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
For Profit Institutions Only

NAME OF INSTITUTION:_____ **AGREEMENT #:**_____
CLAIM MONTH & YEAR _____ **(Enter each facility on a separate line)**

#	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 in included in this number.**
****Only enrolled participants eligible for free or reduced priced meals are to be in included in this number.**

The representations made herein on behalf of the Institution are true and correct to the best of my knowledge. I understand that these representations are being made in connection with the receipt of federal funds and that deliberate misrepresentation may subject me to prosecution under applicable state and federal criminal statutes.

_____ _____ ____/____/____
ORIGINAL Signature of Institution's Authorized Representative Title Date