Sanford Children's Hospital

Claim Form

C

Family Day Care Network
1115 W. 41st. Street
Sioux Falls, SD 57105
(605) 333-0663

Please complete the following:

_____
Provider Name Number

_____
Address

_____
City State Zip

_____
Phone

Claim for the Month of _____

Return top (2) copies along with the attendance records to the Family Day Care Network by the 4th, or by the last working day preceding the 4th, if affected by the weekend or holidays.

MEAL DESCRIPTION	MEAL PRICE	NUMBER OF MEALS	AMOUNT OF REIMBURSEMENT
Breakfast			
Lunch			
Snack			
Supper			
Total Reimbursement			

I am registered for_____children plus_____of my own.
(CACFP requirement may differ on capacity)

Total number of days I provided childcare during the month was: _____
Total number of children I provided care for during the month: _____
(Add the total attendance from in's and out's from "Calendar Keeper")

I hereby certify that I have served all meals and snacks being claimed on this form and these meals and snacks have met the CACFP requirements of the ages of the children being served. I do attest that all information I submit is accurate in all aspects: that the information is given in connection with receipt of Federal Funds and deliberate misrepresentation may result in State or Federal prosecution.

_____ _____
Provider's Signature Date

FOR OFFICE USE

- Enrollment by: _____
- Reviewed by: _____
- Entered by: _____
- Date Entered: _____

Top (2) copies: Send to Family Day Care Network
Bottom Copy: Keep for Family Day Care Provider Records

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