

## CACFP Reimbursement Claim for Child Care Centers

1 Monthly Claim Form					
Institution Name	Agreement Number	Claim Month/Year	Claim Type (check one)		
			<input type="checkbox"/> Original <input type="checkbox"/> Amendment		
2 Attendance Reporting					
Description	Child Care	Head Start	Outside School Hours	Homeless Shelter/ES	At Risk (ASCS)
Number of Sites Claiming					
Average Daily Attendance					
Number of Days Meals were Provided					
3 Income Eligibility					
Number of Free	Number of Reduced Price	Number of Paid	Total Eligible		
4 Meals Served					
Description	Meals Served <small>(Exclude Emergency/Homeless Shelters)</small>	Emergency/Homeless Shelter Meals Served Only	At Risk (ASCS)		
Breakfast			XXXXXXXXXXXXXXXXXX		
AM Snacks			XXXXXXXXXXXXXXXXXX		
Lunch			XXXXXXXXXXXXXXXXXX		
PM Snacks			XXXXXXXXXXXXXXXXXX		
Supper			XXXXXXXXXXXXXXXXXX		
Night Snacks			XXXXXXXXXXXXXXXXXX		
At Risk – Breakfast	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX			
At Risk- AM Snacks	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX			
At Risk- Lunch	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX			
At Risk- PM Snacks	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX			
At Risk- Supper	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX			
At Risk- Night Snacks	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX			
<b>Total Meals Served</b>					
5 Application of CACFP Funds During the Month					Amount
Administrative Expenditures					
Operating Costs					
Food					
Travel					
Equipment Depreciation (for purchases over \$5,000)					
Other					
<b>Total</b>					
6 Certification					
<p><b>I CERTIFY THAT</b> 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 a independent proprietary (“For-profit”) title XX child care center or a sponsoring organization of such centers, for each facility claimed, not less than 25% of the enrolled children or 25% of licensed capacity, whichever is less, were 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</p>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 15%;"> <p><b>Sign Here ►</b> Keep copy for your records</p> </div> <div style="width: 45%; border-bottom: 1px solid black; text-align: center;"> <p>Signature of Authorized Representative</p> </div> <div style="width: 20%; border-bottom: 1px solid black; text-align: center;"> <p>Date of Preparation</p> </div> <div style="width: 20%; border-bottom: 1px solid black; text-align: center;"> <p>Contact Phone Number</p> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%; border-bottom: 1px solid black; text-align: center;"> <p>Printed Name of Authorized Representative</p> </div> <div style="width: 20%;"></div> <div style="width: 20%;"></div> <div style="width: 15%;"></div> </div>					

# Instructions for 2013 CAC 1 Child Care Centers Claim Form

- For claiming meals at **Child Care Centers (includes Child Care, Head Start, Outside School Hours, Homeless Shelter, and At Risk centers)** in program year **2013**.
- For-profit institutions must complete and attach *Certification of Eligibility of Title XIX and XX* for all for-profit sites.
- **Complete and sign all documents in ink!**

## Completing Your Monthly Claim Form

### 1. Institution Information Section

- **Institution Name** Enter complete name as specified on the Institution Agreement (CAC 2).
- **Agreement Number** Enter correct agreement number.
- **Claim Month/Year** Enter month and year that claim applies to (example, October 2006).
- **Claim Type** Check either “Original” or “Amendment.” An “Amendment” claim is for making revisions to a previous claim.

### 2. Attendance Reporting Section

- **Number of Sites Claiming** Enter the number “1” in the column matching your program type
- **Average Daily Attendance** Compute by dividing the center’s monthly attendance by number of days of operation.
- **Number of Days Meals were Provided** Enter the highest number of days food service was provided during the claim month.

### 3. Income Eligibility Section

- Enter the number of **Free, Reduced, Paid, and Total** (Note **Paid = Number Denied + Number with No Applications**.)
- Maintain CACFP Enrollment documentation for all enrolled children.

### 4. Meals Served Section

- Enter the number of eligible meals served during the claim month for each meal type. Enter in the appropriate category—“Meals Served (excluding Emergency/Homeless Shelter)”, “Emergency/Homeless Shelter Meals Served Only”, and “At Risk (ASCS).” Snacks (supplements) must be recorded by “**AM Snacks,**” “**PM Snacks,**” “**Night Snacks,**” or “**At Risk Snacks.**” At Risk Centers may claim At Risk Meals and At Risk Snacks. Only one At Risk snack and At Risk meal can be served to each eligible participant per day.
- **Total Meals Served** must equal sum of all meals by meal types.

### 5. Application of Funds During the Month Section

- Enter institution’s costs by category (Administrative Expenditures, Operating Costs, Food, Travel, Equipment Depreciation (for purchases over \$5,000), and Other) for **Child Care Center** for **claim month**.
- **These costs must have been approved in annual Administrative Budget (CAC 9).**
- **Total Funds** must equal sum of all monthly costs by cost category.
- You must include decimal points for dollar amounts (example \$100.75)

### 6. Certification

- Sign (in ink) by an authorized signer only (i.e., signer must be recorded on the *Statement of Authority*).

## Mailing your claim

- Mail **original signed** claim and copy of *Certification of Eligibility of Title XIX and XX* (if for-profit) to:

DHHS  
Special Nutrition Programs Claims  
2032 Mail Service Center  
Raleigh, NC 27699-2032

## Claim Status and Inquiries Call 866-622-2733 (toll free)