



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
 SUMMER FOOD SERVICE PROGRAM (SFSP)
SITE INFORMATION SHEET (Please TYPE or PRINT clearly)

1. Name of Sponsor:		2. Name of Site:	
3. Street Address of Site (where children are fed). Include street, city, state & ZIP code:			4. County:
5. Site Supervisor's Name:	6. Site Supervisor's Title:	7. Site Supervisor's Email address:	
8. Site Supervisor's Telephone Number: () - Ext.	9. Site Supervisor's Fax Number: () - Ext.		
10. a. Site Location: <input type="checkbox"/> Rural <input type="checkbox"/> Urban <small>Areas considered urban include Kansas City, St. Louis, Columbia, Jefferson City, Joplin, Springfield and St. Joseph. All others are considered rural.</small>	10. b. Urban sites and sponsors with more than one site: Describe the geographical boundaries served and attach a map with the boundaries marked. If boundaries overlap, include a brief statement indicating the necessity for each site.		
11. Site Type (choose only one): <input type="checkbox"/> Open Site Using School Data School Number _____ Percentage of Students Eligible for Free or Reduced Price Meals: _____% School Name _____ District Name _____ <input type="checkbox"/> Open Site Using Census Tract Data (Contact the MDHSS—BCFNA for assistance) <input type="checkbox"/> Migrant Site Using Migrant Organization Information (Mail in documentation to MDHSS—BCFNA) <input type="checkbox"/> Enrolled Site (Income Eligibility Forms must be collected) Projected # Enrolled in SFSP: _____ Projected # Eligible for Free or Reduced Price Meals _____ <input type="checkbox"/> Camp--Income Eligibility Forms are Required <input type="checkbox"/> National Youth Sports Program that meets income eligibility guidelines of the U.S. Dept. of Health and Human Services (DHHS)			
12. Is there regularly scheduled, organized activity at the site? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please list the type of activities or attach a schedule of daily activities.			
13. Does the system used to serve meals to children at the site ensure that each child receives a complete meal, and that meals are counted at the point of service? <input type="checkbox"/> Yes <input type="checkbox"/> No			
14. Does the site have the necessary staff and facilities so that the meal service is organized and properly supervised? <input type="checkbox"/> Yes <input type="checkbox"/> No			
15. Are procedures in place to adjust meal orders to reflect the number of children participating? <input type="checkbox"/> Yes <input type="checkbox"/> No			
16. Does the site have adequate facilities for holding meals at proper temperatures or will meals be served within one hour of delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No			
17. Does the site handle leftover meals by discarding, storing or returning them to a central kitchen? <input type="checkbox"/> Yes <input type="checkbox"/> No			
18. Program regulations require that the sponsor conduct a pre-approval visit to the site, before the Missouri Department of Health and Senior Services will approve the site for participation. Has the sponsor conducted a pre-approval visit to this site? <input type="checkbox"/> Yes <input type="checkbox"/> No			

19. Operating Dates Begin Date (First date SFSP meals to be served at site): ___/___/___ End Date (Last date SFSP meals to be served at site): ___/___/___													
20. Total number of operating days each month: <i>Exclude weekends and holidays if you will not serve meals on those days.</i>			May	June	July	August	September	TOTAL					
21. Meal Service Choices and Beginning/Ending Times: Note: You may choose a combination of two meals or one meal and one snack per day, with the exception of lunch and supper on the same day. There must be at least 3 hours between the beginning of one meal or snack service and the beginning of the next. Breakfast and snacks are limited to one hour from start to finish. Lunch and supper are limited to two hours from start to finish.													
Meal Type	Preparation Method	Begin Time	End Time	Days Meals Served							Estimated Number to be served (ADP)	Estimated Number Eligible (Camps Only)	CAP (MDHSS use only)
				M	T	W	T	F	S	S			
Breakfast	<input type="checkbox"/> Self-Prep <input type="checkbox"/> Vended			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
AM Snack	<input type="checkbox"/> Self-Prep <input type="checkbox"/> Vended			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Lunch	<input type="checkbox"/> Self-Prep <input type="checkbox"/> Vended			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
PM Snack	<input type="checkbox"/> Self-Prep <input type="checkbox"/> Vended			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Supper	<input type="checkbox"/> Self-Prep <input type="checkbox"/> Vended			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
22. <input type="checkbox"/> Meal Time Waiver is requested. Select this option if operating meal service outside of the standard times allowed and provide justification in the space below:													
23. How many children can eat at this site at one time? _____						24. How many staff members supervise the meal service? _____							
25. If the site is a camp or operates sporadically, list the sessions and dates or otherwise describe the schedule below:													
26. If this is an outdoor site, where will meals be served during inclement weather? <i>Please provide the address and procedures for alternate meal service.</i>													
I certify that this site has the capabilities and facilities to provide the meal service planned for the number of participants to be served, and that the information on this form is true and correct to the best of my knowledge. I understand that this information is being given in connection with the receipt of Federal funds, and that withholding information or deliberate misrepresentation may subject me to prosecution under applicable state and federal criminal statutes.													
Signature of Authorized Sponsor Representative						Title				Date			
MDHSS USE ONLY BELOW THIS LINE													
Approval Signature of MDHSS—BCFNA Representative						Title				Date			