

CACFP Reimbursement Claim for Sponsoring Organization of Day Care Homes

1 Institution Information			
Institution Name:		Agreement:	
Provider Name:		Registration Number:	
Claim Month/Year:	Claim Type: <input type="checkbox"/> Original <input type="checkbox"/> Revision # _____		

2 Attendance Reporting	
Total Number of Days Meals were Provided during claim Period	
Total Attendance-Number of participants that were served at least one meal during the claim period	
Total Enrollment- Number of participants enrolled for care	
Average Daily Attendance	

3 Meals Served			
Description	Tier I	Tier II (High)	Tier II (Low)
Breakfast			
AM Snacks			
Lunch			
PM Snacks			
Supper			
Night Snacks			

4 Certification									
<p>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. 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.</p>									
<p>Sign Here ► Keep copy for your records</p>	<table style="width: 100%; border: none;"> <tr> <td style="border-top: 1px solid black; width: 60%;"></td> <td style="border-top: 1px solid black; width: 40%;"></td> </tr> <tr> <td style="text-align: center; padding-top: 5px;">Signature of Authorized Representative</td> <td style="text-align: center; padding-top: 5px;">Date of Preparation</td> </tr> <tr> <td style="border-top: 1px solid black; width: 60%;"></td> <td style="border-top: 1px solid black; width: 40%;"></td> </tr> <tr> <td style="text-align: center; padding-top: 5px;">Printed Name of Authorized Representative</td> <td style="text-align: center; padding-top: 5px;">Contact Phone Number</td> </tr> </table>			Signature of Authorized Representative	Date of Preparation			Printed Name of Authorized Representative	Contact Phone Number
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