APPENDIX F

Child and Adult Care Food Program (CACFP)
Improper Payment Meal
Claims Assessment

(OMB No.: 0584-NEW)

Project Officer: Fred S. Lesnett

Office: Office of Research and Analysis
Food and Nutrition Service
Room 1014
3101 Park Center Drive
Alexandria, VA 22302

Telephone: 703-605-0811
Fax: 703-305-2576
E-mail: Fred.Lesnett@FNS.USDA.GOV

Appendix F:
CACFP Provider Child Enrollment Data Abstraction Table

**CHILD AND ADULT FOOD CARE PROGRAM
(CACFP) MEAL CLAIMS ASSESSMENT
ICF Macro**

**Attn: Erika Gordon, Project Director
11785 Beltsville Drive, Suite 300
Calverton, MD 20705
Tel: (800) 840-8248**

State ID:_____ Sampled FDCH #_____	Sponsor ID:_____ Sponsor Name:_____	Provider ID:_____ Provider Name: _____
Replacement FDCH? Y/N		
Date of Abstraction:____/____/_____ _	Respondent: _____	Reviewed by:_____
Time: _____ am/pm	Interviewer: _____	HQAPVL:_____

CACFP PROVIDER CHILD ENROLLMENT DATA ABSTRACTION TABLE

TOTAL CHILD ENROLLMENT FROM SPONSOR RECORD:	APPROVED FDCH MEAL SERVICE:	BREAKFAST (B)	AM SNACK (AS)	LUNCH (L)	PM SNACK (PS)	SUPPER (S)	EVENING SNACK (ES)
		☐	☐	☐	☐	☐	☐
Total number of infants (11 months old or younger): _____							
Total number of preschool children (1–5 years): _____							
Total number of school-age children (6+): _____							

What is the child's name? (First name, Middle Initial, Last Name)	_____ (First Name, MI, Last Name)
Does your sponsor organization have a unique ID number for this child? What is it?	Provider Child ID: _____
What is the child's date of birth?	____/____/_____ (MM/DD/YYYY)
When did he/she begin attending your day care home?	____/____/_____ (MM/DD/YYYY)

What are the child's parent/parents/guardian's name(s)? (First Name and Last Name)
Can you provide me with the parent(s)/guardian's home address and telephone number(s)?
Parent #1: _____

            Parent/Guardian's Name (1)

Parent #2_____

            Parent/Guardian's Name (2)

_____
Street Address

_____
Street Address

_____ _____
City   State/ZIP Code

_____ _____
City   State/ZIP Code

_____ _____
Primary Phone Number   Alternative Phone Number

_____ _____
Primary Phone Number   Alternative Phone Number

Does _CHILD #1 NAME_ have any siblings that are enrolled in your care?	• Yes Number of siblings in care? • No _____
What is the sibling's name? (First name, Middle Initial, Last Name)	1. _____ (First Name, MI, Last Name)
What is the sibling's name? (First, Middle Initial, Last Name)	2. _____ (First Name, MI, Last Name)
What is the sibling's name? (First Name, Middle Initial, Last Name)	3. _____ (First Name, MI, Last Name)

What days of the week does [_CHILD #1 NAME_] attend your day care?	**What time does [_CHILD #1 NAME_] usually attend your day care for those days?**

	BEFORE-SCHOOL CARE		**AFTER-SCHOOL CARE**	
	Arrive (am/pm)	_Leave (am/pm)_	_Arrive (am/pm)_	_Leave (am/pm)_
1. Monday				
2. Tuesday				
3. Wednesday				
4. Thursday				
5. Friday				
6. Saturday				
7. Sunday				

For which meals that you provide this child do you receive reimbursement for?

Breakfast	AM Snack	Lunch	PM Snack	Supper	EV Snack
☐	☐	☐	☐	☐	☐

Does child's parent(s) provide any meals for him/her to eat while in your care?	
• **NO** • Formula • Breakfast • AM Snack • Lunch • PM Snack • Supper • EV Snack	NOTES ON MEALS: