Child and Adult Care Food Program (CACFP))

INSTITUTION CERTIFICATION REGARDING DUAL PARTICIPATION IN SFSP AND CACFP

**INSTITUTION INFORMATION**

<table>
<thead>
<tr>
<th>Institution Name</th>
<th>____________________________</th>
<th>Legal Name of Institution/principal (if different than above)</th>
<th># of facilities</th>
<th>____________________________</th>
</tr>
</thead>
</table>

Institution’s mailing address:

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip code</th>
</tr>
</thead>
</table>

Is Institution’s physical address same as Institution’s mailing address?  

[ ] YES  [ ] NO

If answering “no” to above question, please list Institution’s mailing address below.

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip code</th>
</tr>
</thead>
</table>

1. Have you ever participated in the Summer Food Service Program (SFSP)?
   - [ ] YES If yes, continue to question 2 and complete the Certification Statement and Signature
   - [ ] NO If no, skip to “Certification Statement and Signature” below.

2. While participating in any federal child nutrition program, has the Institution, the Institution’s corporate organization, officers, or employees, or any of the sites overseen by the institution been: (check all that apply)
   - [ ] Declared seriously deficient
   - [ ] Been disqualified
   - [ ] Listed on the National Disqualified CACFP list (NDL)

If any of the boxes above are selected, please provide the name of the federal child nutrition program and the year in which the infraction occurred: ____________________________

**Certification Statement and Signature**

I certify that the information contained in this application is true and correct to the best of my knowledge. I understand that this information is being given for the receipt of federal financial assistance, and that a deliberate misrepresentation may subject me to prosecution under applicable state and federal criminal statues and to applicable civil penalties.

Signature of Authorized Institution Representative ____________________________ Date ____________________________

Name of Authorized Institution Representative (printed) ____________________________ Title ____________________________