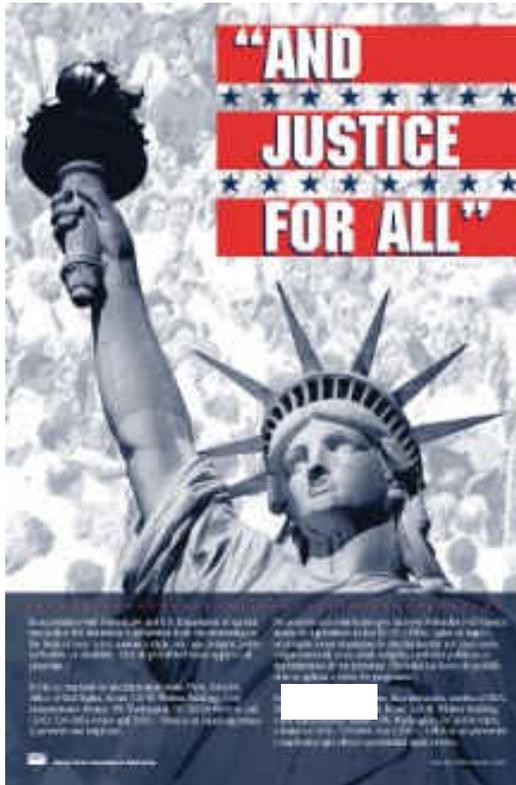
Civil Rights

You may not deny program services to any participants in these categories:

- Race
- Color
- National Origin
- Sex
- Age
- Disability



And Justice for All



This poster must be displayed in each center.

If you have anything *other* than this, take it down.



Participant Privacy

How to Register:

1. Before you can register you must first receive a secure email from registered user.

Note: The following steps will only need to be done once for a **first-time** recipient. Some steps and screen shots may vary depending on your system set up and email client. Please disable pop-up windows.

You have received a secure message

Read your secure message by opening the attachment, **securedoc.html**. You will be prompted to open (view) the file or save (download) it to your computer. For best results, save the file first, then open it in a Web browser. To access from a mobile device, forward this message to mobile@res.cisco.com to receive a mobile login URL.

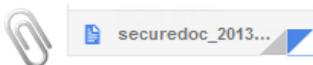
If you have concerns about the validity of this message, contact the sender directly.

First time users - will need to register after opening the attachment. For more information, click the following Help link.

Help - <https://res.cisco.com/websafe/help?topic=ReqEnvelope>
About Cisco Registered Email Service - <https://res.cisco.com/websafe/about>

2. Click to open/download the attached document

Note: Opening/downloading email attachments may differ depending on email client.



- Emailing documents with confidential information?
 - DOB, social security number, etc.
- Must email via secure server
- Ask NDE Staff for guidance



Management Plans: Staff Training

- You **must** train your staff on CACFP requirements
- Follow the management plan **YOU** made

Sponsor Schedule for your Staff Training

67. Sponsor is required to train their staff on the CACFP (e.g., completing meal count sheets, Income Eligibility Forms, calculating quantities, etc.). A minimum of one training must be listed and the date must coincide with the fiscal year for which application is made. Sponsor must document all CACFP/nutrition training provided to staff. Documentation includes dates and topics of training, list of attendees, certificates of attendance, etc.

Month: May	Topic: CACFP Requirements
Month:	Topic:
Month:	Topic:
Month:	Topic:



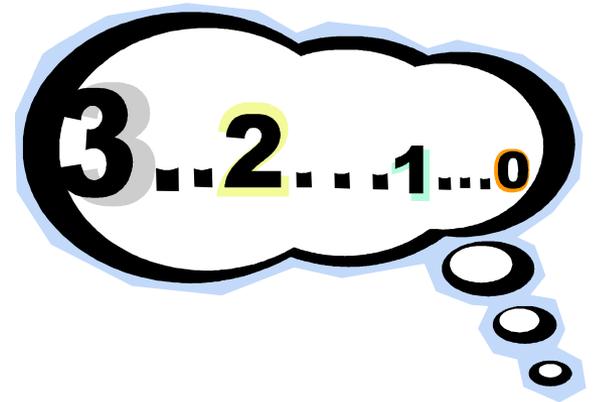
Management Plans: Staff Training

- Training **MUST** be documented
 - Date
 - Attendance
 - Topics covered
- NDE sessions do not fulfill requirement for YOU to train YOUR staff



