



**APPLICATION RENEWAL PACKAGE**  
for Sponsors of Day Care Centers

**CERTIFICATE OF AUTHORITY**

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**

Salutation \_\_\_\_\_ First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Title \_\_\_\_\_

Facility Phone \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone \_\_\_\_\_

Signature \_\_\_\_\_ Email \_\_\_\_\_

**Payment Contact** (if different than Sponsor Administrator)

Salutation \_\_\_\_\_ First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Title \_\_\_\_\_

Facility Phone \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone \_\_\_\_\_

Signature \_\_\_\_\_ Email \_\_\_\_\_

**Authorized Individual 1**

Salutation \_\_\_\_\_ First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Title \_\_\_\_\_

Facility Phone \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone \_\_\_\_\_

Signature \_\_\_\_\_ Email \_\_\_\_\_

**Authorized Individual 2**

Salutation \_\_\_\_\_ First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Title \_\_\_\_\_

Facility Phone \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone \_\_\_\_\_

Signature \_\_\_\_\_ Email \_\_\_\_\_

**BOARD OF DIRECTORS**

<b>Board Chair or Owner</b>		Length of time on board _____		
Salutation	First Name	Last Name		
Date of Birth	Email Address			
Phone	Ext	Fax		
Occupation	Current Employer			
Employer Address 1	Address 2	City	State	Zip
Home Address 1	Address 2	City	State	Zip
Is this member related to another board member or staff of this organization? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If <b>Yes</b> , please specify name and position held: _____				
<b>Executive Director</b>				
Salutation	First Name	Last Name		
Date of Birth	Email Address			
Phone	Ext	Fax		
Occupation	Current Employer			
Employer Address 1	Address 2	City	State	Zip
Home Address 1	Address 2	City	State	Zip
Is this member related to another board member or staff of this organization? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If <b>Yes</b> , please specify name and position held: _____				
<b>Board Member</b>	Title	Length of time on board _____		
Salutation	First Name	Last Name		
Date of Birth	Email Address			
Phone	Ext	Fax		
Occupation	Current Employer			
Employer Address 1	Address 2	City	State	Zip
Home Address 1	Address 2	City	State	Zip
Is this member related to another board member or staff of this organization? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If <b>Yes</b> , please specify name and position held: _____				

Does your organization operate in states other than New York?

 No

 Yes

Which states? \_\_\_\_\_

### **CERTIFICATION STATEMENT**

The Sponsor agrees to:

- Allow access to all persons without regard to color, race, sex, age, disability or national origin.
- Offer the same meals to all participants enrolled in day care, at no separate charge and without physical segregation or other discriminatory action because of color, race, sex, age, disability or national origin.
- Provide an Income Eligibility Form and Letter to Households in accordance with Federal Regulations.
- Offer access to disabled participants as needed.
- Assist participants who speak a language other than English.
- Meet special dietary requirements for disabled participants as outlined by physician's order.
- Display the *And Justice for All* poster at all centers under their administration.
- Maintain CACFP records at the organization or center location for four years.
- Maintain CACFP financial records separate from other funding.

I CERTIFY THAT:

- The names, current mailing addresses and dates of birth of the owner, Chair of the Board of Directors and executive director have been submitted to the State.
- The Sponsor and its principals have not been determined ineligible to participate in any publicly-funded program for violating the program's requirements, in the past seven years.
- None of the Sponsor's principals has been convicted of any activity that indicated a lack of business integrity, in the past seven years.
- None of the following are currently on the CACFP National Disqualified List:
  - our organization
  - our organization's principals
  - our centers
  - our centers' principals
- The Sponsor is currently compliant with the required performance standards of financial viability and management, administrative capability and program accountability as described in 7 CFR226(b)(2)(vii).
- The Sponsor will provide CACFP with immediate notification of any change in the program or application, including but not limited to: change in owner, FEIN, administrator, license, approval status or any lawsuit alleging civil rights violations filed against our organization or any of its facilities.
- All of the information contained in this application package and certification is true and correct.

*Please Sign in Ink*

Signature of Authorized Representative\* \_\_\_\_\_

*Please Type or Print*

Name of Authorized Representative \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_

\*The Authorized Representative must be listed on the Certificate of Authority.

**BUDGET PLAN**

Completed by: \_\_\_\_\_

This form must be completed by an individual who has been authorized on the Certificate of Authority.

	Complete this Column	FOR STATE USE ONLY
		Approved
<b>A. ANTICIPATED ANNUAL CACFP REIMBURSEMENT</b>	\$ _____	\$ _____
<b>B. OPERATING EXPENSES</b>		
1. Total Food Expenses	\$ _____	\$ _____
2. Non-food Supplies		
Paper goods	\$ _____	
Food service related equipment under \$5,000	\$ _____	
Maintenance supplies	\$ _____	
Uniform allowance	\$ _____	\$ _____
3. Food Service Personnel (Complete page 5)		
Salaries	\$ _____	
F I C A	\$ _____	\$ _____
4. Capital Outlay [Food service related equipment over \$5,000]		
List items to be purchased _____	\$ _____	\$ _____
<b>Total Operating Expenses</b>	\$ _____	\$ _____
<b>C. THE DIFFERENCE (A-B=C) (If zero or less, stop here)</b>	\$ _____	\$ _____
<b>D. ADMINISTRATIVE EXPENSES</b>		
1. Administrative Personnel ( Complete page 5)		
Salaries	\$ _____	
F I C A	\$ _____	
Fringe	\$ _____	\$ _____
2. Administrative Costs		
Office supplies, postage, printing	\$ _____	
Nutrition education and training supplies	\$ _____	
Fringe for food service personnel	\$ _____	
Mileage or public transportation costs	\$ _____	
Contract services (bookkeeping/payroll)	\$ _____	
Audit Fees	\$ _____	
Other: _____	\$ _____	\$ _____
<b>E. TOTAL ADMINISTRATIVE EXPENSES</b>		
[May not exceed 15% of A.]	\$ _____	\$ _____

Complete the following chart only if your organization is charging any labor costs to CACFP. List all staff whose salary will be supported in total or in part by the CACFP reimbursement. This may include food service staff (cooks, cook's aides) as well as administrative staff (director, secretary, bookkeeper), not contracted staff.

TITLE OF POSITION	NUMBER OF POSITIONS	HOURS PER DAY WORKED ON CACFP	HOURLY WAGE	NUMBER OF DAYS PER YEAR	TOTAL YEARLY SALARY (all sources)	AMOUNT OF SALARY PAID BY CACFP
<b>FOOD SERVICE PERSONNEL</b>						
						\$
						\$
						\$
						\$
						\$
						\$
					<b>TOTAL</b>	\$
<b>ADMINISTRATIVE PERSONNEL</b>						
						\$
						\$
						\$
						\$
						\$
						\$
					<b>TOTAL</b>	\$