ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF CHILDCARE AND EARLY CHILDHOOD EDUCATION
SUMMER FOOD SERVICE PROGRAM CLAIM FORM

Instructions: Submit original to Special Nutrition Program no later than the 10th of the month following the month covered by the claim. The sponsor must retain a copy.

1. Agreement Number		2.Sponsor Name		Mark X if this is an adjusted claim	

3. Period covered by this claim	4. Total number of days this month food service was provided	5. Average daily number of children Served (round up to next whole #)	6. Funds received during the month: Total income from non-program adults purchasing meals. Deduct this amount from #18

FOOD SERVICE TO CHILDREN (REPORT ONLY MEALS MEETING REQUIREMENTS) ADD SECONDS TO THE TOTAL NUMBER OF MEALS (#7, 9, 11 AND 13)

7. TOTAL NUMBER OF BREAKFAST SERVED	
8. SECOND BREAKFASTS SERVED	
9. TOTAL NUMBER OF LUNCHES SERVED	
10. SECOND LUNCHES SERVED	
11. TOTAL NUMBER OF SUPPLEMENTS SERVED	
12. SECOND SUPPLEMENTS SERVED	
13. TOTAL NUMBER OF SUPPERS SERVED	
14. SECOND SUPPERS SERVED	

I CERTIFY that to the best of my knowledge and belief, 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 existing Agreement(s); and that payment therefore has not been received. I recognized that I would be fully responsible for any excess amounts which may result from erroneous or neglectful reporting herein. I also 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 criminal statutes.

SIGNATURE ON BEHALF OF SPONSOR	TITLE	DATE

All receipts, invoices and evidence of purchase must be retained and available for future audit of a period of 5 years and 3 months after the end of the fiscal year to which they pertain. No further monies may be paid out under this program unless this report is complete and filed as required by existing regulations.
(7 CFR 225 Instruction CFS-2165)

YOUR CLAIM WILL BE RETURNED FOR CORRECTION IF NOT PROPERLY COMPLETED. BE SURE TO SIGN THIS CLAIM BEFORE MAILING TO AVOID DELAYING YOUR REIMBURSEMENT CHECK.

Approved for payment_____ **Date**_____

Input Date_____

(FOR STATE AGENCY USE ONLY)