CACFP Reimbursement Claim for Sponsoring Organization of Child Care Centers

❶ Monthly Claim Form

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

❷ Attendance Reporting

Type of Center Reporting: Child Care ☐ Head Start ☐ Outside School Hours ☐
Homeless ☐ At Risk ☐

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)	Emergency Shelter Meals	At Risk (ASCS)
Breakfast			XXXXXXXXXXXXX
AM Snacks			XXXXXXXXXXXXX
Lunch			XXXXXXXXXXXXX
PM Snacks			XXXXXXXXXXXXX
Supper			XXXXXXXXXXXXX
Night Snacks			XXXXXXXXXXXXX
At Risk – Snacks	XXXXXXXXXXXXX	XXXXXXXXXXXXX	
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 XX child care center not less than 25% of the enrolled children or 25% of licensed capacity, whichever is less, were title XX beneficiaries, or 25% of enrolled children qualified as free or reduced. 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