MEMORANDUM

TO: Child and Adult Care Food Program Administrators
(Sponsors and Independent Centers)

FROM: Mary A. Young, Program Manager
Child and Adult Care Food Program

SUBJECT: Center Program Closure / Change Form, CACFP Policy 09-07

It is a requirement that participants of the Child and Adult Care Food Program (CACFP) notify our office if their organization and/or any of their sponsored center(s) are going to be closed during normal business hours. In addition, it is also a requirement that once an organization and/or sponsored center is approved, any changes made to the meal service times, days of meal service and dates of operation, must be communicated to the South Carolina Department of Social Services office prior to claiming for the meals/snacks served during those times and dates.

In an attempt to help organizations communicate this information to our office, we have developed a Program Closure/Change Form. The attached Closure/Change form is to be completed and mailed or faxed to the South Carolina Department of Social Services’ CACFP office prior to any closure dates and prior to making any changes to the organization or center’s meal service time and/or dates of operation. All completed forms should be sent to the attention of your CACFP Consultant.

If you have any questions concerning this policy memo, please contact your CACFP Consultant.

Attachment:
Center Program Closure/Change Form
**South Carolina Department of Social Services**  
**Child and Adult Care Food Program**  
**Child and Adult Care Food Program Closure/Change Form**

Name of Organization: ____________________________________________  
Agreement Number: __________________

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<tr>
<th>Name of Center</th>
<th>Closure Period (Dates)</th>
<th>Change in Meal Service Time</th>
<th>Effective Date</th>
<th>Reason for Closure/ Change</th>
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Comments/other changes to program (days no longer operating, etc...):

I certify that the above closures/changes are being submitted to SCDSS for approval prior to the closure dates and or prior to any changes have been made to our meal service time(s) and or dates of operation.

____________________________________  
Signature of Authorized Representative

______________________________
Title of Authorized Representative

______________________________
Date

Either fax this form to (803) 898-0960 or mail to SCDSS, Child and Adult Care Food Program, P.O. Box 1520, Columbia, SC 29202-1520

**SCDSS PERSONNEL ONLY**

____________________________________  
Date Approved

______________________________  
SCDSS Rep. Initials