Management Plan: Site Reviews

- Remember: 3, 2, 1
 - 3 site reviews each fiscal year
 - 2 unannounced
 - 1 must observe a meal service
- 5-day reconciliation
- No more than **6 months** apart



Management Plan: Site Reviews

- Visits should be conducted according to management plan submitted

Sponsors of Multiple Sites Only

93. Select the month(s) sponsor review will occur (minimum of 3):

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>





NEBRASKA DEPARTMENT OF EDUCATION

Agenda

Packets &
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Infant
Reminders



Meet the “Maybe” Foods handout

- Meat/meat alternate
- Milk
- Vegetables & fruits
- Grains

- Many foods require CN Label or product formulation statements, or must not contain extenders, byproducts



Crediting Handbook

- Use with *Food Buying Guide*
- Creditable foods:
 - Foods counted toward meal pattern requirements
- Non-creditable foods:
 - Foods that do not count toward meal pattern but do provide calories and nutrients
 - e.g. eggs served at breakfast



Child Nutrition (CN) Label

- Food manufacturer identifies food product's contribution to meal pattern requirements

Pizza

Cheese Pizza

CN

000000*

Each 5.00 oz portion of Cheese Pizza provides 2.00 oz equivalent meat
CN alternate, 1/4 cup serving of vegetable, and 1.50 servings of bread alternate CN
for the Child Nutrition Meal Pattern Requirements. (Use of this logo and
statement authorized by the Food and Nutrition Service, USDA 06/04**).

CN



Product Formulation Statement

- Information sheet from food manufacturer
- Detailed explanation of product content and amount of each ingredient by weight

No CN Label?

MUST HAVE Product Formulation Statement!



Sample Product Formulation Statement (Product Analysis) for Meat/Meat Alternate (M/MA) Products

Child Nutrition Program operators should include a copy of the label from the purchased product carton in addition to the following information on letterhead signed by an official company representative.

Product Name: _____ Code No.: _____

Manufacturer: _____ Case/Pack/Count/Portion/Size: _____

I. Meat/Meat Alternate

Please fill out the chart below to determine the creditable amount of Meat/Meat Alternate

Description of Creditable Ingredients per Food Buying Guide (FBG)	Ounces per Raw Portion of Creditable Ingredient	Multiply	FBG Yield/ Servings Per Unit	Creditable Amount *
		X		
		X		
		X		
A. Total Creditable M/MA Amount¹				

*Creditable Amount - Multiply ounces per raw portion of creditable ingredient by the FBG Yield Information.

II. Alternate Protein Product (APP)

If the product contains APP, please fill out the chart below to determine the creditable amount of APP. If APP is used, you must provide documentation as described in Attachment A for each APP used.

Description of APP, manufacture's name, and code number	Ounces Dry APP Per Portion	Multiply	% of Protein As-Is ²	Divide by 18 ^{2*}	Creditable Amount APP ^{3**}
		X		+ by 18	
		X		+ by 18	
		X		+ by 18	
B. Total Creditable APP Amount¹					
C. TOTAL CREDITABLE AMOUNT (A + B rounded down to nearest ¼ oz)					

¹Percent of Protein As-Is is provided on the attached APP documentation.

²18 is the percent of protein when fully hydrated.

³Creditable amount of APP equals ounces of Dry APP multiplied by the percent of protein as-is divided by 18.

¹Total Creditable Amount must be rounded down to the nearest 0.25oz (1.49 would round down to 1.25 oz meat equivalent). Do not round up. If you are crediting M/MA and APP, you do not need to round down in box A (Total Creditable M/MA Amount) until after you have added the Total Creditable APP Amount from box B to box C.

