Form Approved OMB NO. 0584-0041
EXPIRATION DATE: XX/XX/XXXX

U.S. Department of Agriculture, Food and Nutrition Service

Summer Food Service Program (SFSP)

CLAIM FOR REIMBURSEMENT

Adjusted Claim ☐

1.Sponsor Number		

2.Name and Address of Sponsor Organization			
Org Name 1			
Org Name 2			
Addr 1			
Addr 2			
Addr 3			
City			
State		Zip+	

3.Month on this Claim with Greatest Number of Operating Days

Month Year

4.Month(s) Covered by This Claim

You may include no more than ten operating days of the month preceding and/or following the month with the greatest number of operating days.

	Month	Year
a.		
b.		
c.		

5.Total Number of Days SFSP Meals Served This Month

a.	
b.	
c.	

Number of Meals SERVED TO Eligible Children

	firsts	seconds
6.Breakfasts		
7.Lunches		
8.Suppers		
9.Supplements		

Program Operating and Administrative Costs

10.Operating Costs	
a.Food	
b.Labor	
c.Other	
11.Total Operating Costs	
12.Total Administrative Costs	
13. All Non-USDA Income Received for Food Service	

14.Preparation Date	Name of Authorized Representative [Print]	Title
	Signature of Authorized Representative	Contact Telephone Number

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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 10 operating days of the month before the first full month of operation and/or no more than 10 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: May 2007 = | 0 | 5 | | 2 | 0 | 0 | 7 |

5. Enter the number of days during the claim period in which meal service was provided at one or more sites.

10a. 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.)**

10b. 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 of employee benefits.

10c. 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 10a and 10b.)**

12. 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.)**

13. Enter total amount of funds 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.)**

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.

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 is 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 for 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.

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.

No further monies or other benefits may be paid out under this program unless this report is completed and filed as required by existing regulations (7 CFR 225).

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 collection is 0584-0041. The time required to complete this information collection is .5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection.