# Iowa's Child and Adult Care Food Program

**Polk County Community, Family and Youth Services**
**2309 Euclid Ave - Des Moines, Iowa 50314 - [515]286-3703**

## Iowa Child and Adult Care Food Program

**Agreement between**
**Child Development Home Provider and Home Sponsor**
**For the Period October 1, to September 30, Each Program Year**

| Polk County Community, Family & Youth Services | 77-8050 |
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### Section B. The Child Development Home Provider agrees to:

1. Inform the Sponsor immediately of any changes in the meals and/or snacks to be claimed, change in family size or income (affecting Tier 1 status), hours of operation and days of operation.

Inform Sponsor: Section B-2 Agreement between Provider and Sponsor.

1. Meal service times: Change's in meal service times must be made in writing before you plan to start using the new meal service times. Contact your PC-CACFP representative and request a change form.
   a) When home visits are made for the purpose of observing a meal and the meal is not being prepared or served at the approved time you will not be paid for that meal and a corrective action plan will be completed.

2. Hours and/or days of business operation of your child care home: Changes in your hours or days of operations must be made in writing before you plan to start using the new hours or days. Contact your PC-CACFP representative and request a change form.
   a) If visits are made on approved days within your hours of operation and no one is home; a corrective action plan will be completed.
   b) The yellow copy of the review form and the corrective action plan with the date and time of the attempted visit, signed by the field representative, will be left at the home.
   c) You must call within 2 working days to your field representative to receive reimbursement for meals served the day of attempted visits.

3. Any change in your helpers or co-provider must be reported to PC-CACFP before the new person starts working with you.

4. Any time someone else is taking your place in your child care home you must notify PC-CACFP before the substitution takes place.

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***PROVIDER NAME***: __________________________ ***PROVIDER ID***: ______ ***PROGRAM YEAR***: ____

***EFFECTIVE DATE***: __/ /____Please give the effective date of any changes made below.

***MEAL SERVICE TIME***: Please write in the new time for meals you serve

BREAKFAST: _____ AM SNACK: _____ LUNCH: _____ PM SNACK: _____ SUPPER: _____

***DAYS OF OPERATIONS:*** Please check or "X" the boxes of days to include

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

***HOURS OF OPERATION:*** Please write in the earliest time and the latest time that you are open for child care.

START TIME: _____ AM PM CLOSE TIME: _____ AM PM

Please write in the names of your helpers

HELPER'S NAME: _________________________ HELPER'S NAME: ___________________________

Please write in the name of your co-provider

CDH CATEGORY "C" SECOND PROVIDERS NAME: __________________________________________