Agency application to receive foods from Cranbrook Food Recovery

Part 1: RECIPIENT FDO AGENCY PROFILE

Date of Application: _____

Parent Organization Name: Cranbrook Food Recovery Coalition

Address: 1324 - 2nd St N

City: Cranbrook Postal Code: V1C 4T6

Contact Name: Meredith funston Title: Program Coordinator

Phone: 778 517 5447 Fax: Cell:

Email: cranbrookfoodrecovery@gmail.com

Mission Statement: To recover food still fit for human consumption and distribute it to local non profit groups serving community members

Receiving Organization Name: _____

Mailing Address:
(if different from DROP-OFF) _____

City: _____ Postal Code: _____

Contact Name: _____ Title: _____

Phone: _____ Fax: _____ Cell: _____

Email: _____

*** ***EMERGENCY ONLY CONTACT PHONE***: _____ ***

FOR OFFICE USE ONLY

Approved: ☐ **YES** ☐ **NO**

BY: _____ **Date:** _____

Product Type: ☐ **ENTREE** ☐ **PRODUCE** ☐ **BAKED**

☐ **7-11** ☐ **BREAD**

Our Organization's Target Group Type: _____

Deliveries (Multiples per Week): _____

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Part 2: APPLICATION FOR RECOVERED FOOD

1. **Address of Food Program:** _____

2. **Person in Charge of Food Program Location:** _____

3. **Agency information:**

   i) Status:
   (select one only)

   - ○ Incorporated non-profit
   - ○ Unincorporated private
   - ○ Church sponsored
   - ○ Public

   ii) Funding – are you funded by:
   (select all that apply)

   - Private donations ☐
   - Municipal/City ☐
   - Provincial ☐
   - Federal ☐
   - Social Services ☐
   - Other *(please specify)* ☐ _____

4. **Type of Program:** *(select all that apply)*

   - Emergency Meals/Soup Kitchen ☐
   - Transitional Shelter ☐
   - Drop-in Shelter ☐
   - Other *(please specify)* ☐ _____
   - Residential Program ☐
   - Day/Vocational Program ☐
   - Self-help Group ☐

5. **Who is your target group?** _____

6. **Do you have any restrictions/guidelines/conditions a guest must meet in order to be served?**

   ☐ Yes ☐ No

   If YES, *briefly explain*: _____

7. **Do you have any fees?** ☐ Yes ☐ No

   If YES, *briefly explain*: _____

8. **Hours you can receive food donation deliveries:**

Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
From	To	From	To	From	To	From	To	From	To	From	To	From	To

9. **How many guests do you serve (on average) at each meal?** _____

10. **How many guests do you serve overall?** *(fill in all 3 blanks)*

Daily _____ Weekly _____ Monthly

11. **When was your food program first established?** YYYY MMM

12. **Where do your current food donations originate?** _____

_____

13. **What types of food would be most beneficial to supplement your meal programs?** *(please be specific)*

Entrees _____ Produce _____

Breads _____ Baked Goods _____

14. **Approximately what percentage of your supply will come from this organization?**

○ 0 - 25% ○ 25 - 50% ○ 50 - 75% ○ 75 - 100%

15. **What other type of assistance besides food do you offer for people in need?** *(select all that apply)*

☐ Counseling ☐ No other aid

☐ Information ☐ Referral

☐ Job training/placement ☐ Shelter

☐ Welfare advocacy ☐ Other *(please specify)*: _____

16. **Does your facility meet current Health Authority Requirements?** ☐ Yes ☐ No

If YES, indicate type of license and date acquired:

Type: _____ Date: Click here to enter a date. Certificate #: _____

17. **Do you have third party liability insurance?** ☐ Yes ☐ No

If NO, *please explain*: _____

Before this application can be processed, please contact your local Health Authority regarding your facility and Health Authority standards.