

CACFP Reimbursement Claim for Sponsored Adult Care Center

1 Institution Information	
Institution Name:	Agreement:
Center Name:	Site Number:
Claim Month / Year:	Claim Type: <input type="checkbox"/> Original <input type="checkbox"/> Amendment # _____

2 Adult Care Center Claim	
Number of Days Meals Were Provided	
Total Enrollment	
Average Daily Attendance	
Free	
Reduced-price	
Paid / Denied / No Application	
Number of adults receiving subsidized Title XIX adult care or eligible for free and reduced price meals (For-Profit Centers Only)	

3 Total Meals Served		
Breakfast	Lunch	Supper

4 Total Snacks Served		
A.M.	P.M.	Evening

5 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. 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.</p>									
<p>Sign Here ► Keep copy for your records</p>	<table style="width: 100%; border: none;"> <tr> <td style="border: none; text-align: center;">_____</td> <td style="border: none; text-align: center;">_____</td> </tr> <tr> <td style="border: none; text-align: center;">Signature of Authorized Representative</td> <td style="border: none; text-align: center;">Date of Preparation</td> </tr> <tr> <td style="border: none; text-align: center;">_____</td> <td style="border: none; text-align: center;">_____</td> </tr> <tr> <td style="border: none; text-align: center;">Printed Name of Authorized Representative</td> <td style="border: none; text-align: center;">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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Instructions for 2014 CAC 1 Sponsored Adult Care Center Claim Form

- For claiming meals at **Adult Care Centers** in **program year 2014**.
- 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 claim

1. Institution Information Section

- **Institution Name** Enter complete name as specified on the Institution Agreement (CAC 2).
- **Agreement** Enter correct agreement number.
- **Center Name** Enter complete name as specified on the Center Application.
- **Site Number** Enter correct site 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. Adult Care Center Claim Section

- **Number of Days Meals Were Provided** Enter total number of days food service was provided during the claim month
- **Total Enrollment** Enter the center's enrollment count for Adult Care Center.
- **Average Daily Attendance** Compute by dividing the center's monthly attendance by number of days of operation.
- Enter the number of **Free, Reduced, Paid, and Number of adults receiving subsidized Title XIX adult care or eligible for free and reduced price meals** (For-Profit Centers only). (Note **Paid = Number Denied + Number with No Applications**.)
- CACFP Enrollment forms must be maintained for all participants.

3. Total Meals Served Section

- Enter the number of eligible meals served during the claim month for each meal type.

4. Total Snacks Served Section

- Enter the number of eligible snacks (supplements) served during the claim month. Snacks (supplements) must be recorded by "AM Snacks," "PM Snacks," and "Evening Snacks."

5. 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)