

**PRE-APPROVAL VISIT
TO BE CONDUCTED BY SPONSOR**

1. Center Name _____ CNIPS # _____
 Address _____

 Telephone _____ Director _____
 Type of Center ___ CCP___ PCC___ OSH___ Head Start___ Homeless___ ADC___ Title XIX (ADC)

2. Licensed Capacity _____ Expiration Date ____/____/____
 3. Total number of participants enrolled _____ Number in attendance _____
 4. Indicate type of meals to be claimed for reimbursement.

	Breakfast	AM Snack	Lunch	PM Snack	Supper	Late Night Snack
Time of Meal Service						
Estimated Number to be Served						

5. If claiming more than 2 meals and 1 snack OR 2 snacks and 1 meal, explain procedure to ensure correct meal count. Must use State Agency 17-10).

6. How will meals be provided? _____ Self-Preparation _____ Contract _____ Central Kitchen _____ Other
 7. Has center staff been trained according to USDA meal pattern requirements? _____ Yes _____ No
 8. Is an enrollment form on file for each participant? _____ Yes _____ No
 9. Will family size and income information be obtained for each participant? _____ Yes _____ No
 10. Have record keeping requirements been explained and discussed with the center director? _____ Yes _____ No

11. List names of personnel responsible for CACFP Administration and Food Service. Include specific duties assigned to each.

Administration	Duties
Food Service	Duties

12. Has racial/ethnic information been collected on the area to be served? _____ Yes _____ No

_____/____/____ Signature of Center Director _____/____/____ Date
 _____/____/____ Authorized Sponsor Representative _____/____/____ Date