CACFP Reimbursement Claim for Sponsored Adult Care Center

❶ Monthly Claim Form

Institution Name:	Agreement Number:
Center Name:	Center Code:
Month/Year Claimed:	☐ Original ☐ Amendment #

❷ Attendance Reporting

Average Daily Attendance:	Number of Days Meal Service Provided:

❸ Income Eligibility

Number Free	Number Reduced	Number Paid	Total Eligible

❹ Meals Served

	Meals Served (Excluding Emergency Shelter)
Breakfast	
AM Snacks	
Lunch	
PM Snacks	
Supper	
Night Snacks	
Total Meals Served	

❺ Certification

I CERTIFY THAT this claim is true and correct; that it is in accordance with the terms of existing Agreement(s); that records are available to support this claim; and that payment has not been previously received. Moreover, if submitting facility is an independent proprietary ("For-profit") title XIX or XX adult care center, not less than 25% of the enrolled adults, were title XIX or XX beneficiaries. I further understand that this information is being given in connection with the receipt of Federal funds and that deliberate misrepresentation may subject me to prosecution under applicable State and Federal statutes.

Sign Here ►
Keep copy for your records

_____ Signature of Authorized Representative

_____ Date of Preparation

_____ Printed Name of Authorized Representative

_____ Contact Phone Number