

North Carolina Department of Health and Human Services

Division of Public Health

Women's & Children's Health Section

Nutrition Services Branch

Special Nutrition Programs

CHILD AND ADULT CARE FOOD PROGRAM

ANNUAL APPLICATION

**ADVANCE PAYMENT REQUEST
(Optional)**

1. Institution Name: _____ 2. Agreement _____
3. Mailing Address: _____
4. Street Address: _____
5. 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 in full through claim deductions beginning with the month for which the advance was received. Advance payments will not be made after April 2014. If the Institution's Agreement is terminated and the advance has not been recouped in full as of the date of termination, the Institution agrees that the outstanding advance balance is immediately due and payable to the State Agency.

6. This advance payment agreement will be effective with respect to meals served during the period commencing the 1st day of _____, 20____, and ending the 30th day of September 2014.

Signature on Behalf of Institution

State Agency Representative

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

10. By: _____
Signature of SNP Unit Manager

7. By: _____
(Must be signed by the same person who signs the Agreement)

11. Date: _____

8. Title: _____

9. Date: _____

For State Agency Use Only

Approved for Payment

Instructions for Completing the Advance Payment Request

Completing this form is optional. This document is not required to be submitted.

- 1. Institution Name:** Provide the name of the institution.
- 2. Agreement Number:** Provide the 4 digit agreement number for the institution.
- 3. Mailing Address:** Provide the mailing address for the institution.
- 4. Street Address:** Provide the street or physical address for the institution.
- 5. City, State and Zip:** Provide the city, state and zip code for the institution.
- 6.** Provide the month and year in which the advance is being requested.
 - Advances will be recouped, in full, through claim deduction beginning with the month for which the advance is received. For example, if you were issued an advance in October, the advance will be recouped in full when you file your October claim for reimbursement.
 - Institutions cannot request an advance for a month that has already passed. For example: If you are completing the application in the month of November, you cannot request an advance for the month of October.
- 7. Signature on Behalf of Institution:** This document must be signed by the same person that signed the permanent CACFP agreement in 2012.
 - If that person is no longer employed, by the institution, then provide the signature of the person with the same title. For example, if John Doe was employed as the Board Chair and is no longer with the institution the current Board Chair must sign the form.
- 8. Title:** Provide the title of the person who signed the form.
- 9. Date:** Provide the date in which the form was signed.
- 10. State Agency Representative:** For State Agency Use only, do not complete this section.
- 11. Date:** For State Agency Use only, do not complete this section.