Child Care & Development Council of Oswego County - CACFP Reimbursement Form

Provider Name: _____ Month/Year:_____

Provider Address:_____ Please check one: family _____ group_____ enrolled_____

_____ Phone Number:_____

Are there any children under 2 years old present? Yes / No

Total number of children enrolled_____
Number of School Age Children enrolled _____

Name	DOB	Days Present	Arrival Time	Departure Time	School Age	Part/Full Time
		M T W TH F S SU			Yes/No	Part/Full
		M T W TH F S SU			Yes/No	Part/Full
		M T W TH F S SU			Yes/No	Part/Full
		M T W TH F S SU			Yes/No	Part/Full
		M T W TH F S SU			Yes/No	Part/Full
		M T W TH F S SU			Yes/No	Part/Full

Please be sure to fill in all of the information. Failure to do so will result in your claim being DELAYED or DENIED.

Certification of Provider Claim Documentation and Reconciliation

I certify that, to the best of my knowledge, the number of meals being claimed for reimbursement are done so under the guidelines established under 7 CFR 226.18 of the Child Care Food Program Regulations. I understand this information is given in connection with the receipt of Federal funds and that deliberate misrepresentation may result in State or Federal prosecution.

Provider Signature:_____ Date:_____

Assistant Signature:_____