

**North Carolina Department of Health and Human Services
 Division of Public Health
 Women's & Children's Health Section
 Nutrition Services Branch
 Special Nutrition Programs**

**CERTIFICATION OF ELIGIBILITY
 FOR-PROFIT INSTITUTIONS**

NAME OF INSTITUTION: _____

AGREEMENT #: _____

CLAIM MONTH & YEAR _____ **(Enter each facility on a separate line)**

#	Name of Facility	Facility's License Capacity	# of Participants Enrolled During the Claim Month	# of Participants Receiving Title XX Funds (SSBG) During the Claim Month *	# of Participants Receiving Title XIX Funds During the Claim Month	# of Participants Eligible for F/R Priced Meals During the Claim Month **	State Use Only % of Title XIX/XX or F/RP Participants During the Month

***Only enrolled participants listed on turnaround printout, with a payment from Fund Source Code 25 are to be included in this number.**

****Only enrolled participants eligible for free or reduced priced meals are to be included in this number. Please submit the income eligibility applications and enrollment forms for each participant.**

The representations made herein on behalf of the Institution are 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.

 ORIGINAL Signature of Institution's Authorized Representative

 Title

____/____/____
 Date