CACFP Agreement #_____

NEW YORK STATE | Department of Health | Child and Adult Care Food Program

COVID-19 APPLICATION for Feeding Flexibility

Sponsor Name_____

1. How will meals be provided?	
☐ On-site pick up	☐ At center # _____ ☐ At another location Address: _____ _____ Type of facility: _____
☐ Home delivery	Provide a detailed distribution plan (who is delivering; means of transportation; how food will be kept hot or cold; etc.):
☐ Other type of meal service	Please explain:

2. Provide the following information:

Anticipated start date: ____/____/_____ (mm dd yyyy) Anticipated end date: ____/____/_____ (mm dd yyyy)

3. Which meals will be provided to each child/adult per day?

☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper

Only meal types currently approved can be claimed for reimbursement.

4. Attach the menu that will be used and indicate if the menu is:

☐ A menu previously approved by CACFP
☐ A new or different menu

_____ Name and Title of Representative

_____ Email Address

_____ Signature of Representative

_____ Date

Submit via email to cacfp@health.ny.gov or fax to (518) 402-7252

State Use Only: ☐ **Approved** ☐ **Not Approved** _____ **Staff Initials**

This institution is an equal opportunity provider.