

1. Institution Name: _____ 2. Agreement Number: _____

**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**

**Certification of Single Exclusive CACFP Agreement-Facility
(Unaffiliated Facilities)**

On behalf of **3.** _____, I **4.** _____,
(Name of Facility) (Name of Individual)
certify that this facility is not participating or applying to participate under the auspices of more than one CACFP agreement and that, therefore, our Agreement with the Sponsoring Organization is exclusive.

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.

5. _____
(Signature of Authorized Representative)

8. _____
(Date)

6. _____
(Printed Name)

7. _____
(Title)

**Instructions on Completing the
Certification of Single Exclusive CACFP Agreement-Facility**

1. Provide the name of the institution.
2. Provide the 4 digit agreement number for the institution.
3. Provide the name of the facility or the name of the day care home provider.
4. Provide the name of the responsible individual.
5. Provide the signature of the authorized representative. The signature must be the same as the person listed in number 4.
6. Print the name of the person that signed the form.
7. Provide the title of the person who signed the form.
8. Provide the date in which the form was signed.