

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)

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

SALUTATION FIRST NAME LAST NAME

TITLE

FACILITY PHONE EXT FAX

SIGNATURE EMAIL

Program Contact

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

USDA is an equal opportunity provider and employer.

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

Authorized Individual 3

SALUTATION	FIRST NAME	LAST NAME
TITLE		
FACILITY PHONE	EXT	FAX
SIGNATURE		EMAIL