

**Child and Adult Care Food Program  
Sample Household Contact  
Letter/Script and Survey Form**

Date

Parent/Guardian Name

Address

City, NJ Zip Code

Dear (parent/guardian name):

Hello, I represent (agency) \_\_\_\_\_. Your child care provider, (name here) \_\_\_\_\_, receives reimbursement from the New Jersey Child and Adult Care Food Program (CACFP) for the meals served to your child(ren)'s. In order to ensure program integrity, we will occasionally conduct a household survey to verify your child(ren)'s attendance. Your participation in this survey will help us in maintaining the integrity of the CACFP.

Your child will not be denied benefits if you decide not to participate in this survey.

Should you have questions regarding this survey, you may contact (sponsor contact person) \_\_\_\_\_ at (telephone number of sponsor contact person) \_\_\_\_\_.

Thank you in advance for helping us complete this survey and verify your child(ren)'s participation in the CACFP.

# CHILD AND ADULT CARE FOOD PROGRAM

## Household Contact Survey Form

Sponsoring Agency \_\_\_\_\_

Child(ren) Name(s) \_\_\_\_\_

Parent /Guardian Name: \_\_\_\_\_

Provider/Center Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Date \_\_\_\_\_

Check (✓) one

	Yes	No
1. Are you aware that your provider/center participates in the USDA, CACFP?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the child(ren) still in care at the provider/center noted above?	<input type="checkbox"/>	<input type="checkbox"/>
3. If yes, how many days in the month of _____ was your child(ren) in attendance? _____.		
4. If no longer attending, what was the last day/month for day care? _____		
5. Name(s) and age(s) of child(ren) in care. _____ _____		
6. Is the child(ren) related to provider/staff? If yes, what is the relationship? _____	<input type="checkbox"/>	<input type="checkbox"/>
7. What is the regular school schedule (hours) for the child(ren)? _____		
8. Was your child(ren) in attendance during the month(s) of _____?	<input type="checkbox"/>	<input type="checkbox"/>
9. Were there any days your child(ren) was not in care due to illness, vacation, appointments, etc., during the month of _____? If yes, describe. _____	<input type="checkbox"/>	<input type="checkbox"/>
10. Is your child(ren) in care on weekends? OR: Was your child in care during weekends for the month of _____?	<input type="checkbox"/>	<input type="checkbox"/>
11. Is your child(ren) in care on holidays? OR: Was your child in care during the holidays?	<input type="checkbox"/>	<input type="checkbox"/>
12. What hour(s) is your child(ren) usually in care? _____		
13. What meal(s) are usually serve to your child(ren)? _____ _____		
14. Do you provide either food or money for any meals while your child(ren) is in child care?	<input type="checkbox"/>	<input type="checkbox"/>
15. In general, do you feel your child(ren) benefits from the CACFP?	<input type="checkbox"/>	<input type="checkbox"/>

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Thank you for your cooperation. If you have any questions, please feel free to call \_\_\_\_\_ at \_\_\_\_\_.

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

After completion, please return to: (agency name and address)