



OFFICE OF SUPERINTENDENT OF PUBLIC INSTRUCTION
 Child Nutrition Services
 Old Capitol Building, PO BOX 47200
 OLYMPIA, WA 98504-7200
 (360) 725-6200 TTY (360) 664-3631 Toll Free 1-877-204-6486

AGREEMENT NUMBER

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Child and Adult Care Food Program

ADULT DAY CARE INSTITUTIONS REIMBURSEMENT CLAIM

All claims must be received by the date indicated on the claim form instructions, in order for the claim to be paid by the last day of the month covered by this claim for reimbursement. A copy of this claim must be kept by the institution. Regulation (7 CFR 226.10(e)) requires that original claims for reimbursement be postmarked no later than 60 days following the month of operation and that upward revised claims for reimbursement be postmarked no later than 90 days following the month of operation. Claims postmarked after the deadline may not be paid. Remember to enter the CACFP agreement number in the upper right-hand corner of this form.

PROGRAM IDENTIFICATION	
NAME OF INSTITUTION	MONTH/YEAR OF THIS CLAIM <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> - <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>
ADDRESS	TYPE OF SUBMISSION a. Original <input type="checkbox"/> b. Institution Revision <input type="checkbox"/> c. Date of Revision _____
CONTACT PERSON	

ATTENDANCE REPORTING	
Number of Sites Claiming	
Number of Days Meals were Provided	
Average Daily Attendance	
Total Enrollment of Sites Claiming	

30 DAY STUDY MONTH		INCOME ELIGIBILITY			
From Date	To Date	Number of Free	Number of Reduced-Price	Number of Above-Scale	Total
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

MEALS SERVED	
Breakfast	
A.M. Snacks	
Lunch	
P.M. Snacks	
Supper	
Evening Snacks	
Total Meals/Snacks	

ATTENDANCE DETAIL FOR-PROFIT SITE			
(Attach a list of all for-profit sites claiming this month and provide the information below for each site.)			
Site Name	Total Enrollment	Number of Title XIX Eligible Enrolled	Percent Eligible

YEAR-TO-DATE OPERATING COSTS (Multiple Site Institutions Complete in July, August, and September)	
Year-to-date operating costs are:	\$ <input style="width: 100%;" type="text"/>

CERTIFICATION		
I certify that this claim is true and correct; that records are available to support this claim; that it is in accordance with the terms of existing agreement(s); and that payment therefore has not been received. If a proprietary center, compensation is received from the Department of Social and Health Services for Title XIX adults for not less than 25 percent of total enrollment. For multiple sites, each site must meet the 25 percent criteria.		
Date of Preparation	Printed Name of Authorized Signature	Authorized Signature