

Institution Application

(YOU ARE ENCOURAGED TO ENTER THIS FORM ELECTRONICALLY)

Institution Information										
Institution Name				Agreement Number		Federal ID (FEIN)		Program Year		
								2015-2016		
Mailing Address					Street Address					
Address:					Address					
City:					City:					
State:		Zip Code: (Plus 4 Digit)		-	State:		Zip Code: (Plus 4 Digit)		-	
County:					County:					
Institution's Operating Hours: _____ am/pm to _____ am/pm										
Application Information										
Application Type: (check <u>all</u> that apply)		<input type="radio"/> Child Care Center			<input type="radio"/> Adult Care Center			<input type="radio"/> Day Care Home		
Educational Institution:		<input type="radio"/> yes <input type="radio"/> no								
Organization Type:		<input type="radio"/> Local Government <input type="radio"/> State Government <input type="radio"/> Federal Government		<input type="radio"/> For-profit Organization <input type="radio"/> Private Nonprofit (Secular) <input type="radio"/> Private Nonprofit (Faith-Based)		<input type="radio"/> Other				
Institution Type: (check <u>all</u> that apply)		<input type="radio"/> Sponsoring Org. unaffiliated centers <input type="radio"/> Sponsoring Org. affiliated centers <input type="radio"/> Sponsoring Org. day care homes and unaffiliated centers <input type="radio"/> Sponsoring Org. day care homes and affiliated centers <input type="radio"/> Sponsoring Org. day care homes only				<input type="radio"/> Independent Center				
ENROLLED PARTICIPANTS - CENTERS										
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)		
ENROLLED PARTICIPANTS – DAY CARE HOMES										
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							

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<p>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)</p>			
<p>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.</p>			

Contacts					
Administrator					
Name:	First	Middle	Last		
Phone:	()	-	Ext:	Title:	
Fax:	()	-		E-mail:	
CACFP Program Contact					
Name:	First	Middle	Last		
Phone:	()	-	Ext:	Title:	
Fax:	()	-		E-mail:	

CERTIFICATION AND SIGNATURE	
<p>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.</p>	
<p>I further certify that none of responsible principals, individuals, providers or facilities are on the National Disqualified List.</p>	
<p>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.</p>	
<p>Signature on Behalf of Institution</p>	
<p>Sign Here ▶ _____</p> <p>Signature of Authorized Representative</p>	<p>_____</p> <p>Date of Preparation</p>
<p>_____</p> <p>Printed Name of Authorized Representative</p>	<p>_____</p> <p>Contact Phone Number (optional)</p>