Maintain Form On File For Required Monthly Reimbursement Claim Reconciliation and Review By CACFP State Agency Staff

CHILD AND ADULT CARE FOOD PROGRAM ELIGIBILITY RECORD

SPONSOR NAME: _____ **AGREEMENT #** ____ - ____ - ____

***Annual* Enrollment Date For Participation In Food Program \ **Age of Child at Date of Enrollment (Child Care Sponsors only)**

	Name of Enrolled Participant	Date of Eligibility Application	Date of * CACFP Enrollment	Date of CACFP Withdrawal	ELIGIBILITY DETERMINATION			HOURS OF CARE	DAYS OF CARE (Check (✓) All That Apply)						
	*(Last Name, First Name)-AGE***	*(Mo/Date/Yr)*	*(Month/Yr)*	*(Month/Yr)*	**F** F=Free	**R** R=Reduced	**P** P=Paid	*Time: (From - To)*	M Monday	T Tuesday	W Wednesday	TR Thursday	F Friday	S Saturday	SU Sunday
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Effective Date: _____ **Total Enrollment =** _____ **Free** _____ **+ Reduced** _____ **+ Paid** _____

(USE PENCIL: REVISE TOTALS MONTHLY)

NEW JERSEY DEPARTMENT OF AGRICULTURE / Division of Food and Nutrition / Child and Adult Care Food Program

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