North Carolina Department of Health and Human Services
Nutrition Services Branch-Summer Food Service Program

Sponsor Name: _____ **SFSP Agreement Number: _____**
Address: _____ **City: _____** **Zip: _____**

Email Completed Form to: NCSFSP@dhhs.nc.gov

ADA Amendments

Date Effective_____

SITE Name	Site Address	Meal	Current ADA	New ADA		SITE Name	Site Address	Meal	Current ADA	New ADA

***** Provide last weekly meal consolidation form for each site with an upward ADA amendment.**

Check One: (Experienced school sponsors are exempt)

YES **NO**
☐ ☐ HAS THE REVISED BUDGET HAS BEEN SUBMITTED IN NC CARES

☐ **I certify that with any adjustment(s) to the Average Daily Attendance (ADA), adequate staff have been trained to perform all responsibilities and duties of the Summer Food Service Program. I understand that meal reimbursement is unauthorized until approval has been granted by the State Agency.**

_____ **_____**
Signature of Sponsor **Date**

_____ **_____**
State Agency Approval **Date**

For State Agency use only:

☐☐ **Changes approved, proceed with changes and enter into NC Cares**
☐☐**Changes denied, please provide more information**
☐ _____