Arkansas Department of Human Services

Division of Child Care and Early childhood Education

Special Nutrition Programs/National School Lunch Program

MONTHLY CLAIM FOR REIMBURSEMENT

1. Name and Address of Local Education Agency(ies), Institution(s) or Organizations(s)	Check Box if this is an adjusted claim ☐
	2. Agreement No.

3. Claim Month / Year	4. # Operating Days for Month Claimed	5. Total Enrollment for The Month	6. Average Daily Attendance

7. Breakfast Reimbursement

Breakfast Category	Total Breakfast Served
Free	
Free (Severe Need)	
Reduced	
Reduced (Severe Need)	
Paid	
Paid & (Severe Need)	
Total	
Average Daily Meals (Must round up to next whole #)	

8. Lunch Reimbursement

Lunch Category	Total Lunch Served
Free	
Free (Safety Net)	
Reduced	
Reduced (Safety Net)	
Paid	
Paid (Safety Net)	
Total	
Average Daily Meals (Must round up to next whole #)	

9. After School Snack Reimbursement

Snack Category	Total Snacks Served
Free	
Reduced	
Paid	
Total	
Average Daily Meals (Must round up to next whole #)	

I CERTIFY that to the best of my knowledge and belief, that this Claim is true and correct in all respects, that records are available to support this claim, that it is in accordance with the terms of the existing Agreement(s); and that payment therefore has not been received. I recognize that I will be fully responsible for any excessive amounts that may result from erroneous or neglectful reporting herein.

Reimbursable Program

10. Total number of children approved for reduced-priced meals must be completed on all reports _____

11. Total Number of children approved for free meals (must be completed on all reports) _____

12. Number of participating institution(s) _____

(Claim will not be paid if #10 through #13 is incomplete)

13. Legible Signature of Authorized Representative Title Phone Number Date

_____

Submit Claim Form to Special Nutrition Program no later than the 10th of the month. A copy of the claim must be retained at the facility. NOTE: Check for accuracy and make necessary changes

INSTRUCTIONS

1. Self-explanatory.
2. **Agreement Number** – SNP identifying code – one Alpha and 3 Numbers, i.e., R-000
3. **Month and Year Claimed** – Claim must be submitted within sixty (60) days or it will not be paid, i.e, January 31st claim must be submitted by March 31st.
4. **Operating Days** – The number of days meals were served to enrolled children.
5. **Enrollment –** Total number of children enrolled or total number of children with access to program.
6. **Average Daily Attendance** – Divide the number of operating days into the total attendance for the month and round upward for any percentage. (Total Attendance = Number of students that attended the school in the month of the claim. (Must be completed for ALL participants).
7. **Breakfast Reimbursement** – Complete the form as follows:
   a. Enter the **total number** of breakfasts served in each free, reduced and paid section. **(DO NOT CALCULATE ON CLAIM FORM).**
   b. Enter the total number of all meals served.
   c. **Average Daily Meals** – Total of all meals served divided by number of days of operation for the month of the claim. If there were 20 operating days and 468 breakfasts were served, the Average Daily Meals would be 468 divided by 20 = 23.4. Always round up decimal to the next whole number (the Average Daily Meals would be 24).
8. **Reimbursement (same as Step 7) Agreement Numbers beginning with an F get the Safety Net Amount Lunch only. Agreement Numbers beginning with an R get the Severe Need Rate for Breakfast and Safety Net for Lunch.**
9. **After School Snacks** are only paid for weekends. **Holidays and Weekends** cannot be claimed. **Summer After School Snacks** cannot be claimed unless approved by SNP/NSLP.
10. Total number of children approved for reduced priced meals.
11. Total number of children approved for free meals.
12. Total number of institutions in your operation.
13. Legible Signatures from Authorized Representatives only.

Incomplete/incorrect reimbursement forms will be returned for correction. This will delay payment; therefore, it is to your advantage to carefully review the claim form before submitting it for payment.

All receipts, invoices and other evidence of purchase must be retained and available for further audit for a period of five years plus the current year. No further monies or other benefits may be paid out under this program unless this report is completed and filed as required by existing regulations (7CFS210.215.220).

Special Nutrition Programs
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Little rock, Arkansas 72203-1437
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