

**North Carolina Department of Health and Human Services  
Division of Public Health  
CHILD AND ADULT CARE FOOD PROGRAM**

**CERTIFICATION OF ELIGIBILITY FOR TITLE XIX, OR XX INSTITUTIONS OR FREE AND REDUCED PRICED PARTICIPANTS**

**NAME OF INSTITUTION:** \_\_\_\_\_  
**CLAIM MONTH & YEAR** \_\_\_\_\_ (Enter each facility on a separate line.)

**AGREEMENT #:** \_\_\_\_\_

#	Name of Facility	Facility's License Capacity	# of Participants Enrolled During the Claim Month	# of Participants Receiving Title XX Funds (SSBG) During the Claim Month *	# of Participants Receiving Title XIX Funds During the Claim Month	# of Participants Eligible for F/R Priced Meals During the Claim Month **	State Use Only % of Title XIX/XX or F/RP Participants During the Month

**\*Only enrolled participants listed on turnaround printout, with a payment from Fund Source Code 25 are to be included in this number.**  
**\*\*Only enrolled participants eligible for free or reduced priced meals are to be included in this number.**

I certify that to the best of my knowledge and belief that the information on this form is true and correct in all respects, that records are available to support the above information and that it is in accordance with the terms of existing agreements. I further understand that this information is being given in connection with the receipt of Federal funds and that deliberate misrepresentation may subject me to prosecution under applicable State and Federal statutes.

\_\_\_\_\_  
ORIGINAL Signature of Institution's Authorized Representative                      Title                      / /  
Date