Total weight (per portion) of product as purchased _____

Total creditable amount of product (per portion) _____
(Reminder: Total creditable amount cannot count for more than the total weight of product.)

I certify that the above information is true and correct and that a _____ ounce serving of the above product (ready for serving) contains _____ ounces of equivalent meat/meat alternate when prepared according to directions.

I further certify that any APP used in the product conforms to the Food and Nutrition Service Regulations (7 CFR Parts 210, 220, 225, 226, Appendix A) as demonstrated by the attached supplier documentation.

Signature

Title

Printed Name

Date

Phone Number



Standard of Identity

- FDA standards for content, preparation and food labeling
- Ingredients that foods must contain to be identified by that product name
 - Example: natural cheeses v. cheese products
- For consumer protection: foods meet expectations of the buyer



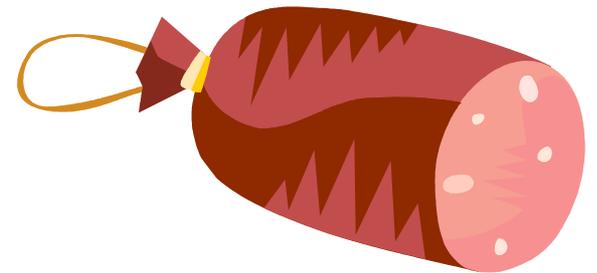
Myth or Truth?

Turkey bacon and chicken nuggets
are always creditable foods.

Myth!



- Turkey bacon, combination foods and chicken nuggets **MUST** have CN label or Product Formulation Statement
- Others:
 - Meat sticks (summer sausage)
 - Meat sauce
 - Commercial pizza
 - Polish sausage, other sausage
 - Salami



Chicken Nuggets

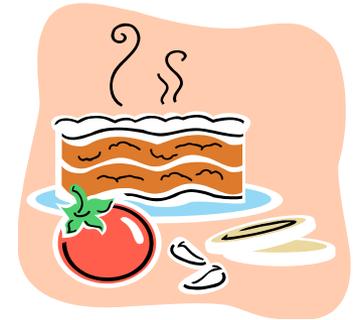
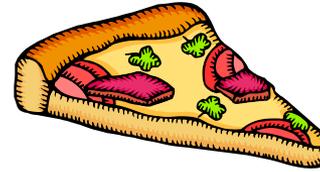
Food	Creditable			Comments
	Yes	Maybe	No	
Chicken Nuggets		x		Only the edible chicken portion is creditable as a meat. Commercial chicken nuggets must have a (1) CN label or (2) Product Formulation Statement signed by an official of the manufacturer (not a sales person). See question 11 on page 31 of this document. For breading/batter crediting, see the grains/breads section.

Deductions will begin July 1, 2014



Combination Foods

- Pot pies
- Pizza
- Lasagna
- Ravioli
- Burritos



- Creditable ONLY with CN label or Product Formulation Statement or homemade with production record



Myth or Truth?

If turkey bacon and sausage are sometimes creditable, pepperoni might be, too.

Truth!



Pepperoni is creditable,
but **only with** CN label.

Luncheon meats must
have CN label (or be in
Food Buying Guide).



Myth or Truth?

I heard all types of bologna and hot dogs are creditable.

Myth!



Hot dogs and bologna must not contain byproducts, cereal or extenders.

Extenders add “bulk” to foods without same nutritional value.



Hot Dogs

- No artificial flavors, colors, fillers or by-products



Byproducts, Cereals & Extenders

- Cereal
- Soy protein concentrate*
- Isolated soy protein*
- Sodium caseinate
- Starchy vegetable flour
- Vegetable starch
- Dry or dried whey
- Whey protein concentrate*
- Dried milk
- Soy flour*
- Wheat gluten
- Tapioca dextrin

*indicates Alternate Protein Product – may be OK but not all created “equal” so MUST obtain product specification



Myth or Truth?

Velveeta counts toward the meat alternate component.

Myth!



Cheese Products

- No standard of identity to consumers
- Nutritional value not consistent between brands



Pasteurized prepared cheese product



Myth or Truth?

