NEW YORK STATE DEPARTMENT OF HEALTH
Child and Adult Care Food Program

Certificate of Authority
for Sponsors of Day Care Centers

CACFP Agreement #_____

Please complete this form to identify staff to represent your organization to CACFP.

SECTION 1 (to be signed by the Chair of the Board of Directors or the owner)

On behalf of_____
NAME OF ORGANIZATION

I hereby authorize the employee(s) below to represent this organization to the New York State Department of Health, Division of Nutrition, Child and Adult Care Food Program, and to submit claims for reimbursement and other documents to CACFP.

Original Signature _____

Print Name_____

Print Title_____ Date _____

SECTION 2

Sponsor Administrator *(CACFP will send all mail to this person)*

SALUTATION FIRST NAME LAST NAME

TITLE

FACILITY PHONE EXT FAX

SIGNATURE EMAIL

Payment Contact *(if different than Sponsor Administrator)*

SALUTATION FIRST NAME LAST NAME

TITLE

FACILITY PHONE EXT FAX

SIGNATURE EMAIL

Authorized Individual 1

SALUTATION FIRST NAME LAST NAME

TITLE

FACILITY PHONE EXT FAX

SIGNATURE EMAIL

Authorized Individual 2

SALUTATION FIRST NAME LAST NAME

TITLE

FACILITY PHONE EXT FAX

SIGNATURE EMAIL

This institution is an equal opportunity provider.