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 Sponsoring Organization Child Care At Risk Center

| Institution Information | |
|---|---|
| Institution Name: | Agreement: |
| Center Name: | Site Number: |
| Claim Month/Year: | Claim Type: ☐ Original ☐ Amendment # _____ |

| At Risk Center Claim | |
|---|---|
| Number of Days Meal Service Provided | |
| Total Enrollment | |
| Average Daily Attendance | |

| Total At Risk Meals Served | |
|---|---|
| At Risk- Breakfast | |
| At Risk- AM Snack | |
| At Risk- Lunch | |
| At Risk- PM Snack | |
| At Risk- Supper | |
| At Risk- Night Snack | |

## 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. 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 Sponsored Child Care At Risk Center Claim

- For claiming meals at **Child Care At Risk Centers** in **program year 2017.**
- **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.
- **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 2013).
- **Claim Type** Check either "Original" or "Amendment." An "Amendment" claim is for making revisions to a previous claim.

### 2. Child 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 Child Care Center.
- Average **Daily Attendance** Compute by dividing the center's monthly attendance by number of days of operation.
- CACFP Enrollment forms must be maintained for all participants.

### 3. Total At Risk Meals Served Section

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

### 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 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)