Child and Adult Care Food Program
PROVIDER SITE APPLICATION

This form must be completed annually for each provider.

Sponsor Information

Sponsor Name:	Sponsor Number:	Program Year:
Frontier Behavioral Health	159267	2025 - 2026

Provider Information

Provider Full Legal Name (first, middle, last):			Registration Type: DCYF
Any Other Name Previously Used:	Date of Birth:		Daycare License Number:
Physical Address:	Mailing Address/PO Box:		License Expiration Date:
City:	State: WA	Zip Code:	License Capacity:
County:	School Names closest to your home:		State ID # (provided by CACFP)
Phone Number:	E-mail:		CACFP Provider ID Number

Tier Information (to be determined by CACFP Office)

Tier Level:

If Tier level 1, please complete the following information: ☐ School ☐ Income ☐ Census

☐ Yes ☐ No Tier I Provider based on Basic Food.

☐ Yes ☐ No Tier I Provider eligible to claim own children based on Basic Food.

Basic Food Number:

Day Care Home Provider Information

Provider eligible to claim own children? ☐ Yes ☐ No

Do you claim meals for infants? ☐ Yes ☐ No Are you using the Infant Meal Form? ☐ Yes ☐ No

Do you care for children in more than one shift? ☐ Yes ☐ No *(If you serve the same meal at two different times, you need 2 shifts)*

Ethnicity: ☐ Hispanic ☐ Not Hispanic **Race**: ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ Asian ☐ White ☐ Multi-Racial

Number of provider's own children:

Age of enrolled children including infants: From:_____ To:_____

Hours of operation: From:_____ To:_____

Months Served

All Months	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Meal Times

M-F	Mon	Tue	Wed	Thu	Fri	Sat	Sun
☐	☐	☐	☐	☐	☐	☐	☐

	First Shift Begin	First Shift End	Second Shift Begin	Second Shift End
Breakfast				
A.M. Snack				
Lunch				
P.M. Snack				
Supper				
Evening Snack				

Start and stop times of meal service information MUST BE in 15 MINUTE INCREMENTS and must start and end on the quarter hour.

If you do not put in a time for one of the meals, you will not be able to claim those meals. Please enter a time for all meals you think you might claim.

Certification

I certify that my home is not participating in the Child and Adult Care Food Program under any other sponsoring 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 OSPI or U.S. Department of Agriculture, 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 race, color, national origin, gender, age, or disability. I understand that all children will receive meals at no extra change while they are in care during any of the scheduled meal services.

Signature of Provider _____ Date _____ Signature of Sponsoring Organization Representative _____ Date _____