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

**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:**

   (a) Facility shares Sponsor’s Tax-exempt status. (Attach a letter from Sponsoring Organization.)
   
   (b) Facility has individual tax exemption. (Attach a copy of IRS Letter of Determination.)
   
   (c) Public (Specify Government Agency) ____________ (Attach a letter from Gov’t. Agency.)
   
   (d) 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:

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

   **TABLE 1: FACILITY INFORMATION**

<table>
<thead>
<tr>
<th>TYPE OF PROGRAM</th>
<th>CERTIFICATE</th>
<th>LICENSE CAPACITY</th>
<th>EXP. DATE</th>
<th>LICENSE AGE RANGE</th>
<th>HOURS OF CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant 0-2(1/2)</td>
<td>NJCC Center License</td>
<td>5</td>
<td></td>
<td>From</td>
<td>To</td>
</tr>
<tr>
<td>Preschool 2(1/2)-5</td>
<td>NJCC Center License</td>
<td>5</td>
<td></td>
<td>From</td>
<td>To</td>
</tr>
<tr>
<td>Outside School 6-12</td>
<td>NJCC Center License</td>
<td>5</td>
<td></td>
<td>From</td>
<td>To</td>
</tr>
<tr>
<td>Military 0-12</td>
<td>Commander Approval Letter</td>
<td>5</td>
<td></td>
<td>From</td>
<td>To</td>
</tr>
<tr>
<td>Adult Day Care 60-Up</td>
<td>License/Gov’t Approval Letter</td>
<td>5</td>
<td></td>
<td>From</td>
<td>To</td>
</tr>
<tr>
<td>At &quot;Risk&quot; School Age 6 - 18</td>
<td>Health &amp; Sanitation &amp; Fire/Bldg. Cert.</td>
<td>5</td>
<td></td>
<td>From</td>
<td>To</td>
</tr>
<tr>
<td>Emergency Shelter 0-12</td>
<td>Health &amp; Sanitation &amp; Fire/Bldg. Cert.</td>
<td>5</td>
<td></td>
<td>From</td>
<td>To</td>
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</table>

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   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
   
   b. Vended*  
   
   *Attach a copy of the central kitchen sanitation report.

6. **MEAL PATTERNS:**

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

<table>
<thead>
<tr>
<th>BREAKFAST</th>
<th>A.M. SUPPLEMENT</th>
<th>LUNCH</th>
<th>P.M. SUPPLEMENT</th>
<th>DINNER</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

   b. REGULAR MEAL SERVICE DAYS:

<table>
<thead>
<tr>
<th>MON</th>
<th>TUES</th>
<th>WED</th>
<th>THURS</th>
<th>FRI</th>
<th>SAT</th>
<th>SUN</th>
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   c. SPECIAL MEALS: Is a different meal pattern served during holidays, summer or school closings? __ YES __ NO

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   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