

CHILD AND ADULT CARE FOOD PROGRAM

FAMILY DAY CARE

CHECKLIST FOR REPORTING INSTITUTION AND FACILITY CHANGES

Sponsoring Organization: _____ Agreement #: "____" - _____ - _____

Sponsor Address: _____ County: _____

City, State: _____ Telephone #: _____ Fax #: _____

USE THIS FORM TO REPORT CHANGES DURING THE AGREEMENT YEAR. Correctly completed applications, attachments, and changes must be submitted to the state agency by the 15th of each month to be approved for meal service effective the first day of the CURRENT month of the change. Changes must be entered in the CARES online system in order to be approved.

As a sponsoring organization, it is your responsibility to ensure that this office receives program records and revisions within the specified timeframes. Records, which do not meet program requirements, correct and return immediately. Errors and incomplete information will cause a delay in your approval. Therefore, you must ensure that your schedule allows ample time for these corrections. Each month application material remains outstanding will result in loss of reimbursement. In addition, to ensure program compliance a review of these records will take place during administrative reviews and audits.

Dear Nutrition Program Specialist:

In accordance with the Child and Adult Care Food Program (CACFP) Family Day Care Agreement, which requires each sponsor to report administrative and operational changes for the food program within ten days, I would like to report the following:

Fill in the "Effective Date"

- | | | |
|--------------------------|---|---|
| <input type="checkbox"/> | 1. Agency's name changed. <i>(Attach new IRS Letter of Determination, NJ Start Registration Confirmation, and Federal ID Letter),</i> | <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |
| <input type="checkbox"/> | 2. Address changed. <i>(Attach Federal ID Letter and W-9)</i> | <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |
| <input type="checkbox"/> | 3. Telephone/fax number changed. | <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |
| <input type="checkbox"/> | 4. FDCFP Person responsible changed. | <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |
| <input type="checkbox"/> | 5. Budget Revisions. <i>(Attach Budget Revision Form)</i> | |
| <input type="checkbox"/> | 6. Federal Financial Accountability Transparency Act (FFATA) information changed | |
| <input type="checkbox"/> | 7. Tier changes <i>(List Provider with new Tier Determination)</i> | |
| <input type="checkbox"/> | 8. Homes deleted. <i>(List Provider and Reason(s) for Termination)</i> | |
| <input type="checkbox"/> | 9. Homes added. See list below. <i>(Attach Provider Application Documents)</i> | |
| <input type="checkbox"/> | 10. Registration certificates updated. <i>(Attach Registration Certificate(s))</i> | |
| <input type="checkbox"/> | 11. Provider(s) Reinstated. <i>(Attach Provider Application Documents)</i> | |
| <input type="checkbox"/> | 12. Provider's name changed. <i>(Attach Registration Certificate(s))</i> | |
| <input type="checkbox"/> | 13. Provider's address changed. <i>(Attach Registration Certificate(s) and Pre-approval Form)</i> | |
| <input type="checkbox"/> | 14. Provider's meal service times changed. | |

NEW PROVIDERS ONLY						
#	New	Provider's Name	Tier Code	Registration Exp. Date	Address	Phone #
1.						
2.						

(USE THE BACK PAGE FOR ADDITIONAL NEW PROVIDERS AND/OR UPDATES.)

☐ (Please Check)

☐ I have completed, saved, and submitted the necessary changes in the CARES online system to complete the revision process.

(Name and Title of Sponsor/Representative)

(Signature of Sponsor/Representative)

List any additional changes for Family Day Care Food Program homes below:

ADDITIONAL PROVIDERS AND UPDATES													
#	New	Reinstated	Provider's Name	Provider #	Tier Code Change	Registration Exp. Date	New Address	New Phone #	Meal Service Times and Enrollment Revisions				
(no more than 5 non-resident children are allowed during a meal service).													
3.									Shifts	Breakfast	AM Snack	Lunch	PM Snack
									1 st Shifts				
									2 nd Shifts				
4.									Shifts	Breakfast	AM Snack	Lunch	PM Snack
									1 st Shifts				
									2 nd Shifts				
5.									Shifts	Breakfast	AM Snack	Lunch	PM Snack
									1 st Shifts				
									2 nd Shifts				
6.									Shifts	Breakfast	AM Snack	Lunch	PM Snack
									1 st Shifts				
									2 nd Shifts				
7.									Shifts	Breakfast	AM Snack	Lunch	PM Snack
									1 st Shifts				
									2 nd Shifts				
8.									Shifts	Breakfast	AM Snack	Lunch	PM Snack
									1 st Shifts				
									2 nd Shifts				
9.									Shifts	Breakfast	AM Snack	Lunch	PM Snack
									1 st Shifts				
									2 nd Shifts				
10.									Shifts	Breakfast	AM Snack	Lunch	PM Snack
									1 st Shifts				
									2 nd Shifts				
11.									Shifts	Breakfast	AM Snack	Lunch	PM Snack
									1 st Shifts				
									2 nd Shifts				
12.									Shifts	Breakfast	AM Snack	Lunch	PM Snack
									1 st Shifts				
									2 nd Shifts				

(SEE REVERSE SIDE FOR PROGRAM REQUIREMENTS)
CACFP Telephone # 984-1250. Fax (609) 984-0878

- ☐ (Please Check)
- ☐ I have completed, saved, and submitted the necessary changes in the CARES online system to complete the revision process.