North Carolina Department of Health and Human Services
Division of Public Health/Nutrition Services Branch
Special Nutrition Programs

Child and Adult Care Food Program (CACFP)
NC CARES Program
Toll Free: 866 NC-CARE-3 (866-622-2733)

CACFP Reimbursement Claim for Adult Care Centers

Monthly Claim Form

❶ Institution Information

Institution Name	Agreement Number	Claim Month/Year	Claim Type (check one)
			☐ Original ☐ Amendment _____

❷ Attendance Reporting

Number of Sites Claiming	
Number of Days Meals were Provided	
Average Daily Attendance	

❸ Income Eligibility

Number of Free	Number of Reduced Price	Number of Paid	Total Eligible

❹ Meals Served

Breakfast	
AM Snacks	
Lunch	
PM Snacks	
Supper	
Night Snacks	
Total Meals Served	

❺ Application of CACFP Funds During the Month

Administrative Expenditures	
Operating Costs	
Food	
Travel	
Equipment Depreciation (for purchases over $5,000)	
Other	
Total	

❻ 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 institution is an independent proprietary ("For-profit") title XIX or title XX adult care center, for each facility claimed, not less than 25 percent of the enrolled adults were title XIX or title 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