Imitation cheese is not creditable.

Truth!



Cheeses

- Not creditable:
 - Imitation cheese
 - Cream cheese/Neufchatel cheese
- What IS creditable:
 - Cheese food
 - Cheese food substitute
 - Cheese spread
 - Cheese spread substitute
 - Cheese, natural or processed



Myth or Truth?

It doesn't matter which milk I serve
as long as it's cow's milk.

Myth!



Many Myths!

- Must be 1% or skim for children 2 years and older
- Whole is recommended for children 1 year old to 2nd birthday
- Document milk type on meal production record



**Deductions
will be made!**



Myth or Truth?

I know how much milk to pour for each age group just by looking at the cups they drink from

Show me



What's in that cup?

Milk measuring activity

3 Volunteers Needed:

- 1st Volunteer – Age 1 -2
- 2nd Volunteer – Ages 3-5
- 3rd Volunteer – Age 6-12
 - Pick a cup for each meal (Breakfast, Lunch & Snack)
 - Pour the amount of liquid (milk) required for each meal



Child and Adult Care Food Program



Age: 1-2 3-5 6-12

Breakfast

Fluid Milk	1/2 cup (c)	3/4 cup (c)	1 cup (c)
Juice or Fruit or Vegetable	1/4 c	1/2 c	1/2 c
Grains/Breads	1/2 slice* (or 1/2 serving)	1/2 slice* (or 1/2 serving)	1 slice* (or 1 serving)
or cold dry cereal	1/3 oz. or 1/4 c	1/2 oz. or 1/3 c	1 oz. or 3/4 c
or cooked cereal	1/4 c	1/4 c	1/2 c

Snack (select two different components from the following four **)

Fluid Milk	1/2 cup (c)	1/2 cup (c)	1 cup (c)
Juice or Fruit or Vegetable	1/2 c	1/2 c	3/4 c
Meat or Meat Alternate	1/2 oz.	1/2 oz.	1 oz.
or yogurt	2 oz. or 1/4 c	2 oz. or 1/4 c	4 oz. 1/2 c
or peanut or other seed or nut butters	1 Tbsp.	1 Tbsp.	2 Tbsp.
or egg (large)	1/2	1/2	1/2
Grains/Breads	1/2 slice* (or 1/2 serving)	1/2 slice* (or 1/2 serving)	1 slice* (or 1 serving)

Lunch/Supper

Fluid Milk	1/2 cup (c)	3/4 cup (c)	1 cup (c)
Meat or Poultry or Fish	1 oz.	1-1/2 oz.	2 oz.
or cheese	1 oz.	1-1/2 oz.	2 oz.
or cottage cheese, cheese food or cheese spread	2 oz. or 1/4 c	3 oz. or 3/8 c	4 oz. or 1/2 c
or egg (large)	1/2	3/4	1
or cooked dry beans or peas	1/4 c	3/8 c	1/2 c
or peanut or other nut butters or seed butters	2 Tbsp.	3 Tbsp.	4 Tbsp.
or peanuts, soynuts, tree nuts or seeds	1/2 oz. = 50%	3/4 oz. = 50%	1 oz. = 50%
or yogurt	4 oz. or 1/2 c	6 oz. or 3/4 c	8 oz. or 1 c
Vegetables and/or Fruits (2 or more kinds)	1/4 c Total	1/2 c Total	3/4 c Total
Grains/Breads	1/2 slice* (or 1/2 serving)	1/2 slice* (or 1/2 serving)	1 slice* (or 1 serving)

POINTS TO REMEMBER

- Keep menu production records current.
- The minimum required amount of each food must be served.
- Use full-strength juice.

* or an equivalent serving of an acceptable grains/breads such as cornbread, biscuits, rolls, muffins, etc., made of whole grain or enriched meal or flour, or a serving of cooked enriched or whole grain rice or macaroni or other pasta products. Refer to the grains/breads list for correct weights.

** For snack, juice or yogurt may not be served when milk is served as the only other component.



What's in that cup?

