North Carolina Department of Health and Human Services
Division of Public Health/Nutrition Services Branch
Special Nutrition Programs

Child and Adult Care Food Program (CACFP)

Institution Application
(YOU ARE ENCOURAGED TO ENTER THIS FORM ELECTRONICALLY)

Institution Information			
Institution Name	**Agreement Number**	**Federal ID (FEIN)**	**Program Year**
			2016-2017

Mailing Address		Street Address	
Address:		**Address**	
City:		**City:**	
State:	**Zip Code: (Plus 4 Digit)** -	**State:**	**Zip Code: (Plus 4 Digit)** -
County:		**County:**	

Institution's Operating Hours: _____ am/pm to _____ am/pm

Application Information		
Application Type: (check <u>all</u> that apply)	○ **Child Care Center**	○ **Adult Care Center** ○**Day Care Home**
Educational Institution:	○ **yes** ○ **no**	
Organization Type:	○ **Local Government** ○ **For-profit Organization** ○ **State Government** ○ **Private Nonprofit (Secular)** ○ **Other** ○ **Federal Government** ○ **Private Nonprofit (Faith-Based)**	
Institution Type: (check <u>all</u> that apply)	○ **Sponsoring Org. unaffiliated centers** ○ **Sponsoring Org. affiliated centers** ○ **Sponsoring Org. day care homes and unaffiliated centers** ○ **Sponsoring Org. day care homes and affiliated centers** ○ **Sponsoring Org. day care homes only**	○ **Independent Center**

ENROLLED PARTICIPANTS - CENTERS					
Centers (Complete for the month prior to date application signed)	**(a) Free**	**(b) Reduced- Price**	**(c) Paid or Denied**	**(d) No Application**	**(e) Total Number of participants (a+b+c+d)**

ENROLLED PARTICIPANTS – DAY CARE HOMES				
Homes (Complete for the month prior to date application signed)	**(a) Enrolled Non-Residential Children**		**b) Enrolled Eligible Provider's Own Children**	**c) Total Children Enrolled (a+b)**
	Tier I	**Tier II**		

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Institutions with day care home providers: Please attach a list of your day care home providers who qualify as Tier I based on SNAP participation. Include: provider's last name and first name; provider's date of birth; provider's complete address including street name, city, state, and zip code; provider's SNAP number; food stamp case number; and date of tiering. (If none qualified, write a statement to that fact).

Institutions with more than one facility only: Attach verification that all facilities and key staff have been trained prior to program operation. Sign and date each attachment.

Contacts

Administrator

Name:	First	Middle	Last

Phone:	( ) -	Ext:	Title:	
Fax:	( ) -		E-mail:	

CACFP Program Contact

Name:	First	Middle	Last

Phone:	( ) -	Ext:	Title:	
Fax:	( ) -		E -mail:	

CERTIFICATION AND SIGNATURE

I certify that the information in this Institution Application is true and correct to the best of my knowledge and that my designee or I will immediately report to the NC Department of Health and Human Services any changes that occur to information submitted. I know that deliberate misrepresentation or withholding of information may result in prosecution under applicable state and federal statutes, and that the CACFP will be available to all eligible participants regardless of race, color, national origin, sex, disability or age.

I further certify that none of responsible principals, individuals, providers or facilities are on the National Disqualified List.

I certify that this information is true and correct and that none of the principals or providers of this institution are disqualified from participating in the CACFP.

Signature on Behalf of Institution

Sign Here▶_____   _____

Signature of Authorized Representative   Date of Preparation

_____   _____

Printed Name of Authorized Representative   Contact Phone Number (optional)