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
1.	2.	3.	2013-2014

Mailing Address				Street Address			
4. Address:				9. Address			
5. City:				10. City:			
6. State:		7. Zip Code: (Plus 4 Digit)	-	11. State:		12. Zip Code: (Plus 4 Digit)	-
8. County:				13. County:			

Institution's Operating Hours: 14. _____ am/pm to 15. _____ am/pm

Application Information

16. Application Type: (check all that apply)	○ Child Care Center	○ Adult Care Center	○ Day Care Home
17. Educational Institution:	○ yes ○ no		
18. Organization Type:	○ Local Government ○ State Government ○ Federal Government	○ For-profit Organization ○ Private Nonprofit (Secular) ○ Private Nonprofit (Faith-Based)	○ Other
19. Institution Type: (check all 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

20. 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)
	21.	22.	23.	24.	25.

ENROLLED PARTICIPANTS – DAY CARE HOMES

26. 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		
	27.	28.	29.	30.

Institution Name	Agreement Number	Federal ID (FEIN)	Program Year
31.	32.	33.	2013-2014

34. 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)

35. 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

36. Name:	First	Middle	Last		
37. Phone:	( ) -	**Ext:**		**38. Title:**	
39. Fax:	( ) -			**40. E-mail:**	

CACFP Program Contact

41. Name:	First	Middle	Last		
42. Phone:	( ) -	**Ext:**		**43. Title:**	
44. Fax:	( ) -			**45. 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▶ 46._____ **47.** _____

Signature of Authorized Representative — Date of Preparation

48._____ **49.**_____

Printed Name of Authorized Representative — Contact Phone Number (optional)

Instructions for Completing the Institution Application

This document can be completed in NC CARES. If completing the document in NC CARES, ensure that you are in the correct program year before completing the application. You should enter the information in Program Year 2014. If you are completing the paper version of this form, ensure you have the most current version of this form. The bottom left hand side should read Institution Application, Effective October 1, 2013.

1. Institution Name: Provide the name of the institution.
2. Agreement Number: Provide the 4 digit agreement number for the institution.
3. Federal ID (FEIN): Provide the complete Federal ID Number.
   Program Year: Should read 2013-2014.
4. Address: Provide the mailing address where the institution receives mail.
5. City: Provide the city where the institution receives mail.
6. State: Provide the state where the institution receives mail.
7. Zip Code: **Provide the zip code plus the 4 digit postal code** where the institution receives mail. Please include the full zip code, including the last four digits.
   The postal code can be found at https://www.usps.com/zip4
8. County: Provide the county where the institution receives mail.
9. Address: Provide the physical address of where the institution is located. If the physical address and the mailing address are the same, it is appropriate to write "same" in the box.
10. City: Provide the city where the institution is located.
11. State: Provide the state where the institution is located.
12. Zip Code: **Provide the zip code plus the 4 digit postal code** where the institution is located. Please include the full zip code, including the last four digits.
    The postal code can be found at https://www.usps.com/zip4
13. County: Provide the county where the institution is located.
14. Institution's Operating Hours: Provide the time the institution opens.
15. Institution's Operating Hours: Provide the time the institution closes.
16. Application type: Check the appropriate application type for the institution.
17. Educational Institution: Check the appropriate response for the institution.
18. Organization Type: Check the appropriate response for the institution.
19. Institution Type: Check the appropriate response(s) for the institution. Check all that applies.
20. Centers (If the institution has centers, complete this section for all participants enrolled in each center).
21. Free: Provide the enrolled participants that are classified as free by their income eligibility applications **for the month prior to submitting the update application.**
22. Reduced-Price: Provide the enrolled participants that are classified as reduced by their income eligibility applications **for the month prior to submitting the update application.**
23. Paid or Denied: Provide the enrolled participants that are classified as paid or denied by heir income eligibility **applications for the month prior to submitting the update application.**
24. No Application: Provide the enrolled participants that do not have an income eligibility application **for the month prior to submitting the update application.**
25. Total Number of participants: Provide the total number of participants by adding a + b + c + d.
26. Homes (If the institution has day care homes, complete this section for all participants enrolled in each day care home).

Instructions for Completing the Institution Application (cont.)

27. Tier I: Provide the total number of enrolled non-residential children in tier I status. This number should contain all tier I and tier II high children from mixed tier homes and tier I children from tier I mixed homes.
28. Tier II: Provide the total number of enrolled non-residential children in the tier II low homes and tier II low children from mixed tier homes.
29. Enrolled Eligible Provider's Own Children: Provide the total number of provider's own children. These children should not have been included in the tier I or tier II boxes.
30. Total Children Enrolled: Provide the total number of enrolled children by adding a + b.
31. Institution Name: Provide the name of the institution.
32. Agreement Number: Provide the 4 digit agreement number for the institution.
33. Federal ID (FEIN): Provide the complete Federal ID number.
34. Institutions with day care home providers: In the space provided or on an attachment, provide a list of providers who qualify as Tier I based on SNAP participation. Include the provider's last name and fist name; provider's date of birth; provider's complete address including street name, city, state, and zip code; provider's social security number, SNAP case number, and the date of tiering.

    If there are no providers that qualify for tier I based on SNAP participation, the institution should enter a complete sentence to state that fact. A sentence such as "No providers qualify for tier I based on SNAP participation" is an acceptable sentence.
35. Institution with more than one facility only: In the space provided or on an attachment, provide a statement or documentation that the institution has trained all facilities and key staff prior to program operation. The documentation must be signed and dated.
36. Name: Provide the Administrator's first, middle and last name.
37. Phone: Provide the Administrator's telephone number including area code. Provide an extension if applicable.
38. Title: Provide the title of the Administrator.
39. Fax: Provide the Administrator's fax number including the area code.
40. E-mail: Provide the Administrator's e-mail address. Ensure this section is completed accurately, and all letters/numbers are legible.

    CACFP Program Contact: (NOTE: This should be a person from the institution that has knowledge of the CACFP. If the State Agency contacts your institution in reference to the CACFP, the person listed should be familiar with the CACFP).
41. Name: Provide the CACFP Contact's first, middle and last name for your institution
42. Phone: Provide the CACFP Contact's telephone number including area code. Provide an extension if applicable.
43. Title: Provide the title of the CACFP Contact.
44. Fax: Provide the CACFP Contact's fax number including the area code.
45. E-mail: Provide the CACFP Contact's e-mail address. Ensure this section is completed accurately, and all letters/numbers are legible.
46. Signature of Authorized Representative: Provide the signature of the institution's authorized representative. NOTE: The person that signs this form must be listed on the CAC 18- Statement of Authority.
47. Date of Preparation: Provide the date the form was signed.
48. Printed Name of Authorized Representative: Provide the printed name of the institution's authorized representative. The printed name must be the same person that signed the document.
49. Contract Phone Number (Optional): Provide the Authorized Representative contact telephone number including the area code.