

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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Instructions for 2014 CAC 1 Sponsored Day Care Homes Claim Form

- For claiming meals for **Day Care Homes** in program year **2014**.
- **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.
- **Claim Month/Year** Enter month and year that claim applies to (example, October 2006).
- **Provider Name** Enter the complete name as specified on the Day Care Home Provider Site Information
- **Registration Number** Enter the correct registration number specified on the Day Care Home Provider Site Information
- **Claim Month/Year** Enter month and year that claim applies to (example, October 2006)
- **Claim Type** Check either "Original" or "Revision." A "Revision" claim is for making revisions to a previous claim.

2. Attendance Reporting Section

- **Total Number of Days Meals were Provided** Enter the highest number of days food service was provided within claim month for Day Care Homes.
- **Total Attendance** Enter the number of participants that were served at least one meal during the claim month
- **Total Enrollment** Enter the number of participants enrolled for care
- **Average Daily Attendance** Compute by dividing the home's total attendance by the number of days meals were provided

3. Meals Served Section

- Enter the number of eligible meals served during the claim month for each meal type and tier. Snacks (supplements) must be recorded by "**AM Snacks**," "**PM Snacks**," and "**Night Snacks**."
- **Total Meals Served** must equal sum of all meals for a meal type by tier.

4. 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 to:

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

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