State of New Jersey
Department of Agriculture
Division of Food and Nutrition
PO BOX 334
TRENTON, NEW JERSEY 08625-0334

Please Type or Print

CHILD AND ADULT CARE FOOD PROGRAM – FACILITY APPLICATION

(COMPLETE ONE FORM PER PROGRAM)

1. FACILITY INFORMATION

Agreement # ____ - ____ - ____

Facility Name_____

Street Address_____

City, State_____ **Zip Code**_____ **Area Code** _____ - _____- _____

Name of Person at Facility Responsible for CACFP_____

2. TYPE OF TAX EXEMPTION:

_____ Facility shares Sponsor's Tax-exempt status. **(Attach a letter from Sponsoring Organization.)**

_____ Facility has individual tax exemption. **(Attach a copy of IRS Letter of Determination.)**

_____ Public (Specify Government Agency)_____ **(Attach a letter from Gov't. Agency.)**

_____ Proprietary Title XIX / XX Center. **(Provide certification to demonstrate that at least 25% of enrolled participants were either Title XIX beneficiaries or Title XX beneficiaries during the most recent calendar month.)**

3. DAY CARE APPROVAL LETTERS AND CERTIFICATES: (Attach a copy of your License Approval Letter to this form)

Check the type of program and list the certification expiration date, age group, capacity and hours of care for the facility.

(✓)	*(Complete Only One Line Per Form)* TYPE OF PROGRAM	*CERTIFICATE	LICENSE CAPACITY	EXP. DATE	LICENSE AGE RANGE		HOURS OF CARE	
					From	To	From	To
	Infant 0-2(1/2)	NJCC Center License						
	Preschool 2(1/2)-5	NJCC Center License						
	Outside School 6-12	NJCC Center License						
	Military 0-12	Commander Approval Letter						
	Adult Day Care 60-Up	License/Gov't Approval Letter						
	At "Risk" School Age - 18	Health & Sanitation & Fire/Bldg. Cert.						
	Emergency Shelter 0-12	Health & Sanitation & Fire/Bldg. Cert.						

ADULT DAY CARE CENTERS ONLY *Must complete this section (a. – e.)*

Attach copy of current **license or letter of approval. Document must be current and include approved level of service (client capacity).**

a. Name of the federal, state, or local government agency that has licensed or approved the program to provide day care services to functionally impaired adults. _____

b. Does this program have an individual plan of care for all functionally impaired participants? ☐ YES ☐ NO

c. Does this center provide a structured, comprehensive health program, social & related support services? ☐ YES ☐ NO

d. Does this program receive Title III funds for any meals served? ☐ YES ☐ NO

e. List the effective date of the health and sanitation certificate for this site? _____/_____/_____ **(Attach a copy)**

4. FACILITY ENROLLMENT/ELIGIBILITY DATA:

a. Does this facility have complete CACFP eligibility applications on file for all participants?

☐ YES ☐NO

b.

#Enrolled	#Free	#Reduced	#Paid

5. TYPE OF FOOD SERVICE:

a. Self Preparation
☐ On-Site
☐ Satellite from Central Kitchen*
Central Kitchen Address:
_____
**Attach a copy of the central kitchen sanitation report.*

b. Vended*
☐ Bid - $10,000 & over *(proprietary agency)*
☐ Bid - $100,000 & over *(not-for-profit agency)**
☐ Small Purchases (under $10,000 or $100,000*)
☐ School Food Service Contract
(Attach a copy of the contract to this form)

6. MEAL PATTERNS:

a. Check each meal type which is served on a regular basis for which you are claiming reimbursement in the CACFP.

☐ **BREAKFAST** ☐ **A.M. SUPPLEMENT** ☐ **LUNCH** ☐ **P.M. SUPPLEMENT** ☐ **DINNER**

***Meal Service Time*:** _____:_____ _____:_____ _____:_____ _____:_____ _____:_____

b. REGULAR MEAL SERVICE DAYS: ☐ MON ☐ TUES ☐ WED ☐ THURS ☐ FRI ☐ SAT ☐ SUN

c. SPECIAL MEALS*: Is a different meal pattern served during holidays, summer or school closings?* ☐ ***YES*** ☐ ***NO***

If Yes, Check: ☐ ***BREAKFAST*** ☐ ***A.M. SUPPLEMENT*** ☐ ***LUNCH*** ☐ ***P.M. SUPPLEMENT*** ☐ ***DINNER***

Meal Service Time: _____:_____ _____:_____ _____:_____ _____:_____ _____:_____

7. DATES OF OPERATION:

First date of meal service: ___/____/___. Will this facility close during the year? ☐ **YES** ☐ **NO**

If yes, list the dates when this facility will be closed for 2 or more weeks: ____/_____/____ - ____/_____/____

I understand that this information is being given in connection with the receipt of Federal funds; that Department officials, may for cause, verify information; that the information provided on this form is true to the best of my knowledge and that deliberate misrepresentation may subject me to prosecution or civil action under applicable State and Federal criminal or civil statues.

_____ _____ _____/_____/_____

Signature of Authorized Sponsor Institution Representative **Title** **Date**