COMPENSATION APPROVAL APPLICATION
FOR SPONSORING ORGANIZATION OF CHILD AND ADULT CARE FOOD PROGRAM

THIS APPLICATION IS NOT TO BE USED AS YOUR ORGANIZATION'S COMPENSATION PLAN

SPONSOR NAME: __________________________________________________________________________________

MAILING ADDRESS: _______________________________________________________________________________

EMAIL ADDRESS: __________________________________________ TELEPHONE: ___________________

INSTRUCTIONS: ALL sponsoring organizations participating in the CACFP must answer the following question:

DOES YOUR SPONSORING ORGANIZATION PAY ANY SALARIES FOR ADMINISTRATIVE AND/OR FOOD
SERVICES FROM YOUR CACFP ACCOUNT? THIS SALARY INCLUDES ENTIRE OR PARTIAL SALARY.

☐ NO If NO, then you are not required to answer the remaining questions on the application. The organization’s official representative must verify the certification statement at the end of the form with his/her signature and date.

☐ YES If YES, then complete the application by answering all questions with explanations where needed. Type or print clearly in black ink. Attach an additional sheet of paper if more space is needed. A copy of your organization’s compensation plan of personnel payroll policies must be attached to this application for approval.

EXCEPTION: The following sponsoring organizations are not required to submit a copy of their compensation plan:

Check type: ☐ Public school, college, or university
☐ Military base
☐ State agency
☐ City government

IS THE COMPENSATION PLAN ON FILE AT YOUR ORGANIZATION? ☐ YES ☐ NO

FOR SPONSORS OF MULTIPLE ADULT AND/OR CHILDCARE CENTERS:
If the sponsor has multiple centers and the compensation plan differs at each center, then this form must be completed for each site and a copy of the corresponding plan attached.

SALARY:

WHICH PERSONNEL ARE PAID WITH CACFP FUNDS IN YOUR ORGANIZATION?

☐ Food Service
☐ Administrative Service
☐ Both Administrative and Food Service

IS THIS SALARY PAID WITH CACFP FUNDS? Please check one. ☐ YES ☐ NO

If yes, check one of the following: ☐ IN FULL or ☐ IN PART
If salaries are paid in part with CACFP funds, please specify the source for the remainder of the salary.

☐ Center Funds ☐ Other (Please describe) __________________________________________________________

<table>
<thead>
<tr>
<th>CNP Staff Approval date</th>
<th>Annual Effective Date</th>
<th>FY Revision Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annual Total Food Service Labor</th>
<th>Annual Administrative Funds Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CNP Staff Denial Date</th>
<th>CNP Staff signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reason for Denial _____________________________________________________________
**SALARY OR RATE OF PAY SCALE:** (Use additional sheet if necessary) Indicate your organization’s pay scale (lowest to highest):

Our salary or rate of pay scale starts at _____________________________ and ends at _____________________________ for all employees.

Are CACFP Funds used to pay salaries.  ☐ YES  ☐ NO

If you checked YES, then complete the following:

1. List the title or position of each employee paid with CACFP funds.
2. Give the rate of pay.
3. Indicate if paid by hr./wk./mo.
4. Give the number of hours per day.
5. Give the number of days per week.
6. Give the number of weeks per year.
7. Show the total yearly salary earned (gross earnings) for CACFP position. Round to nearest whole number.

### FOOD SERVICE

<table>
<thead>
<tr>
<th>TITLE/POSITION</th>
<th>RATE OF PAY</th>
<th>HR/WK/MO</th>
<th>HRS/DAY</th>
<th># DYS Per WK</th>
<th># WKS Per YR</th>
<th>TOTAL YEARLY SALARY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### ADMINISTRATIVE FUNDS

<table>
<thead>
<tr>
<th>TITLE/POSITION</th>
<th>RATE OF PAY</th>
<th>HR/WK/MO</th>
<th>HRS/DAY</th>
<th># DYS Per WK</th>
<th># WKS Per YR</th>
<th>TOTAL YEARLY SALARY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If NO, then complete the following:

Explain under what circumstances are personnel doing comparable work NOT paid the same salary and given the same benefits.

---

**JOB DESCRIPTIONS**

For each of the CACFP personnel listed, list specific duties of the position or attach a copy of the job description.

**Food Service:**

---

**Administrative Service:**

---
TIME SHEETS ARE REQUIRED.

☐ YES ☐ NO Do any of your CACFP personnel perform other jobs at your organization? If YES, then how many people? __________

☐ YES ☐ NO Are time sheets used to document hours of CACFP and other employment duties for these personnel?

OVERTIME PAY

☐ YES ☐ NO Are there provisions for OVERTIME PAY? If YES, describe and include rate of pay.

CONTRACT AND/OR CONSULTING SERVICES

☐ YES ☐ NO Do you employ contract and/or Consulting Services and pay them with CACFP funds? IF YES, complete the following: Give details of service(s) provided, expenses of service, and documentation procedures.

FRINGE BENEFITS:

☐ YES ☐ NO DO YOU OFFER FRINGE BENEFITS TO ALL OF YOUR EMPLOYEES? If YES, Check the ones applicable to your organization and briefly explain the benefit offered below unless it is explained in your organization’s handbook of policies and procedures. If you offer other benefits not listed, please specify under, “OTHER”.

☐ YES ☐ NO Employee Accident and Health Insurance (includes medical, dental, life, accidental death, dismemberment, unemployment).

☐ YES ☐ NO Paid Vacation (Annual Leave)

☐ YES ☐ NO Sick Leave

☐ YES ☐ NO Retirement Plan

☐ YES ☐ NO Education Assistance

☐ YES ☐ NO Holiday Policy

☐ YES ☐ NO Travel Policy (includes use of agency vehicles, lodging, expense advances/documentation, mileage reimbursement)

☐ YES ☐ NO Employee Morale Activities (unallowable expense for CACFP account: gifts, social events, meals, flowers, etc., exceeding $25)

☐ YES ☐ NO Other
If you do not offer fringe benefits to all of your employees, please explain:

__________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________

CERTIFICATION STATEMENT

I CERTIFY THAT THE INFORMATION ON THIS FORM AND SUBSEQUENT ATTACHMENTS 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 DELIBERATE MISREPRESENTATION MAY SUBJECT ME TO PROSECUTION UNDER APPLICABLE STATE AND FEDERAL CRIMINAL STATUTES. THE U.S. DEPARTMENT OF AGRICULTURE PROHIBITS DISCRIMINATION IN ALL OF ITS PROGRAMS AND ACTIVITIES ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, GENDER, AGE OR DISABILITY.

PRINT NAME AND TITLE OF OFFICIAL REPRESENTATIVE

SIGNATURE OF OFFICIAL REPRESENTATIVE

DATE

USDA Non-Discrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:
(1) Mail: U.S. Department of Agriculture
    Office of the Assistant Secretary for Civil Rights
    1400 Independence Avenue, SW
    Washington, D.C. 20250-9410;
(2) Fax: (202) 690-7442; or
(3) Email: program.intake@usda.gov

“This institution is an equal opportunity provider”.

4 | Page