Child Management Associates
Confirmation of Absence from Household

Provider name:_______

Provider address: _____

I _____ confirm on this day _____
(provider name) **(date)**

that the following person(s) does not reside in my household, and is not present in my household during the hours I provide daycare services. My daycare services are provided in accordance with the hours of care listed on my FDCH.

Name of person NOT in household	Age	Current Address

I understand that if the above listed person(s) is found to be residing in my home or is present in my home during daycare hours, I may face the following consequences, up to an including termination from the CACFP program:

1. **Invalid License:** The provider's license will be considered invalid according to Utah State Office of Education Child Nutrition Program requirements for Relative Care Certification.
2. **Overclaim:** Providers who fail to abide by CACFP rules and regulations are subject to pay back any and all funds paid to the provider at such time they failed to meet the required standards.
3. **Serious Deficiency:** A provider determined to be Seriously Deficient will be placed on the National disqualified list and remain on the list until such time as the State agency determines that the serious deficiency(ies) that led to placement on the list has(ve) been corrected, or until seven years have elapsed since the agreement was terminated for cause. However, if the day care home has failed to repay debts owed under the program, it will remain on the list until the debt has been repaid.

I hereby certify that the information in this document is true and correct. I understand that this information is being given in connection with the receipt of federal funds; that information may be verified; and that deliberate misrepresentation will subject me to prosecution under applicable state and federal criminal statues (CFDA 10.558) including placement on the national serious deficiency data base which will bar me from participating with the federal food program for seven years.

Provider Signature:_____ **Date:**_____

11/02/10