**Arkansas Department of Human Services**
**Division of Childcare and Early Childhood Education**
**Special Nutrition Programs – Child and Adult Care Food Program (CACFP)**

# Center Reimbursement Claim Form

**1.Name and Address:**________________________________________ **SNP Agreement No.**____________

_____________________________________________________________ **Place and X of this line is this is an adjusted** ______________

_____________________________________________________________

| **2. Month & Year of this Claim**<br>**Month** ____________ **Year** ___________ | **3. Number of days Food Service Provided**<br>____________ | **4. Average Daily Attendance**<br>**a. Child/Adult Centers** Largest single meal service divided by number of days food service provided. Always Round up to the next whole number. ____________<br>**B. Outside School Hours** ______________ |
|---|---|---|

| **Total Number of Meal Services Claimed** | | **Child Care and Adult Centers** | **Outside School Hours Centers** |
|---|---|---|---|
| **5. Breakfast** | | ____________ | ___________ |
| **6. Lunch** | | ____________ | ___________ |
| **7. Snack Supplements** | | | |
| **AM Snack** | ___________ | | |
| **PM Snack** | ___________ | | |
| **Late Snack** | ___________ | | |
| **Total Snacks (AM +PM+Late)** | = | ____________ | |
| **8. Supper** | | ____________ | ____________ |

**NOTE: All multi-site centers must include form CACC-5 (FP-1 for profit organizations only) or equivalent supporting data.**

**Note: (1) Total of all participants receiving at least one meal service.**
**(2) A current signed and dated income eligibility form (SNP-10) must be on file to claim participants in the "Free" or "Reduced" Category.**

**Free** _________

**Reduced** _________

**Paid** _________

**10. Number of Centers Operating this Month** _______

**11. Food Cost for this Month**
**(Itemized receipts must be on file) $**____________

**I certify to the best of my knowledge and belief that this claim is true and correct in all aspects. Records are available to support this claim and that it is in accordance with the terms of any and all existing Agreements. I recognize that I will be fully responsible for any excess amounts that may result from erroneous or neglectful reporting. I understand that this information is being given in connection with the receipt of Federal funds. I fully understand that deliberate misrepresentation may subject me to prosecution under applicable State and Federal Statutes.**

**<u>Please check all entries for accuracy and completeness before submission of this claim.</u>**

**12. Original signature of Authorized Representative** **Title** **Date**

_____________________________________________ ______________________ ___________

**For SNP Office Use Only – Processed by:**

CFS 2115 (AR SNP 7/07)