**TEMPLATE for Independent Centers**

***Delete Instructions Prior to Submission for Approval***

**Instructions: Institutions participating in NC CACFP may adapt this template to reflect their institution’s policies and procedures or use an existing edit check policy. All edit check policies must include the elements listed below under “Policy.” Highlighted items should be modified to reflect your Institution’s procedures.**

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|  |  | | |  |  |  |
|  | (Institution Name) | | |  | (CACFP Agreement Number) | |
| **PURPOSE** | | | | | | |
| To establish a protocol for [INSTITUTION] to ensure accurate monthly claims for reimbursement based on the approved meals, number of enrolled participants, and operating days. | | | | | | |
| **POLICY** | | | | | | |
| Prior to submitting the monthly claim to the State agency, [INSTITUTION] will perform edit checks on the meal claim. The edit check will include the following actions: | | | | | | |
| * Verify the types of meals the institution is approved to claim. * Ensure the number of meals claimed does not exceed the product of total of enrollment times operating days times approved meal types.   (# Total Enrollment X # Operating Days X # Approved Meal Types = # Meals Claimed) | | | | | | |
| * Review discrepancies between meal counts and attendance to determine if the claim is accurate. | | | | | | |
| **PROCEDURES** | | | | | | |
| *Detailed description of steps taken by the institution to ensure that approved meals, number of enrolled participants and operating days have been evaluated prior to filing monthly claims* | | | | | | |
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| **INSTITUTION INFORMATION** | | | | | | |
|  |  |  |  | | |  |
|  | (Print Name of Authorized Representative) |  | (Title of Authorized Representative) | | |  |
|  |  |  |  | | |  |
|  | (Signature of Authorized Representative) |  | (Date) | | |  |
|  | **Date(s) of annual policy review:** | | | | |  |
| References: 7 CFR §226.10 (c), 226.11 (b), 226.13 (b) | | | | | | |