

FACILITY INFORMATION
FAMILY/GROUP DAY CARE HOME

Facility Information

Name _____

(First)

(Middle Int.)

(Last)

Physical Address _____

Date Of Birth :(mm/dd/year) _____ E-Mail Address (optional) _____

Phone Number: (Home)_(_____) (Cell)_(_____)

Hours of Operation: From _____ To _____ COUNTY: _____

School System Coverage Area: _____

School Coverage: (Elem.-High) _____

Type of Facility: _____ Family Day Care _____ Group Day Care

PROVIDERS CHILDREN PARTICIPATING IN CACFP: _____ under 5 as of (9/1) _____ over 5 (but not yet 13)

Enter Number of children in each category

_____ disabled 13 and older

OTHER CHILDREN PARTICIPAING IN CACFP: Regular Enrolled _____ Migrant (15 and under) _____

DISABLED PERSONS (19 and older) PARTICIPATING IN CACFP: _____

OPERATING MONTHS: Jan., Feb., Mar., Apr., May, June, July, Aug., Sept., Oct. Nov., Dec. (Circle operating months)

Approved for weekends: ___yes ___no Approved for Holidays: ___yes ___no If yes (list) _____

APPROVED MEALS/TIMES: BK _____, AM Snack _____, Lunch _____

PM Snack _____, Supper _____, Late Snack _____

SHIFTS Approval: (list meals): _____

LICENSE INFORMATION: (Capacity) Day Time _____ Age Range: _____ Night Time _____ Age Range: _____

Hours Of Operation: Day _____ Night _____ License Type _____ License # _____

Issue Date: _____ Expiration Date: _____

TIERING STATUS: Tier I _____ School Data _____ Income _____ Census _____ Tier 2 _____ Higher _____ Lower _____ Mixed _____

(Tiering Status to be determined by Sponsor)

PROVIDER SIGNATURE: _____ Date _____

SPONSOR SIGNATURE: _____ Date _____