SOUTH CAROLINA
DEPARTMENT OF SOCIAL SERVICES
CACFP - FAMILY NUTRITION PROGRAMS
Post Office Box 1520, Columbia, South Carolina 29202-1520
(803) 898-0959

Fax Number (803) 898-0960

Step by Step Instructions for Filling Out Claim for Reimbursement Child and Adult Care Food Program (Child and Adult Care Centers)

GENERAL INSTRUCTIONS

- Report data for one calendar month only.

- This claim will be returned, as payment cannot be made, if it is not properly completed. If you have any questions about how to complete this form, please contact the South Carolina Department of Social Services, Child and Adult Food Care Program **(SCDSS CACFP)** staff for assistance at **(803) 898-0959.**

- Sign and date this claim before mailing it. If your name is not on the **"Statement of Authority"** which was submitted to our office earlier, you may not sign this form.

- Submit the original and two copies to SCDSS. All claims must be received by the **15th** of the month following the claim month. One copy must be kept by the institution or sponsor.

  Mail to: S. C. Department of Social Services
  Division of Finance
  Post Office Box 1520
  Columbia, SC 29202-1520

- Any revised claim submitted after the legislatively mandated deadline of 90 days after the end of the claim month **"may not"** be paid.

- Please notify our office immediately, in writing, if your center is closing its business operation or if the physical location is scheduled to change.

- Record all entries to the right in each group of blocks. If certain blocks are not applicable enter the number **"0"** in the last box to the right or leave them blank.

  Example: Item **#9-C** asks for the total amount of suppers. If this amount is **"0"** then make the entry as follows: 0 or _____ .

SPECIFIC INSTRUCTIONS

☐ ORIGINAL CLAIM ☐ REVISION (Check One) 1. 2. 3.

- Check the appropriate box to indicate **"Original Claim", "Revision 1", "Revision 2"** or **"Revision 3".** An original claim is any claim for which you have not received payment.

- A revised claim completely voids all previous claims for the same month. Therefore, when you do a revised claim, include all reporting data for the entire month's operation. Also, be sure to maintain all records and documentation to support the claim for reimbursement.

ITEMS

1. AGREEMENT NUMBER: **CC00000**	2. NAME AND ADDRESS OF INSTITUTION: John Doe DCC 000 West Street Columbia, SC 00000
3. FEDERAL ID# 00-00000000	

- Item 1 & 2. Enter your agreement number, name and address as found in your approval letter.

- Item 3. Enter your Federal Identification number.

4. Month and Year Claimed:

☐☐ ☐☐☐☐

- Item 4. Enter, by number, the month and year this claim covers.

Example: May 2002 ☐☐ ☐☐☐☐

5. TOTAL NUMBER OF DAYS FOOD SERVICE WAS PROVIDED FOR MONTH CLAIMED

☐☐

- Item 5. Enter the total number of days food service was provided by our providers during the claim month.

FOR DSS USE ONLY
Y M M D D

- Do not enter any information in this section.

	FREE	REDUCED	PAID	TOTAL
6a. ENROLLMENT THIS MONTH	☐☐☐☐☐	☐☐☐☐☐	☐☐☐☐☐	☐☐☐☐☐

Item 6a. Enter the total number of enrolled participants in each applicable income eligibility category. This information will be taken from the Master Roster.

Total enrollment should include all enrolled participants that were in attendance at least one day during the month.

A current and complete income eligibility application must be filed for all participants included in the **"Free"** or **"Reduced"** category.

6b. Proprietary Title XIX, Title XX or F/RP Centers Only (Check One)	**XIX,XX**	**F/RP**	**Total Center Enrollment**	**Total Title XIX, XX or F/RP Enrollment**	**Percentage Title XIX, XX or F/RP**
1. _____	☐	☐	☐☐☐☐	☐☐☐☐	☐☐☐☐
2. _____	☐	☐	☐☐☐☐	☐☐☐☐	☐☐☐☐
3. _____	☐	☐	☐☐☐☐	☐☐☐☐	☐☐☐☐
4. _____	☐	☐	☐☐☐☐	☐☐☐☐	☐☐☐☐
5. _____	☐	☐	☐☐☐☐	☐☐☐☐	☐☐☐☐
6. _____	☐	☐	☐☐☐☐	☐☐☐☐	☐☐☐☐
7. _____	☐	☐	☐☐☐☐	☐☐☐☐	☐☐☐☐

6b. This section is to be completed only by proprietary Title XIX and XX centers or sponsors and for proprietary free and reduced institutions. For each center with meals being reported for the claim month, indicate the

total center enrollment, and the Title XIX or XX enrollment or free and reduced enrollment. Divide the Title XIX, Title XX or free and reduced (F/R) enrollment by the total center enrollment to determine the Title XIX, Title XX or F/R percentage. Do not report meals for any Title XIX, Title XX or F/R center that does not have **25%** or more participants receiving Title XIX, Title XX or F/R benefits enrolled for this claim month. The total center enrollment for all centers reported for the claim month in **6b** should equal the **"Total"** enrollment in **6a.**

Total Number of Meals Served to Participants in Care Centers

	A. Breakfasts	B. Lunches	C. Suppers	D. Supplements
7. Paid:	_____	_____	_____	_____
8. Free:	_____	_____	_____	_____
9. Reduced:	_____	_____	_____	_____
10. Total	_____	_____	_____	_____

Item 7 - 9. **(Cols. A-D)** To be completed institutions which are reimbursed based on the **actual** count of eligible meals served to eligible participants enrolled in all centers. Centers include regular child or adult care centers, OSHC centers and proprietary Title XX, Title XIX and F/R centers. If none, enter a **"0"**.

