Claim Form for Reimbursement

CHILD AND ADULT CARE FOOD PROGRAM

PO Box 4210 Helena, MT 59620-4210 Fax: 406 444-2750

(1) Institution: _____

(2) ID | | | | | | - | | (3) Claim Month_____ 20_____

Claims are due on or before the *10th* of each month. *Claims not received within 60 days of the claim month will not be paid* without USDA approval for a one-time exception. [REF: 7 CFR 226.10(e)]

Refer to Claim Instructions to complete this page.

This claim form is available on the CACFP web at https://dphhs.mt.gov/assets/ecfsd/childcare/cacfp/ClaimForm.pdf. ***Retain a copy for your files.***

Center Information:	**Monthly Attendance:**	**Total Number of CACFP Meals Served to Children:**
(4) Licensed Capacity _____	(9) Free _____	(13) Breakfast _____
(5) Number of Facilities _____	(10) Reduced _____	(14) Lunch _____
(6) Total Monthly Attendance _____	(11) Paid _____	(15) Supper _____
(7) Average Daily Attendance _____	(12) Total Enrolled _____	(16) Snack _____
(8) Total Days Meals Served _____	**Refer to Monthly Attendance Records**	**Refer to Meal Participation Record**
(6,8 refer to Meal Participation Record)		

17. I certify that to the best of my knowledge and belief, this claim is true and correct, records are available to support it, it is in accordance with an existing agreement and applicable licensing requirements, and payment has not be received. I understand that this information is being given in receipt of federal funds and that deliberate misrepresentation of the information may be subject me to prosecution under applicable state or federal laws.

18. For Profit Institutions Only: Free/Reduced Certification, See Claim Instruction #18

This institution certifies that at least 25% of enrolled children or 25% of licensed capacity, **whichever is less**, are classified as Free and Reduced. Completed IEF's are on file to meet eligibility requirements for this reporting month.

# of F/R Participant _____ Total Enrollment _____ Licensed Capacity _____ %Result_____

19. Authorized Signature_____ 20. Date _____

21. Title _____ 22. Phone _____

CLAIM INSTRUCTIONS

*** Income Eligibility Forms must be given to all participants and kept on file except At Risk and Head Start programs.**
*** Participants without an Income Eligibility Form are claimed at the Paid rate.**
*** All participants must be listed on the Monthly Attendance Records as Free Reduced or Paid.**

1. Name of your Institution.
2. ID number – example: 12345-A or 12345-B.
3. Claim month and year.
4. Licensed Capacity: Found on Child Care License.
5. Number of Facilities: Total number of sites.
6. Total Monthly Attendance: Use the Meal Participation Record.
7. Average Daily Attendance: Monthly Attendance divided by number of days meals were served.
8. Number of days CACFP meals were served. Use the Meal Participation Record.
9. Free: Total number of Free participants: Use the Monthly Attendance Record for Free participants.
10. Reduced: Total number of Reduced participants: Use the Monthly Attendance Record for Reduced participants.
11. Paid: Total number of Paid participants: Use the Monthly Attendance Record for Paid Participants.
12. Total Enrollment: Add Free, Reduced and Paid participants.
    For Profit Centers: If a claim does not meet 25% of enrollment or capacity, please notify State Agency at 444-4347.
13. Total number of breakfast meals: Use the Meal Participation Record.
14. Total number of lunch meals: Use the Meal Participation Record.
15. Total number of Supper meals: Use the Meal Participation Record.
16. Total number of Snack/Supplement meals: Use the Meal Participation Record.
17. Sign and date Claim Certification.
18. **Free/Reduced Certification: Worksheet:**
    1. Add Free and Reduced participants: 5 Free + 3 Reduced = 8 total Free/Reduced Participants

    2. Compare Enrollment and Licensed Capacity numbers, use the smaller number.
       <u>Enrollment = 30</u> Capacity = 40

    3. Multiply the smaller number by .25 (30 x .25 = 7.5)
       The number of Free/Reduced participants must be equal to or greater than this number to meet the 25% minimum eligibility to submit a claim for this month.

    4. **Example # 1:** Enrollment = 30 x .25 = 7.5
       Number of Free and Reduced participants = 8
       8 is greater than 7.5 (25% of enrollment)
       This claim is payable.

       Example #2: Capacity = 40 x .25 = 10
       Number of Free and Reduced participants = 8
       8 is less than 10 (25% of capacity)
       This claim is not payable

19. Signature of authorized personnel.
20. Current date.
21. Title of personnel signing the claim form.
22. Phone number.