Certificate of Authority for Day Care Home Sponsors

CACFP Agreement #: _____

Instructions

This form identifies staff who will represent your organization to Child and Adult Care Food Program (CACFP). Please mail this with original wet ink signatures (for all individuals listed) to:

NYS DOH DON CACFP
150 Broadway, Suite 600
Albany, NY 12204

SECTION 1: This section must be signed by your organization's Chair of the Board of Directors.

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: Individuals to represent your organization to CACFP.

Sponsor Administrator

The primary contact for CACFP who will receive all official communication including mail, emails and calls. It is recommended this person have knowledge of all CACFP activities within the Sponsorship and be available to answer calls from CACFP.

Salutation: _____ First Name: _____ Last Name: _____

Title: _____ Cell Phone Number: _____

Facility Phone Number: _____ EXT: _____ Fax: _____

E-mail: _____

Signature: _____

Program Contact

Individual responsible for daily CACFP operations for your organization.

Salutation: _____ First Name: _____ Last Name: _____

Title: _____ Cell Phone Number: _____

Facility Phone Number: _____ EXT: _____ Fax: _____

E-mail: _____

Signature: _____

This institution is an equal opportunity provider.

CACFP Agreement #: _____

Payment Contact

This person will be contacted when there is an issue with claims or payment (if different than Sponsor Administrator).

Salutation: _____ First Name: _____ Last Name: _____

Title: _____ Cell Phone Number: _____

Facility Phone Number: _____ EXT: _____ Fax: _____

E-mail: _____

Signature: _____

Authorized Individual 1

Additional staff with knowledge of CACFP who can be of assistance when the Sponsor Administrator is not available.

Salutation: _____ First Name: _____ Last Name: _____

Title: _____ Cell Phone Number: _____

Facility Phone Number: _____ EXT: _____ Fax: _____

E-mail: _____

Signature: _____

Authorized Individual 2

Salutation: _____ First Name: _____ Last Name: _____

Title: _____ Cell Phone Number: _____

Facility Phone Number: _____ EXT: _____ Fax: _____

E-mail: _____

Signature: _____

Authorized Individual 3

Salutation: _____ First Name: _____ Last Name: _____

Title: _____ Cell Phone Number: _____

Facility Phone Number: _____ EXT: _____ Fax: _____

E-mail: _____

Signature: _____