

Institution Application

(YOU ARE ENCOURAGED TO ENTER THIS FORM ELECTRONICALLY)

Institution Information										
Institution Name				Agreement Number		Federal ID (FEIN)		Program Year		
								2009-2010		
Mailing Address				Street Address						
Address:				Address:						
Address 2:				Address 2:						
City:				City:						
State:		Zip Code:		State:		Zip Code:				
County:				County:						
Institution's Operating Hours: _____ am/pm to _____ am/pm										
Application Information										
Application Type: (check all 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"/> For-profit Organization <input type="radio"/> State Government <input type="radio"/> Private Nonprofit (Secular) <input type="radio"/> Other <input type="radio"/> Federal Government <input type="radio"/> Private Nonprofit (Faith-Based)								
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					
Holiday and Vacation Schedule										
Institution's Holiday and Vacation Schedule. (Please check all holidays and vacation days that apply and record the date(s)/year the institution will be closed) October 1-September 30										
		Date(s)/Year				Date(s)				
{ }	Columbus Day	_____	{ }	President's Day	_____	{ }	Vacation	_____		
{ }	Veteran's Day	_____	{ }	Good Friday	_____	{ }	Other	_____		
{ }	Thanksgiving	_____	{ }	Easter Monday	_____	{ }	Other	_____		
{ }	Christmas	_____	{ }	Memorial Day	_____	{ }		_____		
{ }	New Year's Day	_____	{ }	July 4 th	_____	{ }		_____		
{ }	Martin Luther King	_____	{ }	Labor Day	_____	{ }		_____		
ENROLLED PARTICIPANTS										
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)		
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							

Please list the person(s) and his/her title that is responsible for ensuring that none of the responsible principals, providers, and facilities are on the National Disqualified List.

Please describe the procedures you use to ensure that none of the responsible principals, providers and facilities are on the National Disqualified List.

Institutions with day care home providers: Please attach a list of your day care home providers who qualify as Tier I based on Food Stamp 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 social security number; food stamp case number; and date of tiering. (If none qualified, write a statement to that fact)

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

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

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 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 ▶

Keep Copy for your records.

Signature of Authorized Representative

Date of Preparation

Printed Name of Authorized Representative

Contact Phone Number (optional)