

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)

Center Application

(YOU ARE ENCOURAGED TO ENTER THIS FORM ELECTRONICALLY)

Agreement Number	Institution Name	Center Name	Center's Federal ID Number	Program Year
				2016-2017
Site Mailing Address		Site Street Address		
Address:		Address:		
City:		City:		
State:	Zip Code: (Plus 4 Digit)	-	State:	Zip Code: (Plus 4 Digit)
County:			County:	
Site Contact				
Name:	First	Middle	Last	
Phone:	() -	Ext:	Title:	
Fax:	() -		E-mail:	
Program Type (select <u>one</u> only "⊙")				
<input type="radio"/> Adult Care Center	<input type="radio"/> At Risk - ASCS	<input type="radio"/> Head Start	<input type="radio"/> At Risk – ASCS	
<input type="radio"/> Child Care Center	<input type="radio"/> OSHC	<input type="radio"/> Emergency Shelter	(check if program type ASCS)	
Center Type (select <u>one</u> only "⊙")				
<input type="radio"/> State Government	<input type="radio"/> Federal Government	<input type="radio"/> Private Nonprofit		
<input type="radio"/> Local Government	<input type="radio"/> Private For Profit			
Type of Food Service (select <u>one</u> only "⊙")		Vendor/School Name		
<input type="radio"/> On-Site Preparation	<input type="radio"/> Central Kitchen			
<input type="radio"/> School Food Authority	<input type="radio"/> FSMC			
At Risk - ASCS				
School Name:		% Enrolled for free and reduced meals		
Activities: (check <u>all</u> that apply)	<input type="radio"/> Educational	<input type="radio"/> Enrichment		
Organization Type (select <u>one</u> only "⊙")				
<input type="radio"/> Profit	<input type="radio"/> Non-Profit			
Number of Title XX (or Title XIX):				
Licensing		Operating Months (check all that apply)		
Licensed by: (select <u>one</u> only)	<input type="radio"/> DHHS	<input type="radio"/> State	<input type="radio"/> Exempt	<input type="radio"/> Oct
License Capacity:		<input type="radio"/> Nov	<input type="radio"/> Dec	<input type="radio"/> Jan
Enrollment:		<input type="radio"/> Feb	<input type="radio"/> Mar	<input type="radio"/> Apr
		<input type="radio"/> May	<input type="radio"/> Jun	<input type="radio"/> Jul
		<input type="radio"/> Aug	<input type="radio"/> Sep	

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Hours of Operation and Meals Served (check all that apply)

This Center will open at:			And will close at:						
Meal	Begin	End	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Breakfast			<input type="checkbox"/>						
AM Snack			<input type="checkbox"/>						
Lunch			<input type="checkbox"/>						
PM Snack			<input type="checkbox"/>						
Supper			<input type="checkbox"/>						
Night Snack			<input type="checkbox"/>						
At-Risk Breakfast			<input type="checkbox"/>						
At-Risk AM Snack			<input type="checkbox"/>						
At-Risk Lunch			<input type="checkbox"/>						
At-Risk PM Snack			<input type="checkbox"/>						
At-Risk Supper			<input type="checkbox"/>						
At-Risk Night Snack			<input type="checkbox"/>						

Emergency/Homeless Shelter Meals

Meal	Begin	End	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Breakfast			<input type="checkbox"/>						
AM Snack			<input type="checkbox"/>						
Lunch			<input type="checkbox"/>						
PM Snack			<input type="checkbox"/>						
Supper			<input type="checkbox"/>						
Night Snack			<input type="checkbox"/>						

I certify that the information in this Center Application is true and correct, that it is in accordance with the terms of existing Agreement(s). I further understand that this information is being given in connection with the receipt of Federal funds and that deliberate misrepresentation may subject me to prosecution under applicable State and Federal statutes.

Sign Here ► _____

Signature of Authorized Representative

Date of Preparation

Printed Name of Authorized Representative

Contact Phone Number (optional)