Item 10. **(Cols. A-D)** To be completed by institutions using the claiming percentage method of reimbursement.

Complete only line **#10.** Leave lines **7, 8** and **9** blank. Enter the total number of meals served to eligible participants enrolled in centers. If none, enter a **"0"**.

Item 11. Enter average daily attendance.

For each day during the claim period, count the number of eligible participants in attendance for each participating center. To arrive at the average daily attendance, divide the centers total monthly attendance by the number of operating days. Add the average for each center and insert the number. **(See example included in this instruction package.)**

Item 12. Number of centers this claim period for which you are claiming meals.

Only enter the number of participating centers that are operating this claim month which have met the eligibility and reimbursement requirements as cited in the applicable program regulations.

Item 13. Food Cost.

Enter the total food cost for the center(s) for this claim month. Food cost includes expenses for food and milk purchased for center participants.

Item 14. Self-explanatory.

14. ALL CENTERS: PLEASE CHECK THE BOX BELOW IF YOU HAVE A CHANGE IN STAFF INVOLVED WITH THE CHILD AND ADULT CARE FOOD PROGRAM:

☐COOK ☐PERSON WHO DOES CACFP PAPERWORK
☐DIRECTOR ☐OTHER _____

WE WILL CONTACT YOUR CENTER TO DO TRAINING WITH NEW STAFF ON THE CHILD AND ADULT CARE FOOD PROGRAM.

Item 15. Self-explanatory.

Check new address.

Item 16. Remarks

Enter any remarks you would like. Identify the type of snack you have included on the claim form, i.e., am snack, pm snack, evening snack.

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). I recognize that I will be fully responsible for any excess amounts which may result from erroneous or neglectful reporting herein. I further certify that all claims for reimbursements shall be submitted to the South Carolina Department of Social Services within the time frame prescribed by the department. I understand that failure to submit claims within the prescribed time frame may result in such claims not being paid.

Read this **"Statement of Certification"** before signing **item 17.**

Item 17 & 18. Signature and title of authorized representative.

This signature must be that of the individual designated to sign the claim for reimbursement on the statement of authority. If this person has changed, a new **"Statement of Authority"** must be submitted prior to **SCDSS** processing the claim.

Item 19. Preparation date.

19. Preparation Date:		
MO	DA	YEAR
☐☐	☐☐	☐☐☐☐

Date the claim for reimbursement is prepared. This date must be after the last calendar day of the claim month.

All receipts, invoices and other evidence of purchases must be retained and available for future audit for a period of three years after the end of 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 226).

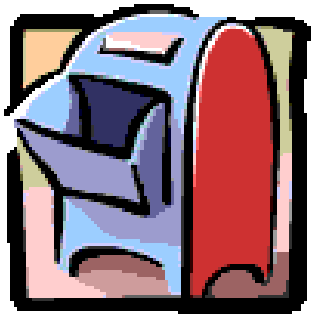
Example for Computing Average Daily Attendance (Centers)

Date	Total Attendance	
10/1	-	Saturday
10/2	-	Sunday
10/3	29	
10/4	30	
10/5	29	
10/6	24	
10/7	23	
10/8	-	Saturday
10/9	-	Sunday
10/10	26	
10/11	23	
10/12	22	
10/13	29	
10/14	30	
10/15	-	Saturday
10/16	-	Sunday
10/17	29	
10/18	30	
10/19	31	
10/20	24	
10/21	26	
10/22	-	Saturday
10/23	-	Sunday
10/24	28	
10/25	29	
10/26	30	
10/27	31	
10/28	26	
10/29	-	Saturday
10/30	-	Sunday
10/31	24	
Total	573/21 days = 27.29	

Always round up, therefore average daily attendance = 28

Note: If you sponsor more than one center you must add the ADA for each center and report this total in Item 10.

Before you



(Mail)

Your claim

Check the following:

Check the following areas before submitting your Claim for Reimbursement:

1. Check the box **"Original Claim"** in the top of claim for all original claims.

2. If you are submitting a revised claim be sure to check in the appropriate revision box in the top center of the claim form.

3. Be sure to complete **item 3** which identifies what month the claim is for.

4. Be sure to enter, in **item 4,** the correct number of days for which meal service was provided for the claim month.

5. In the section **"Date of Preparation",** be sure to enter the actual date the claim was prepared.

6. **"Title and Signature",** failing to complete this section will result in a delay in your reimbursement.

7. **ALWAYS:**

   - Submit claims in ink only **(no pencil).**
   - State Agency providers must submit an accompanying Inter Departmental Transfer **(IDT)** with all claims.
   - When submitting an original/revised claim send in the original and 2 copies.


SAMPLES


SAMPLES


SAMPLES

Non-profit or Public Institution

Actual Method

Non-profit or Public Institution

Claiming Percentage

For-Profit

Title XIX, Title XX

Or

Free/Reduced (F/R)

Claiming Percentage

For-Profit

Title XIX, Title XX

or

Free/Reduced (F/R)

Actual Method