



**CLAIM FOR REIMBURSEMENT  
for Sponsors of Day Care Centers**

Sponsor Name	Claim Month	Claim Year	Adjusted Claim? YES ____ NO ____
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Center Number	
Center Name	
<b>Attendance Reporting</b>	
Total Days of Operation	
Total Attendance	
<b>Income Eligibility Categories for All Participants</b>	
Free Category	
Reduced Category	
Paid Category	
Total Enrolled	
<b>For Profit Centers Only</b>	
Number of Children with Tuition Subsidy	
<b>Meals/Snacks Served</b>	
Breakfast	PM Snack
AM Snack	Supper
Lunch	Night Snack
<b>Second Meals/Snacks Served</b>	
Breakfast	PM Snack
AM Snack	Supper
Lunch	Night Snack
<b>At-Risk Snacks/Suppers</b>	
Total Days of Operation	
Total Attendance	
Snacks	Seconds
Suppers	Seconds

Center Number	
Center Name	
<b>Attendance Reporting</b>	
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<b>Income Eligibility Categories for All Participants</b>	
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Total Enrolled	
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Lunch	Night Snack
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Total Days of Operation	
Total Attendance	
Snacks	Seconds
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**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 amount that 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. I agree to contact CACFP if there are any changes in the approved application and sponsor agreement.

\_\_\_\_\_  
Signature

\_\_\_\_\_ Date Signed

\_\_\_\_\_ Title

\_\_\_\_\_ This Form Prepared By

\_\_\_\_\_ Telephone (include Area Code)

**FOR STATE USE ONLY**

Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PROCESSED \_\_\_\_ RETURNED \_\_\_\_ REJECTED \_\_\_\_

\_\_\_\_\_ Date / Initials

## GENERAL INSTRUCTIONS

- A. If you have any questions while completing the claim, please call **CACFP at 1-800-942-3858** for assistance.
- B. This Claim for Reimbursement for Sponsors of Day Care Centers (DOH-3703) must be typed or handwritten legibly in black or blue ink. Report program information for only one calendar month on each claim form.
- C. To be paid for meals served, this claim form must be submitted to CACFP. Contact CACFP if you would like to claim online.
- D. CACFP encourages sponsors to submit claims by the 10th of the month following the claim month. CACFP can accept claims received within 60 days of the last day of the claim month.
- E. Reimbursement for all meals and snacks (except At-Risk and Shelters) is calculated as a percentage of the number of enrolled participants in the free, reduced and paid reimbursement categories, as reported on this claim. At-Risk meals for approved centers and meals claimed for Shelters are paid at the free rate.
- F. All program records including income eligibility forms, attendance, meal counts, receipts, invoices, etc. must be kept and available for review for a period of 3 years after the submission of the final claim for the fiscal year for which they pertain.
- G. Your claim will be returned or payment delayed if not complete.

## SPECIFIC INSTRUCTIONS

Complete the claim form from top to bottom. Write all of the information for your first center in the left column, the next center is written into the middle column and the next center is written into the right hand column. If you have more than three centers, use additional pages.

**CACFP Agreement #:** Write in your 4 digit CACFP agreement number, which can be found on your CACFP application and approval letter.

**Sponsor Name:** Enter the complete name of your Organization as stated on your CACFP application and approval letter.

**Claim Month:** Enter, in numbers, the month that this claim or adjusted claim covers.

**Claim Year:** Enter, in numbers, the year that this claim or adjusted claim covers.

**Adjusted Claim:** Check if this claim is an ADJUSTED CLAIM. An adjusted claim allows you to report changes to the original claim; i.e., additional meals or less meals you may have over-claimed. The adjusted claim must report the correct number of meals; CACFP will calculate your reimbursement by comparing it against your original claim.

**Center Number:** Enter the four-digit number assigned to each center.

**Center Name:** Write in the name of the center corresponding to the CACFP center number.

### **Attendance Reporting**

**Total Days of Operation:** Enter the number of days the center was in operation during the month of the claim

**Total Attendance:** Add together the number of participants in attendance for each day of operation, and then enter the grand total of these numbers.

**Income Eligibility Categories for All Participants:** Enter the number of participants whose income eligibility form makes them eligible to be claimed in the free, reduced or paid category. Any participant without an income eligibility form must be reported in the paid category. The total should equal the number of participants enrolled in care during the claim month. If only At-Risk meals are claimed, or the center is an emergency shelter, do not complete this section.

**For Profit Centers Only:** For-profit centers are eligible to submit a claim only if 25% of the enrolled participants, or 25% of the licensed capacity (whichever is less) receive subsidized tuition payments or are eligible to be claimed in the free or reduced income eligibility category. If the number of free and reduced does not equal 25%, write in the total number of children whose tuition is subsidized by the Office of Children and Family Services or ACS/HRA.

**Meals/Snacks Served:** Enter the total number of meals served to eligible participants at the center.

**Second Meals/Snacks Served:** For vended centers approved to claim Seconds, enter the number of second meals served.

### **At Risk Snacks/Suppers:**

**Total Days of Operation:** Enter the number of days the center was in operation during the month of the claim.

**Total Attendance:** Add together the number of participants in attendance for each day of operation, and then enter the grand total of these numbers.

A child receiving At-Risk and non-At-Risk meals (for example, At-Risk Snack and Breakfast) would be reported in both Total Attendance sections of the claim.

If the center has both At-Risk meals and traditional meals, some or all of the participants may be reported in both Section 1 and Section 6. For example, if a center is approved to serve At-Risk Snacks and lunch, a child receiving both meals would be reported in the total attendance of both sections.

SIGN the claim before submitting it to CACFP. Only the original signature of an authorized representative, as indicated on the Certificate of Authority (DOH-3671), will be accepted.

Make a copy for your records and mail the original form to:

CACFP, NYS Dept of Health  
150 Broadway FL 6 West  
Albany, NY 12204-2719