Date:

CACFP OUTREACH
Potential Institution Information

AGENCY INFORMATION

CACFP Specialist:		NSLP Specialist *(If Applicable)*:			
NAME OF INSTITUTION:				Agree # *(If Other CNP)*:	
Address:					
Address 2:					
City:		**State (NJ):**		**Postal Code:**	
Phone #:		**County:**			
Fax #:		**Contact Name:**			
Email:		**Contact Title:**			
Multi-state agency? List the Other States in which the agency Operates: *(N/A If it does not Apply)*					

TAX STATUS / INSTITUTION CHARACTERISTICS/ OPERATION:

Tax Exemption: ☐ PUBLIC ☐ PNP ☐ Proprietary

☐ Head Start ☐ Church ☐ Military ☐ **NSLP** ☐ Title XX *(SSBG, Abbott)* ☐ Title XIX

OPERATION: ☐ Independent ☐ Sponsoring Organization

Multi-purposed agency? List all programs owned and/or operated by the agency: *(N/A If it does not Apply)*	

Select a Program: ☐ **Traditional CC** ☐ **At Risk** ☐ **Emergency Shelter** ☐ **ADC** ☐ **FDC** ☐ **NSLP**

DAY CARE INFORMATION

Years Day Care in Operation:	
Is/Are any Residential Program(s)?	
Is/are the Facility(ies) managed by a management company? *(N/A If it does not Apply)* ***(If yes, explain)***	

ENROLLMENT NUMBERS:

	Under 2 ½		2½ -5		6 –12		School Age–18	**Total Enrollment:**	

What is the primary purpose of the program for the age groups?	**Ages 0- 6:**					
	Ages 6-12:					
List the Hours of Care:						
Number of facility(ies):		**Licensed:**	☐ **No**	☐ **Yes**		
Age:		**Max Cap.:**		**Exp. Date:**		
Average Income:		**Low:**		**Average:**		**High:**

NSLP TRACKING INFORMATION

Date of email to LEA:

Date due for receipt of "Acknowledgment":

Date copy of form given to SNP Specialist:

Date of approval letter from SNP:

Family Day Care Section will need to be included

ADULT DAY CARE INFORMATION								
AFP ENROLLMENT NUMBERS:								
	Under 60		**60 or Older**		**Total**			
Are any of the participants Title III Recipients?					☐No ☐Yes			
Does your Facility have a Structured Comprehensive Program?					☐No ☐Yes			
Explain:								
Is an Individual Plan of Care on file for each participant?					☐No ☐Yes			
Number of Facilities:		**Licensing/Approval Agency:**						
License/Contract Approval Dates:			**Capacity:**					
Average Income:		**Low:**		**Average:**		**High:**		

TYPE OF FOOD SERVICE OPERATION PROPOSED:	
☐ Self-Prep	☐ Commercial Vended ☐ FSMC
Name of Company _____ (Attach "CACFP At-Risk Afterschool Meals Program At-risk Afterschool Meals Program Acknowledgment of Participation and Procurement")	
If vended, describe food service anticipated:	**Note: Do not show this question for FDC**
What Meal Types does the agency anticipate serving?	***(Circle one)*** B AM L PM D
First time in food program?	☐No ☐Yes ***(If no, explain)***_____
List participation history in other Child Nutrition Programs as a Institution or Facility: *(N/A If it does not Apply)*	**NSLP** *(circle all that apply)*: NSLP-SBP-ASSP-SMP (National School Lunch Program-School Breakfast Program – After School Snack Program- Special Milk Program) **CACFP:** **SFSP:**
How did you learn about our program?	
List Next Training Session Available:	

ADDITIONAL COMMENTS:

Date of G-4

Date Input