

CENTER CLAIM FOR REIMBURSEMENT

Child and Adult Care Food Program

Read instructions carefully **BEFORE** completing claim. Claim must be submitted no later than the 10th of the month following the month being claimed. Submit claim form with the original signature to: N.M. Children, Youth & Families Department, Family Nutrition Bureau, P.O. Drawer 5160, Santa Fe, NM 87502. A copy is to be retained by the Sponsor for future reference. **Any original claim or upward adjusted claim submitted 60 days after the due date will require substantial justification and use of a one-time exception request to receive payment.**

1. Vendor Number	2. Agreement Number <input style="width: 80%;" type="text"/>	All receipts, invoices and other evidence of program expenditures must be retained and available for future audit for a period of three (3) years after the end of the fiscal year to which they pertain. 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 (7CFR 226).	4. Center Type	# of Centers	ADA
Sponsor Name & Address	3. Month/Year Claimed ____ / ____ <input type="checkbox"/> Adjusted Claim		Child Care		
			Head Start		
			Outside School		
			Adult Care		
			At Risk - Snack		
			Emergency Shelter		
			Combined Total		

5. Name of Center	Center Type*	Center ADA**	At Risk ADA	Enrollment Eligibility				# of Subsidized Children	Total Days of Operation	Total Number of Meals Served at Center(s)				
				Free	Reduced	Paid	Total			Breakfast	Lunch	Supper	Snack	At Risk Snack
Totals														

* C = Child Care; H = Head Start; 0 = Outside School Hours; A = Adult; AR = At Risk; ES = Emergency Shelter
 ** ADA is determined by adding daily attendance for the month then dividing that total by the number of days of operation. Always round up!!

6. CERTIFICATION BY AUTHORIZED REPRESENTATIVE (a completed Certificate of Authority must be on file)

I certify, 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 and conditions of existing agreements, and that payment therefore has not been received. I recognize that I will be fully responsible for any excess amounts which may result from erroneous or neglectful reporting herein. Also, I am aware that deliberate misrepresentation or withholding of information may result in prosecution under applicable state and federal statutes.

Print Name
Signature
Phone #
Date

