

## SUMMER FOOD SERVICE PROGRAM (SFSP) JUSTIFICATION

<b>Name of Facility</b>			
<b>Facility Agreement</b>		<b>Date of Request</b>	
<b>Person Submitting Request</b>		<b>Phone Number</b>	

By checking this box, I request permission to OPT-IN to the Summer Food Service Program Extension.

***Please complete the following justification to be considered for the SFSP Extension.***

1. In your area is the public or private school district operating a feeding program?  Yes  No
  
2. Are there any Feeding Programs within 1 (one) mile of the sites you would like to continue operating under SFSP?  Yes  No

If Yes, please list the sites:

3. Please provide a detailed justification reflecting the need for the SFSP extension.

**SUMMER FOOD SERVICE PROGRAM (SFSP) JUSTIFICATION**

**DO NOT WRITE BELOW THIS LINE**  
**HEALTH AND NUTRITION UNIT USE ONLY**

- 
- Approved until \_\_\_\_\_ (Date) \_\_\_\_\_ (Program)
  - Denied

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*DCCECE Health and Nutrition Assistant Director or  
Administrator Signature*

*Date*

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