

CACFP Reimbursement Claim for Sponsored Adult Care Centers

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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