Tier Code: _____
Registration #: _____
Registration Expiration: _____

State of New Jersey

DEPARTMENT OF AGRICULTURE
Division of Food & Nutrition
PO Box 334
Trenton NJ 08625-0334

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

DOUGLAS H. FISHER
Secretary

CHILD AND ADULT CARE FOOD PROGRAM - FAMILY DAY CARE PROVIDER APPLICATION

1. **SPONSORING ORGANIZATION:** _____ **Agreement #:** _____ -_____-_____

SPONSOR ADDRESS:_____ **County:** _____

Name of Provider: _____ **Date of Birth:** ___/___/___ **Registration #:** _____

Address:_____ **Zip Code:** _____

City, State: _____ **Telephone Number:** _____

2. **FDCFP ENROLLMENT -** *Count each child in one category only. Meals for provider's children may be claimed if household income meets free or reduced standards. A foster child is a family of one. Meals may be claimed for a foster child if non-residential children are present.*

PROVIDER'S CHILDREN	FOSTER CHILDREN	NON-RESIDENTIAL CHILDREN	DISABLED MIGRANT	TOTAL ENROLLED	WHAT TIME ARE CHILDREN IN CARE? *(Other than Provider's own children and Foster children)* *From:* _____ *To:* _____

Days of week child care provided: *(Other than Provider's own children)* *(Circle Days of Operation during the week)* MON TUE WED THUR FRI SAT SUN

No. Operating weeks

AGE RANGE: *Youngest:* _____ *Oldest:* _____

3. **MEAL SERVICE**: *A maximum of (3) meals per day per child shall be claimed. Of those (3) meals, (1) must be a supplement, (i.e. Snack).*

Reimbursement will be received only for meals served to children 12 years old and younger. If provider has older migrant or Disabled persons enrolled for care in the home, the sponsoring organization will need to determine their eligibility.

Check each meal type, for which you are claiming reimbursement in the CACFP. Each meal type must be three hours apart from the start of one meal to the beginning of the other meal.

☑ CHECK MEAL TYPES SERVED	MEAL SERVICE TIME 1st Shift	2nd Shift
☐ *BREAKFAST*	*am*	*am*
☐ *A.M. SUPPLEMENT*	*am*	*am*
☐ *LUNCH*	*am/pm*	*am/pm*
☐ *P.M. SUPPLEMENT*	*pm*	*pm*
☐ *DINNER*	*pm*	*pm*
☐ *EVENING SUPPLEMENT*	*pm*	*pm*

THIS SECTION MUST BE COMPLETED BY TIER II HOMES ONLY

TIER II HOMES** have three options for receiving reimbursement* ☑ ***Check One:

☐ ***OPTION 1*** *– Elect to receive Tier II low reimbursement for meals served to all children enrolled in my day care home.*

☐ ***OPTION 2*** *– Elect to have the sponsoring organization collect income eligibility information for the children enrolled in my home and make determinations regarding their eligibility via the use of an income eligibility application distributed to the parents/guardians. I will receive the higher Tier rate of reimbursements for meals served to children eligible for free or reduced price meals. Sponsors are prohibited by law from disclosing eligibility determinations of any child enrolled in my home.*

☐ ***OPTION 3*** *– Elect to have the sponsoring organization, collect eligibility information regarding only certain children enrolled for care who may be categorically eligible for Tier I reimbursement rates base upon their participation in a Federal or State funded program. I will receive the higher Tier rate of reimbursements for meals served to children eligible for free or reduced price meals. Sponsors are prohibited by law from disclosing eligibility determinations of any child enrolled in my home.*

*****Note: Tier II Providers cannot receive reimbursement for meals served to their own children (POC).***

I CERTIFY *that my day care program is only operating under the auspices of the above sponsoring organization. The FDCFP program requirements and program options included, on this form have been reviewed with me and the above information is true to the best of my knowledge.*

Signature of Provider _____ **Date** _____ / _____ /_____

● FOR SPONSORING ORGANIZATION USE ONLY ●

1. This provider is approved to claim reimbursement for meal service from the Family Day Care Food Program. ***(Attach Certificate)***

☑ **CHECK TYPE OF APPROVAL:** ☐ New Jersey Registration # _____ ☐ *Military* _____

☐ This Provider is approved to claim meals served to her own child(ren) and a current eligibility application is on file.
☐ This Provider is participating in the Family Day Care Food Program for the first time. ***(Attach Sample Menu)***
☐ This Provider has participated in FDCFP in the past. _____*(Agency /Month/Year)* _____*(Provider Number)*

2. This provider is eligible for one of the following:

☐ **TIER I Sub codes**: *(Check one)* ☐ **A** (School Data) ***Name and Number of Qualifying School***: _____ _____ ***(Attach School Data sheet and Attendance Zone Verification letter (if applicable))***

☐ **B** (Census) ***(Attach Map)*** ☐ **C** (Provider's Income) ***(Attach proof of Income)***

☐ **TIER II** -
Provider Selected *(Circle one)* **Option: 1 2 3**
☐ (Tier II Low Rates)
☐ (Tier II High Rates) ☐ (Tier II Mixed Rates)

I HEREBY CERTIFY that to the best of my knowledge, this home is not participating in the Family Day Care Food Program under any other sponsoring organization. I further CERTIFY that all of the above information is true and correct. I understand that this information is being given in connection with the receipt of federal funds; that Department officials may, for cause, verify information; and that deliberate misrepresentation may subject me to prosecution or civil action under applicable state and criminal statutes. In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

_____ _____ / _____ / _____

(Signature of Sponsoring Organization Representative) *(Date)*

Distribution: ***White – CACFP*** ***Yellow– Sponsoring Organization*** ***Pink – Provider***