North Carolina Department of Health and Human Services  
Division of Public Health  
Women’s & Children’s Health Section  
Nutrition Services Branch  
Special Nutrition Programs  
CHILD AND ADULT CARE FOOD PROGRAM  
APPLICATION PROCESS CHECKLIST  
Independent Centers

1. Institution Name: ____________________________  2. Agreement Number: ______________

Please Check (✓) each item after completion in the **first column**. Failure to accurately complete all required documents, and submit the required number of documents requested, including this checklist, may delay program approval.

<table>
<thead>
<tr>
<th>Form (Form)</th>
<th>Institution (use only)</th>
<th>SNP Regional Consultant (use only)</th>
<th>Special Nutrition Programs (use only)</th>
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</thead>
<tbody>
<tr>
<td>CACFP Checklist</td>
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<tr>
<td>Program Agreement (DHHS CAC 2)</td>
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<tr>
<td>Attachment A- General Terms and Conditions</td>
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<td>Attachment B- Certifications</td>
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<td>Attachment C- Notice of Certain Reporting and</td>
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<td>Audit Requirements, if applicable</td>
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<td>Attachment D– State Grant Certification</td>
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<tr>
<td>No Overdue Tax Debts (if applicable)</td>
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<td>Attachment E- Conflict of Interest Policy</td>
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<td>Contractors Certification</td>
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<td>Institution Application</td>
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<td>Center Application (CAC 7)</td>
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<td>Management Plan (DHHS CAC 8G)</td>
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<td>Annual Budget for Independent Centers (DHHS CAC 9)</td>
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<td>Media Release</td>
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<td>Preaward Compliance</td>
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<td>Statement of Authority (DHHS CAC 18)</td>
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<tr>
<td>Certification Regarding Other Publicly Funded Programs</td>
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<td>Certification Regarding Criminal Convictions</td>
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<td>Information on Owners and Principals</td>
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<tr>
<td>Certification of Single Exclusive CACFP Agreement</td>
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<td>Truth of Applications and Names and Addresses</td>
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<td>CACFP Fact Sheet</td>
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<td>Nondiscrimination Policy</td>
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<td>Outside Employment Policy</td>
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<td>Free /Reduced Price Policy</td>
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<tr>
<td>Participant Information for New Institutions</td>
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</tbody>
</table>

**Provide copies of the following:**

- Current federal, state or local license
- Current Sanitation Inspection Report
- IRS Letter of Tax Exempt Status (private nonprofit)

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**At Risk Centers ONLY (Additional Forms)**

- Institution Certification Regarding Dual Participation
- Participant Information New Centers Summary
  - At risk Centers

DHHS CAC Checklist 01/14-New
CHILD AND ADULT CARE FOOD PROGRAM
APPLICATION PROCESS CHECKLIST
Independent Centers

1. Institution Name: ________________________________________ 2. Agreement Number: ____________

Please Check (✓) each item after completion in the first column. Failure to accurately complete all required documents, and submit the required number of documents requested, including this checklist, may delay program approval.

The following forms will need to be included ONLY if you will be receiving catered meals.

<table>
<thead>
<tr>
<th>Institution (use only)</th>
<th>SNP Regional Consultant (use only)</th>
<th>Special Nutrition Programs (use only)</th>
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<tbody>
<tr>
<td>Food Service Contract (DHHS CAC 16) (Public schools only)</td>
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<tr>
<td>Attachment A-General Terms and Conditions</td>
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<tr>
<td>Attachment B- Certifications</td>
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</tr>
<tr>
<td>Food Service Contract (DHHS CAC 17) (Food Service Management Company)</td>
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<td></td>
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<tr>
<td>Attachment A-General Terms and Condition</td>
<td></td>
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<tr>
<td>Attachment B- Certifications</td>
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<tr>
<td>Total Food Dollars $____________</td>
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</tbody>
</table>

You are not authorized to claim meal reimbursement until you receive the final approval letter from N.C. Department of Health and Human Services.

For State Agency Use Only: Initial Date Received ______ Initial Date Returned if incomplete ______
Complete for new institution only Initial Date Returned if incomplete ______ 2nd Date received from institution ______
Date of Pre-op visit ______ 2nd Date returned if incomplete ______
Date of sanitation report ______ 3rd Date received from institution ______
Date of licensing report ______ 3rd Date returned if incomplete ______

4th Date received from institution ______
Date mailed to 2nd party reviewer ______
Date 2nd party reviewer submitted ______

To be completed by SNP Consultant: For approval ______
Reviewed NDL: ______
Reviewed Tax Revocation List: ______
Consultant Initials: ____________

DHHS CAC Checklist 01/14-New
Instructions for Completing the Checklist for Independent Institutions

1. **Institution Name:** Provide the name of the institution.

2. **Agreement Number:** Leave blank.

3. **Institution (use only):** This is the only column that should be completed by the institution’s representative. Put a ✓ by each document being submitted with the application.

4. **SNP Regional Consultant:** For State Use only, do not complete this section.

5. **Special Nutrition Programs:** For State Use only, do not complete this section.

6. **Total Food Service Amount:** If you have a food service agreement, provide the total dollar amount from the food service agreement.

7. **For State Agency Use Only:** For State Use only, do not complete this section.

8. **Reviewed NDL:** For State Use only, do not complete this section.