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

Institution Information

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

Attendance Reporting

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

Income Eligibility

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

Meals Served

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

Application of CACFP Funds During the Month

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

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

Instructions for 2017 CAC 1 Adult Care Centers Claim Form

- For claiming meals at **Adult Care Centers** in **program year 2017.**
- 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!**
- **Claims must be received by the State Agency or postmarked within 60 days from the last day of the claim month.**

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 2016).
- **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** Enter the number "1"
- **Number of Days Meals Provided** Enter the highest number of days food service was provided during the claim month for Adult Care Center.
- **Average Daily Attendance** Compute by dividing the center's monthly attendance by number of days of operation.

3. Income Eligibility Section

- Enter the number of **Free**, **Reduced**, **Paid,** and **Total**. (Note **Paid** = **Number Denied** + **Number with No Applications**.)
- CACFP Enrollment forms must be maintained for all participants.

4. Meals Served Section

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

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 **Adult Care Center** for **claim month**.
- **These costs must have been approved in the 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., you 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)