- What did you notice?
- Cups sizes can be deceiving.
- How can you ensure you're providing the adequate minimum amounts to your participants?



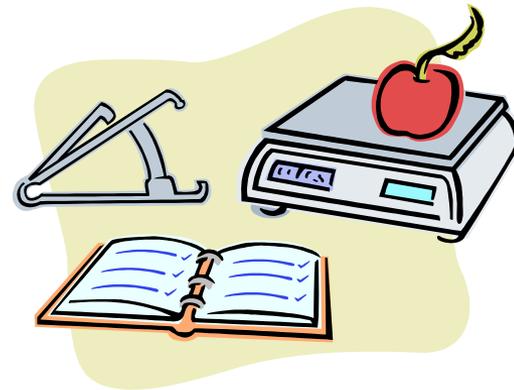


Essential Kitchen Tools



Every kitchen, including the infants room, should have the following equipment:

- Measuring Cups
- Measuring Spoons
- Liquid Measuring Cup
- Scale



Myth or Truth?

I can substitute water and/or juice for milk at breakfast and/or lunch when a child requests it.

Myth!



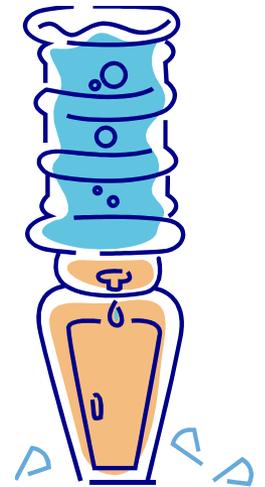
Milk Substitutes

- **NO** water or juice in lieu of milk. **EVER.**
- Only approved substitutes are creditable.



What About Water?

- Required that water be available
- **NOT** meal pattern component
- **NOT** take the place of milk in meal pattern
- May be offered in addition to fluid milk at breakfast and lunch



Myth or Truth?

Any soy milk is a creditable substitute for cow's milk in meal pattern.

Myth!



Milk Substitutes

Creditable Substitutes:

- Lactose-reduced milk
- Lactose-free milk
- Low-fat buttermilk
- Acidified milk



Non-Dairy Creditable Substitutes:

- 8th Continent soy milk
- Kikkoman Pearl Organic soy milk
 - creamy vanilla & chocolate
- Pacific Brand Ultra Soy Milk
 - plain and vanilla



Why Milk Substitutions?

Disability

Intolerance

Parent request



Disability: defined

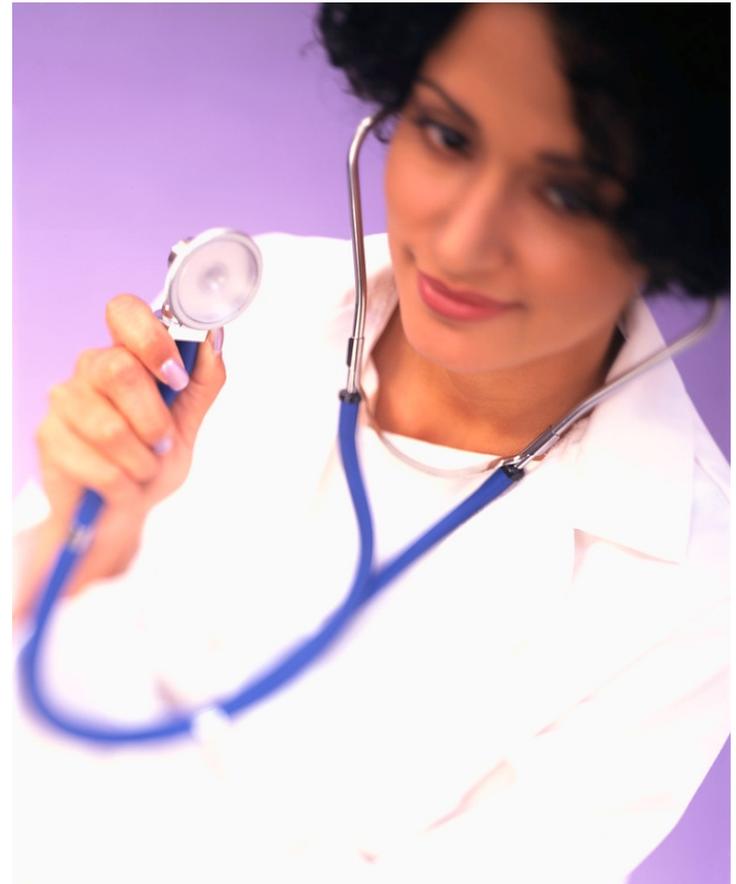
- American Disabilities Act definition of disability extended to “Major Bodily Functions” including (not limited to):
 - Digestive
 - Bladder
 - Bowel
 - Neurological
 - Endocrine



