CACFP Monthly Summary Sheet

Please attach this form with completed monthly Menus and Meal Count/Attendance Sheets. Mail or deliver them, so they are received by the date due to: SACCN
CACFP Claim
37 Everts Avenue
Queensbury, N.Y. 12804

For SACCN Use Only
Provider Number
Tier 1 Tier 2 Mixed
Enrollments Checked
Infant Menus Checked
Meal Visit Visit Sheet Checked
Menus Checked Numbers Checked
Processed By Date Entered

Provider _____________________________________________ Phone _______________________

Month __________________ Year ______________ Number of days meals claimed ______

_________ Total number of children present for care this month.

_________ Total attendance for the month. (Add together the total number of children present each day, this number is found in the Totals at the bottom of the Time (In/Out) column on the Meal Count/Attendance Sheet.)

Total meals claimed for reimbursement:

_________ Breakfast _______ AM Snack

_________ Lunch _______ PM Snack

_________ Supper _______ Evening Snack

Children new to care this month: Children who have permanently left care:

Name ____________________________ Name ____________ Last Day Claimed __________________

______________________________________________

___________________________________________

___________________________________________

School age children were present on the following days:

Date __________ Reason Present _____________________________

______________________________________________

______________________________________________

______________________________________________

Certification of Claim Documentation

I, ___________________________, certify that to the best of my knowledge, the number of meals being claimed for reimbursement is accurate and true. I understand that reimbursement for meals claimed is given in connection with Federal funds. Meals and snacks claimed are only for those children present and fed for that meal or snack. I have claimed no more than three meals/snacks per child per day, and all meals meet the food requirements. I also understand that deliberate misrepresentation of program records may subject me to prosecution under applicable State and Federal criminal statues.

Provider ______________________________ Date ________________