

**North Carolina Department of Health and Human Services  
Women's and Children's Health  
Child and Adult Care Food Program  
TRUTH OF APPLICATIONS AND NAMES AND ADDRESSES  
7 C.F.R. § 226.6 (b)(1)(xv) and (b)(2)(v)**

**Institution Name:** \_\_\_\_\_

**Agreement #:** \_\_\_\_\_

**All information submitted to the State agency with this application is true and correct to the best of my knowledge. 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.**

\_\_\_\_\_/\_\_\_\_\_  
(Signature of Board Chair or Owner) (Date)

\_\_\_\_\_/\_\_\_\_\_  
\*(Signature of Executive Director) (Date)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Title)

\_\_\_\_\_/\_\_\_\_\_  
(Printed Name) (Date of Birth)

\_\_\_\_\_/\_\_\_\_\_  
(Printed Name) (Date of Birth)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City, State, and Zip Code)

\_\_\_\_\_  
(City, State, and Zip Code)

**\* If the institution does not have an Executive Director, please include the requested information for the Director or equivalent position.**