

CACFP Reimbursement Claim Independent Center Claim Child or Adult Care

Institution and Claim Information				
Institution Name	Agreement Number	Claim Month/Year	Claim Type (check one)	
			<input type="checkbox"/> Original	<input type="checkbox"/> Revision
Attendance Reporting				
Description	Child Care	Adult Care	Homeless Shelter/ES	At Risk (ASCS)
Total Days of Operation				
Total Attendance for the Month				
Total Number of Enrolled				
Number of Shifts				
Number of Enrolled Participants in Each Reimbursement Category				
Free Category	Reduced Category	Paid Category	Total Enrolled	-----

Number of Meals/Snacks Served				
Meal Type	Child Care Meals Served	Adult Care Meals Served	Homeless Shelters/ES	At Risk (ASCS)
Breakfast				-----
AM Snacks				-----
Lunch				-----
PM Snacks				-----
Supper				-----
Night Snacks				-----
At Risk - Breakfast	-----	-----	-----	
At Risk- AM Snacks	-----	-----	-----	
At Risk- Lunch	-----	-----	-----	
At Risk- PM Snacks	-----	-----	-----	
At Risk- Supper	-----	-----	-----	
At Risk- Night Snacks	-----	-----	-----	
All Centers Must Complete the CACFP Cost Report and Attach to this Claim				
For Profit Centers Must Complete the Certificate of Eligibility of Title XIX and XX and Attach to this Claim				
Certification and Authorized Signature				
<p>I CERTIFY THAT this claim is true and correct; that it is in accordance with the terms of existing Agreement(s); that records are available to support this claim; and that payment has not been previously received. Moreover, if submitting institution is an independent proprietary ("For-profit") title XX child care center or a sponsoring organization of such centers, for each facility claimed, not less than 25% of the enrolled children or 25% of licensed capacity, whichever is less, were title XX beneficiaries. I further 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 statutes.</p>				
<p>Sign Here ►</p>				
<p>Keep copy for your records</p>	<p>_____ Signature of Authorized Representative</p>		<p>_____ Date of Preparation</p>	
	<p>_____ Printed Name of Authorized Representative</p>		<p>_____ Contact Phone Number</p>	

Instructions for 2018 CAC 1 Independent Center Claim Form (Child or Adult)

The CAC 1 Independent Center Claim is for claiming meals at:

Child Care Centers	At-Risk Centers
Head Start	Homeless or Emergency Shelter (ES)
Outside School Hours	Adult Care Centers

Completing your claim

1. Institution and Claim Information Section

Institution Name - Enter complete name as specified on the Institution Agreement (CAC 2).

Agreement Number - Enter your assigned CACFP agreement number.

Claim Month/Year - Enter month and year that claim applies to (example, October 2016).

Claim Type - Check either "Original" or "Revision." Only check "Revision" if making a revision to a previously submitted claim.

2. Attendance Reporting Section

Total Days of Operation – Enter the number of days meals were served during the claim month.

Total Attendance – Enter the total number of enrolled CACFP participants who were served meals for the month.

Number of Shifts – Enter the number of shifts in the column matching your program type.

***Average Daily Attendance (ADA)** – The ADA number will be computed by the NCCares system and is based on monthly attendance reported, divided by the number of operating days reported.

3. Enrolled Participants Section (Income Eligibility)

Enter the number of **Free**, **Reduced**, and **Paid** enrolled participants who were served meals during the claim month.

* **Paid** = Number denied participants + Number of participants with no application.

4. Meals Served Section

Enter the number of eligible meals served during the claim month for each meal type. The number of meals should be placed in the appropriate center category.

*At Risk Centers must use the spaces designated for At Risk meals and snacks. Only one At Risk snack and one At-Risk meal can be served to each eligible participant per day.

5. Certification and Authorized Signature Section

Claim form must be signed in ink, by an authorized signer. Authorized persons must be recorded on the *Statement of Authority* form.

Claims must be postmarked or received by the State Agency within 60 days from the last day of the claim month. All Centers must have attached the CACFP Cost Report to their claim submission. For-profit center must also have attached the *Certification of Eligibility of Title XIX and XX*. All CACFP forms can be found at www.nutritionnc.gov.

Mailing your claim

Mail original signed claim and attachment(s) to:

DHHS
Special Nutrition Programs
2032 Mail Service Center
Raleigh, NC 27699-2032

Claim Status and General Inquires, call 866-622-2733 (toll free)
