



CHILD & ADULT CARE FOOD PROGRAM (CACFP)
Notice to Change Sponsoring Organization

Effective on _____, I intend to change from _____
DATE NAME OF CURRENT SPONSORING ORGANIZATION
to _____ to participate in the CACFP.
NAME OF NEW SPONSORING ORGANIZATION

Provider Name _____ PV Number _____

Facility Address _____
Street City State Zip

Mailing Address, if different _____

Please read and initial each paragraph.

_____ I understand that I am choosing a new Sponsoring Organization (Sponsor) among all other Sponsors available to me to participate in the CACFP, whose names and contact information is at <http://dphhs.mt.gov/hcsd/ChildCare/CACFP.aspx>, under "Contact Us", or <http://dphhs.mt.gov/Portals/85/hcsd/documents/ChildCare/cacfp/SOContactList2016.pdf>. I can also call the State agency at (406) 444-4347 or write to them at CACFP-DPHHS, PO Box 202925, Helena, MT 59620 for information about all of the Sponsors available to me.

_____ I understand that I can participate in the CACFP under only one Sponsor during a calendar month.

_____ I understand that my participation in the CACFP with the new Sponsor can begin effective from the date of my preapproval visit by the new Sponsor.

_____ I understand that I can change Sponsors only one time per year. One time per year means once during any 12-month period.

_____ I understand that I cannot change Sponsors while I am in corrective action in the CACFP. I understand that any corrective action I am in must be closed before I can change Sponsors.

_____ I certify that all of the above information is true and correct. I understand that I am giving this information in connection with the receipt of federal funds and deliberate misrepresentation may subject me to prosecution under applicable state and federal criminal statutes.

Provider signature _____ Date _____

Original- Current Sponsor

Copy – Provider

Copy- New Sponsor

Copy - State agency CACFP (provided to the State agency by the New Sponsor)