**TEMPLATE**

***Delete Instructions Prior to Submission for Approval***

**Instructions: Institutions participating in NC CACFP may adapt this template to reflect their institution’s policies and procedures or use an existing confidentiality policy. All confidentiality policies must include the elements listed below under “Policy.” Highlighted items should be modified to reflect your Institution’s procedures.**

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|  | (Institution Name) | | | | | |  | (CACFP Agreement Number) | | |
| **PURPOSE** | | | | | | | | | | |
| * To establish a protocol to prevent unauthorized persons from obtaining access to confidential data collected and maintained for the institution’s CACFP operation. | | | | | | | | | | |
| **POLICY** | | | | | | | | | | |
| * All records containing confidential information for the CACFP at this institution are securely maintained. | | | | | | | | | | |
| * Access to confidential information is limited to authorized representatives of the institution. | | | | | | | | | | |
| * Ethnic and racial data is used for reporting purposes only. | | | | | | | | | | |
| * The following confidential information is collected for each participant upon enrollment and annually:   + Ethnic and Racial Data   + Income Eligibility Data * Medical statements collected for participants who require meal modifications are considered confidential. | | | | | | | | | | |
| **PROCEDURES** | | | | | | | | | | |
| * The | |  | shall maintain all data in the strictest confidence. | | | | | | | |
|  | | (Title of Authorized Representative) | | | | | | | | |
| * Ethnic and racial data and income eligibility data is stored in (specify location):   Medical statements are stored in (specify location): | | | | | | | | | | |
| * Collected data is maintained on file for three years plus the current fiscal year. After this period, data is destroyed (i.e. shredded and discarded). | | | | | | | | | | |
| * Access to data is restricted to the following staff: | | | | | | | | | | |
| Position Title | | | | | Name (First and Last) | | | | | |
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| **INSTITUTION INFORMATION** | | | | | | | | | | |
|  |  | | |  | |  | | | |  |
|  | (Print Name of Authorized Representative) | | |  | | (Title of Authorized Representative) | | | |  |
|  |  | | |  | |  | | | |  |
|  | (Signature of Authorized Representative) | | |  | | (Date) | | | |  |
|  | **Date(s) of annual policy review:** | | | | | | | | |  |