PROVIDER DATA SHEET

2024

Authorization Number D-1793
Organization Name Children's Nutrition of Florida, Inc.

1. Provider Information

Provider Name ______
Street Address ______
City ______ State FL Zip ______ County ______
Home Phone # ______ Cell Phone # ______
Email Address ______ @ ______

2. List the names of all children under 13 that live in your home ______

3. Days you provide care for children ❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday

4. Operating Hours (per DCF License) Start ______ Finish ______

5. Meals Claimed ❑ Breakfast ❑ Morning Snack ❑ Lunch ❑ Afternoon Snack ❑ Supper

6. Meal Times:

	Start	Finish
Breakfast		
Morning Snack		
Lunch		
Afternoon Snack		
Supper		

OFFICE USE ONLY (REQUESTED/APPROVED CHANGES)

Start	Finish

7. Holidays you will be serving and claiming meals

- ❑ New Years Day
- ❑ Good Friday
- ❑ Labor Day
- ❑ Fri. after Thanksgiving
- ❑ MLK Jr. Day
- ❑ Memorial Day
- ❑ Veteran's Day
- ❑ Christmas Eve
- ❑ President's Day
- ❑ Independence Day
- ❑ Thanksgiving Day
- ❑ Christmas Day
- ❑ Juneteenth

8. Is your name, address and phone number listed CONFIDENTIAL with DCF? ❑ Yes ❑ No

9. Do you transport children and if so, list times ______

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

______
Provider's Signature

______
Signature Date

Approved by ______
Title ______
Date ______