

**SPECIAL NUTRITION PROGRAMS
CERTIFICATE OF AUTHORITY**

Agreement #: _____

This is to certify that _____
(PRINT NAME OF AUTHORIZED PERSON)

(SIGNATURE OF AUTHORIZED PERSON)

(TITLE)

IS DESIGNATED AS THE AUTHORIZED REPRESENTATIVE OF THE

(NAME OF INSTITUTION)

(TELEPHONE NUMBER)

(STREET ADDRESS)

(CITY, STATE, ZIP)

Authority is hereby given to the above designated representative to enter into an agreement whether by handwritten or electronic signature, on behalf of the above-named institution for the operation of the Child and Adult Care Food Program, National School Lunch Program, and/or Summer Food Service Program, on all remaining forms for this application and any other documents or Division reports relating thereto, including claims for reimbursement.

Non-Profit Institution

BY: _____
(SIGNATURE: EXECUTIVE DIRECTOR, PRESIDENT OF BOARD OF DIRECTORS OR SCHOOL SUPERINTENDENT) (DATE)

For-Profit Institution (CACFP Only)

BY: _____
(SIGNATURE: OWNER(S)) (DATE)

By my signature above, I understand that Special Nutrition Programs **must** be advised immediately of any change in authorized personnel and my designation of the above-named representative does not relieve me of any liability for the mistakes, fraud or any other illegal activity performed by the designated representative in the name of or on behalf of the above-named institution.

On-line Password Request(s)

(If interested in Direct Deposit, please call the SNP Office at 501.682.8869 or 1.800.482.5850 ext. 28869)

Name: _____ Last 4 of SSN: _____
Last First M.I.

Answer one (only one) of the following security questions:

What is your mother's maiden name? _____

What was your first pet's name? _____

What city were you born in? _____

What is your favorite color? _____

Start Date

End Date