

CACFP Reimbursement Claim for Adult Care Centers

1 Institution Information			
Institution Name	Agreement	Claim Month/Year	Claim Type (check one)
			<input type="checkbox"/> Original <input type="checkbox"/> Amendment # _____
2 Attendance Reporting			
Number of Sites Claiming			
Number of Days Meals were Provided			
Average Daily Attendance			
3 Income Eligibility			
Number of Free	Number of Reduced Price	Number of Paid	Total Eligible
4 Meals Served			
Breakfast			
AM Snacks			
Lunch			
PM Snacks			
Supper			
Night Snacks			
Total Meals Served			
5 Application of CACFP Funds During the Month			
Administrative Expenditures			
Operating Costs			
Food			
Travel			
Equipment Depreciation (for purchases over \$5,000)			
Other			
Total			
6 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>	_____ Signature of Authorized Representative	_____ Date of Preparation	
	_____ Printed Name of Authorized Representative	_____ Contact Phone Number	