Milk Substitute for Disability

Doctor's statement:

- Identify disability
- Foods to be omitted
- Appropriate substitutes
 - Reimbursable if required substitute meets meal pattern
- Signature of MD
- Center must provide



Medical Statement Form to Request Special Meals and/or Accommodations

This form may be used to request meal modifications for participants in the Child Nutrition Programs in Nebraska (National School Lunch, Child and Adult Care Food Program, and Summer Food Service Program). There are three types of meal modification requests that can be made using this form (all request options require the parent or guardian to initially complete Sections 1 to 9 in Part A of the form):

- **Modification Option # 1:** Used to request **substitution for fluid cow's milk** due to Lactose Intolerance, Vegan, Religious, Cultural, or Ethical Reasons. This request can be made by the parent/guardian completing Sections 10 in Part A of this form. It does not require a physician/medical authority signature or completion of either the Part B or Part C Medical Statement portions of this form. **Note:** *The school/agency may at their discretion, offer a nutrient equivalent non-dairy milk substitute for a participant with a medical or special dietary need that is NOT life threatening or considered a disabling condition.*
- **Modification Option #2:** Used to request a **modification due to a disability**, including the potential for a severe allergic reaction (anaphylaxis) to food. Part B, Sections 11 to 22 must be completed by a licensed physician (*M.D. or D.O.*). **Note:** *Schools/agencies participating in one or more of the federal programs listed above are required to make accommodations for participants who are unable to eat the regular meals because of a disability that restricts their diet.*
- **Modification Option #3:** Used to request a meal **modification due to a food allergy/intolerance, or other medical condition** that does not rise to the level of a disability. Part C, Sections 21 to 30 must be completed by a Licensed Physician (*MD or DO*), Physician's Assistant (*PA*), Advance Practice Registered Nurse-Nurse Practitioner (*APRN-NP*), or Chiropractor. A Licensed Medical Nutrition Therapist (*LMNT*) also may complete and sign Part C when acting under the consultation of a licensed physician. **Note:** *Schools/agencies may, at their discretion, make substitutions for participants who have a special dietary need that does not meet the definition of a disability.*

Parent/Guardian:

The *Medical Statement Form* helps the school/agency provide meal modifications for participants who require them. Your participation in this process is very important. The sooner you provide this signed and completed form to the school/agency, the sooner the staff can prepare the food required. Your signature is required for the school/agency to take action on the medical statement. The school/agency staff cannot change food textures, make food substitutions, or alter the participant's diet without completion of the necessary portions of this form.

Definitions*: (As used for purposes of medical statements and modification requests on this form):

The term **"disability"** means, with respect to an individual: (A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such impairment; or (C) being regarded as having such impairment. (See 42 U.S.C. 12102)*

The term **"physical or mental impairment"** means (1) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genitourinary; hemic and lymphatic; skin; and endocrine; or (2) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term *physical or mental impairment* includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments; cerebral palsy; epilepsy; muscular dystrophy; multiple sclerosis, cancer; heart disease; diabetes; mental retardation; emotional illness; and drug addiction and alcoholism. (See 7 CFR 15b. 3(j).)*

The term **"major life activities"** includes, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. A major life activity also includes the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions. (See 42 U.S.C. 12102)*

