CHILD CARE FOOD PROGRAM
PROVIDER DATA SHEET

Authorization Number:	D-1402	Organization Name:	Infant and Child Nutrition, Inc.

1. Provider Information:

Provider Name:_____

Street Address: _____

City: _____ State: _____ Zip: _____ County:

Phone Number: _____ Fax Number: _____

Email Address: _____

2. Is your name, address and phone number listed as CONFIDENTIAL with DCF or your local licensing agency?

❑ Yes ❑ No

3. Names of all children that reside in your home: _____

4. Days you provide care for children other than those that reside in your home: (Check all that apply)

❑ Sunday ❑ Monday ❑Tuesday ❑Wednesday ❑ Thursday ❑ Friday ❑ Saturday

5. Operating Hours: Start: _____ Finish: _____

6. Meals to be Claimed: (Check all that apply)	Breakfast	Morning Snack	Lunch	Afternoon Snack	Supper	Evening Snack
	❑	❑	❑	❑	❑	❑

7a. Do You Have Child Care Shifts? ○ Yes ○ No
(If Yes, go to 7b. If No, skip to #8)

7b. Meals to be Claimed by Shift:
(Complete all that apply)

	Start Time		Finish Time	Breakfast	Morning Snack	Lunch	Afternoon Snack	Supper	Evening Snack
1st Shift:	_____	To	_____	❑	❑	❑	❑	❑	❑
2nd Shift:	_____	To	_____	❑	❑	❑	❑	❑	❑
3rd Shift:	_____	To	_____	❑	❑	❑	❑	❑	❑
4th Shift:	_____	To	_____	❑	❑	❑	❑	❑	❑

8. Meal Time Information:

	Weekdays Start Time	Weekdays Finish Time		Weekends Start Time	Weekends Finish Time
Breakfast	_____	_____	Breakfast	_____	_____
Morning Snack	_____	_____	Morning Snack	_____	_____
Lunch	_____	_____	Lunch	_____	_____
Afternoon Snack	_____	_____	Afternoon Snack	_____	_____
Supper	_____	_____	Supper	_____	_____

I certify that all information on this Provider Data Sheet is true and correct.

_____
Provider's Signature

_____
Signature Date

Approved by: _____

Title: _____

Date: _____