

**North Carolina  
Department of Health and Human Services  
Women's and Children's Health  
Child and Adult Care Food Program**

**ADVANCE PAYMENT REQUEST**

Institution Name: \_\_\_\_\_ Agreement #: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State and Zip: \_\_\_\_\_

Advance payments are administered based on considerations of prior reimbursement claims and/or other information as deemed appropriate with substantiating documentation. By accepting this advance, the Institution agrees that the advance will be recouped through claim deductions, in full, the month following the month of issuance of the advance. Advance payments will not be made after April 2009. If the Institution's agreement is terminated and the advance has not been recouped in full, on the date of Agreement termination, the Institution agrees that the outstanding advance balance is immediately due and payable to the State agency.

This advance payment agreement will be effective with respect to meals served during the period commencing the 1<sup>st</sup> day of \_\_\_\_\_, 20\_\_\_\_, and ending the 30<sup>th</sup> day of September, 2009.

**Signature on Behalf of Institution**

The undersigned represents the Institution and has the authority to request an advance for and on behalf of said agency. The undersigned further represents that s/he has read, understands, and agrees to the terms of this request.

By: \_\_\_\_\_  
(Must be signed by the same person who signs the agreement)

\_\_\_\_\_  
Title

Date: \_\_\_\_\_

**State Agency Representative**

By: \_\_\_\_\_  
Signature of SNP Unit Manager

Date: \_\_\_\_\_

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**For State Agency Use Only**

**Approved for Payment**

Initials: \_\_\_\_\_ Date: \_\_\_\_\_