The term **"has a record of such an impairment"** means the participant has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities. (See 7 CFR 15b. 3(i).)*

The term **"regarded as having such an impairment"**, as defined in USDA federal Food and Nutrition Service regulations at 7 CFR 15b, means that the participant (1) has a physical or mental impairment that does not substantially limit major life activities but that is treated by a recipient as constituting such a limitation; (2) has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others towards such impairments, or (3) has none of the impairments defined in paragraph (j) of this section but is treated by a recipient as having such an impairment. ("Recipient" would be a school/agency receiving nutrition services reimbursement.) (See 7 CFR 15b. 3(m) and 42 U.S.C. 12102)*

**Definitions are based upon the Americans with Disabilities Act Amendments Act of 2008 (See Title 42 of the United State Code, Section 12102), and USDA Food and Nutrition Service regulations (See Title 7 of the Code of Federal Regulations, Part 15b.) Refer to the full texts of these laws and regulations for more detail.*



MEDICAL STATEMENT FORM TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

This form is to be used to request meal modification(s) for participants in the National School Lunch Program,
Child and Adult Care Food Program, and/or Summer Food Service Program
(See Attached Instructions for Completing this Form)

PART A: Parent/Guardian completes this section – please print.		
1. Name of Participant:	2. Date of Birth:	
3. Name of Parent/Guardian:	4. Telephone:	
5. Address:	6. City:	7. State/Zip:
8. Email Address:		
<p>9. I give permission for the school/agency personnel responsible for implementing my child's prescribed diet order to share information with employees in order to accommodate this food modification request at other school/agency activities involving food.</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Parent/Guardian Signature: _____ Date: _____</p>		
<p>10. Modification Option #1. Milk Substitution Request Only (If applicable, Parent/Guardian must check box and sign):</p> <p><input type="checkbox"/> Participant is requesting substitution for fluid cow's milk due to lactose intolerance, vegan diet, religious, cultural, or ethical reasons. This milk substitution request can be made by the parent/guardian signing this form.</p> <p>Parent/Guardian Signature: _____</p> <p>IMPORTANT: For a student who does not have a recognized disability, the only fluid cow's milk substitutions allowed by USDA are (1) Lactose-free fluid cow's milk or a (2) Non-dairy beverage with a nutrient profile equivalent to fluid cow's milk as specified in federal regulations. Currently, the only beverages meeting these specifications are certain brands of soymilk.</p> <p>A physician/medical authority signature and completion of Parts B or C of this form is NOT required if this is the only requested substitution.</p>		

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Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

As stated above, all protected bases do not apply to all programs, "the first six protected bases of race, color, national origin, age, disability and sex are the six protected bases for applicants and recipients of the Child Nutrition Programs.



PART B: (Modification Option #2) Medical Statement - For participants *with* a disability

Completion of this PART B Medical Statement is required when the modification request is due to a disability, including a potential for a serious allergic reaction to a food (includes anaphylaxis).

To be completed by a licensed physician (M.D. or D.O).

1. **Disability** (Specify the disability, food allergy/intolerance or medical condition and explain why the disability restricts the participant's diet.)

Check major life activities affected:

- Walking Seeing Hearing Speaking Breathing Working Learning
 Performing manual tasks Caring for self (including eating) Other _____

Check major bodily functions potentially affected (either acutely or long term):

- Endocrine Growth Respiratory Neurological Circulatory Bladder Gastrointestinal
 Cardiovascular Reproductive system Immune system

- Potential for a Serious Allergic Reaction to Food (includes anaphylaxis).** Specify the food or foods:

2. Specify any dietary restrictions or special diet instructions for meals:

3. If applicable, list the foods to be omitted and substituted in their diet (attach additional sheets if needed):

Foods to be Omitted		Suggested Substitutions		
4. Modified Texture:	<input type="checkbox"/> Not applicable	<input type="checkbox"/> Chopped	<input type="checkbox"/> Ground	<input type="checkbox"/> Pureed
5. Modified Thickness of Liquids:	<input type="checkbox"/> Not applicable	<input type="checkbox"/> Nectar	<input type="checkbox"/> Honey	<input type="checkbox"/> Pudding Thick
6. Special Feeding Equipment:	If applicable, list special feeding equipment (e.g. large handled spoon, Sippy cup, etc.):			

