

U.S. DEPARTMENT OF AGRICULTURE
Food and Nutrition Service

PLACE "X" IN
BOX IF THIS IS
AN ADJUSTED
CLAIM

Check for accuracy and make any changes that are necessary.

CLAIM FOR REIMBURSEMENT
SUMMER FOOD SERVICE PROGRAM
FOR CHILDREN

1. AGREEMENT NO.

2. NAME AND ADDRESS OF SERVICE INSTITUTION

INSTRUCTIONS: Submit original and one copy to FNS Regional Office which administers your program not later than the 10th of the month following the month covered by the claim. A copy must be retained by the sponsor. Record all entries in the right most positions in the boxes provided for each item.

<p>3. MONTH COVERED BY THIS REPORT</p> <p>MONTH</p> <table border="1"> <tr><td> </td><td> </td></tr> </table> <p>YEAR</p> <table border="1"> <tr><td> </td><td> </td><td> </td><td> </td></tr> </table>							<p>4. PERIOD COVERED BY THIS CLAIM (YOU MAY INCLUDE NO MORE THAN 9 OPERATING DAYS OF THE MONTH PRECEDING CLAIM MONTH AND/OR NO MORE THAN 9 OPERATING DAYS OF MONTH FOLLOWING CLAIM MONTH.)</p> <p>FROM:</p> <table border="1"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table> <p>MONTH DAY YEAR</p> <p>TO:</p> <table border="1"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table> <p>MONTH DAY YEAR</p>													<p>5. TOTAL NUMBER OF DAYS THIS CLAIM PERIOD FOOD SERVICE WAS PROVIDED</p> <table border="1"> <tr><td> </td><td> </td></tr> </table>			<p>6. AVERAGE DAILY NUMBER OF ELIGIBLE CHILDREN SERVED</p> <table border="1"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>								

FOOD SERVICE TO CHILDREN (Report only meals meeting requirements in the Agreement.)

7. Total number of breakfasts served _____

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8. Total number of lunches served _____

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9. Total number of suppers served _____

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10. Total number of supplements served _____

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FUNDS RECEIVED DURING MONTH

11. All income specifically designated for FOOD SERVICE including donations and payments for meals from all sources except USDA.

DO NOT
KEY
PR 8 MC

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PROGRAM COST DURING CLAIM PERIOD (Include all costs incurred whether or not payment was actually made.)

DO NOT
KEY
PR 8 MC

12. Food _____

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13. Labor (Excluding Administrative Costs) _____

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14. Other (Excluding Administrative Costs) _____

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15. **SUBTOTAL** (Items 12+ 13+ 14) _____

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16. Administrative Costs _____

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17. **TOTAL PROGRAM COSTS** (Items 15 + 16) _____

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FOR FNS USE ONLY

ADJOVR

Adjustment / Override Code _____

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Official Submission Date _____

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I CERTIFY that to the best of my knowledge and belief, 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 of existing Agreement(s); 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. I also understand that this information is being given in connection with the receipt of Federal funds; and that deliberate misrepresentation may subject me to prosecution under applicable State and Federal criminal statutes. I further certify that all claims for reimbursement shall be submitted to the Regional Office no later than the legislatively mandated deadline of 60 days after the end of the claim period. I understand that failure to submit claims within the 60 day deadline may result in such claims not being paid.

<p>DATE OF PREPARATION</p> <p>MONTH DAY YEAR</p> <table border="1"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>							<p>TITLE</p>	<p>SIGNATURE OF AUTHORIZED REPRESENTATIVE</p>

<p>All receipts, invoices, and other evidence of purchase must be retained and available for future audit for a period of 3 years after the date of submission of the final claim for the fiscal year to which they pertain.</p>	<p>No further monies or other benefits may be paid out under the program unless this report is completed and filed as required by existing regulations (7 C.F.R. 225)</p>
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INSTRUCTIONS

SPECIAL NOTE: An **ADJUSTED CLAIM FOR REIMBURSEMENT** completely voids all previously submitted claims for the same month. Therefore, you must include **ALL** of your reporting data for the entire month's operations.

This information should cover activities during one calendar month; however, you may include no more than 9 operating days of the month before the first full month of operation and/or no more than 9 days of the month after the last full month of operation. Amount of reimbursement will be computed by USDA, based on rates in effect.

YOUR CLAIM WILL BE RETURNED FOR CORRECTION IF NOT PROPERLY COMPLETED. BE SURE TO SIGN THIS CLAIM BEFORE MAILING TO AVOID DELAYING YOUR REIMBURSEMENT CHECK.

ITEM (all items self-explanatory unless noted below)

3. Enter the number of the month and year this claim covers.

Example: June 1988 =

0	6
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1	9	8	8
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5. Enter the number of days during the claimperiod in which meal service was provided at one or more sites.
6. Compute by adding the total number of **eligible** children served watch day by all sites to get a cumulative total number of **eligible** children served for the claim period, and dividing by the number of days of operation for the same claim period. **(Item 5.)**
11. Enter total amount of fund received for food service from individual donations. State and local contributions, payments for adult meals, and reimbursement from other Federal programs. **(DO NOT INCLUDE "start-up funds", "advance payments", and "monthly reimbursement payments" from this USDA program or loans to the program.)**
12. Enter all **food** costs including milk. Such costs shall include, in addition to the purchase price, the cost of processing, distributing, transporting, storing, or handling of any purchased or donated food including USDA donated commodities. **(DO NOT INCLUDE the value of donated food.)**
13. Enter **labor costs** which include all wages earned in connection with the food preparation, delivery and service, include costs incurred during the month covering payroll deduction for social security, withholding tax, insurance, retirement, etc., as well as employer's contribution during the month for employee benefits.
14. Enter program costs **other** than for food, labor and administrative. These costs include service costs e.g., rental fees for food service facilities, rental or use allowance of food service equipment, repairs to equipment eligible for use allowance, and utilities, and cost of supplies used e.g., cleaning materials, paper plates, plastic eating utensils, straws. **(DO NOT INCLUDE costs reported in item 12 and 13.)**
16. Enter **administrative** costs related to planning, organizing and managing the Program, and rental cost of office space and equipment. **DO NOT INCLUDE interest costs and costs for purchase of land, buildings and equipment.)**

REVIEW YOUR ENTRIES, WHEN YOU ARE SATISFIED THEY ARE TRUE AND CORRECT TO THE BEST OF YOUR KNOWLEDGE, SIGN THE CLAIM, ENTER YOUR TITLE AND THE DATE CLAIM WAS PREPARED.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0584-0041. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection.