North Carolina Department of Health and Human Services
Division of Child and Family Well-Being, Community Nutrition Services Section
Child and Adult Care Food Program

Adult Enrollment Form

INSTITUTION NAME: Granville Health FACILITY NAME: HSADC AGREEMENT#: 6586

This facility is involved in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). CACFP needs proof of enrollment for all participants. Please complete the following information. Be sure to sign and date in the space provided. Thank you.

This information can be provided by the participant or an adult household member.

Participant's Name:	**Participant's Age:**	
Is the adult participant 60 years of age or older?	☐ Yes	☐ No
Is the adult participant a "*functionally impaired adult*"?	☐ Yes	☐ No

7 CFR §226.2 defines "functionally impaired adult" as "chronically impaired disable persons 18 years of age or older, including victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction, who are physically or mentally impaired to the extent that their capacity for independence and their ability to carry out activities of daily living is markedly limited. Activities of daily living include, but are not limited to, adaptive activities such as cleaning, shopping, cooking, taking public transportation, maintaining a residence, caring appropriately for one's grooming or hygiene, using telephones and directories, or using a post office. Marked limitations refer to the severity of impairment, and not the number of limited activities and occur when the degree of limitations is such as to seriously interfere with the ability to function independently."

	Resides in own home:	
Does the adult participant reside in his/her own home?	☐ Yes	☐ No
	Group living arrangement:	
If the adult participant does not reside in his/her own home, does the adult participant reside in a *"group living arrangement"*?	☐ Yes	☐ No

7 CFR §226.2 defines "group living arrangement" as "residential communities which may or may not be subsidized by federal, State or local funds but which are private residences housing an individual or a group of individuals who are primarily responsible for their own care and who maintain a presence in the community but who may receive on-site monitoring."

If the adult participant does not reside in his/her own home or in a *"group living arrangement"* please describe the type of residence:

_____

Participant/Adult Household Member Signature: _____ **Date**: _____

Printed Name of Person Signing Above: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Telephone Number: ( ) _____ Work Telephone Number: ( ) _____

For Institution Use Only:

Signature of Institution's Representative: _____ Date: _____

Date the participant enrolled: _____ Date the participant withdrew: _____

This institution is an equal opportunity provider.