7. M.D. or D.O. Signature:

8. Date:

9. Printed Name/Title:

10. Phone:



PART C: (Modification Option #3) Medical Statement *(For participants without a disability)*

Completion of this PART C Medical Statement is required when the requested modification is due to a food allergy/intolerance, or other medical condition that does not rise to the level of a disability. *Please note: The school/agency may make food substitutions, at their discretion, for individual children who do not have a disability, but who are medically certified as having a special medical or dietary need.*

To be completed by a Licensed Physician (MD or DO), or other recognized medical authority for this purpose: Physician's Assistant (PA), Advance Practice Registered Nurse-Nurse Practitioner (APRN-NP), or Chiropractor. A Licensed Medical Nutrition Therapist (LMNT) also may complete and sign Part C when acting under the consultation of a licensed physician.

Please note: LMNT's must list the referring physician in Section 26.

1. **Diagnosis** *(Specify the food allergy/intolerance or medical condition and explain why it restricts the participant's diet.)*

2. **Specify any dietary restrictions or special diet instructions for meals:**

3. **If applicable, list the foods to be omitted and substituted in the diet (attach additional sheets if needed):**

Omit Foods Listed Below:	Substitute Foods Listed Below:

4. Modified Texture:	<input type="checkbox"/> Not applicable	<input type="checkbox"/> Chopped	<input type="checkbox"/> Ground	<input type="checkbox"/> Pureed
5. Modified Thickness of Liquids:	<input type="checkbox"/> Not applicable	<input type="checkbox"/> Nectar	<input type="checkbox"/> Honey	<input type="checkbox"/> Pudding Thick

6. Signature of Physician/Other Medical Authority/LMNT:

7. Name of referring physician working with LMNT *(if applicable)*:

8. Printed Name and Title:

9. Phone Number:

10. Date:



Milk Substitute Without Disability

- Example: lactose intolerance (non-life-threatening)
 - Lactose-reduced milk
 - Lactose-free milk or acidophilus milk
 - Approved soy milk
- MD statement
 - Foods to be omitted
 - Substitutions
- Center encouraged to provide substitution (not required, however)

**Must meet
meal pattern**



Review

Milk: What If?

- No medical disability requiring alternate milk: center does NOT have to provide
- Parent brings approved milk substitute: center may claim the meals
- Parent wants child 2 yrs+ to have 2% or whole milk: center **MAY NOT** claim those meals
- Parent requests water or juice: center **MAY NOT** claim



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Myth or Truth?

I don't need to record specific fruits or vegetables on the infant feeding records.

Myth!



Infant Menu Reminders

- Specify fruit and vegetables
 - peaches, peas, etc.
- Specify type of infant cereal
 - oats, rice, wheat, etc.
- Specify breast milk or formula
 - Prepare only the amount of breast milk the baby usually drinks at one feeding
 - Specify amount prepared, not consumed



Infant Menu Reminders

- Hot dogs – not creditable
- Nuggets – not creditable (includes breaded chicken patty)
- Fish sticks – not creditable
- Combination commercial (jar) baby dinners (chicken and noodles)
- “Desserts” —not creditable (Hawaiian Delight, Peach cobbler...)
- Combination table foods (example: goulash – specify the meat only)



Infant Cereal: Not just carbohydrates

- Infant cereal is fortified with iron
 - Infant iron storage is depleted by ~6 months old
 - Introduce infant cereal at 6 months old to provide source of iron
- Why is iron important:
 - Brain development
 - Prevent iron-deficiency anemia



Myth or Truth?

Sponsors are entitled to participate
in CACFP.

Myth!



CACFP is a Privilege

Centers **MUST** follow all rules and regulations to be eligible to participate.

Federal Funds come with Federal/State Regulations





NEBRASKA DEPARTMENT OF EDUCATION