



**Montana Child & Adult Care Food Program
 Sponsor of Day Care Homes
 Claim for Reimbursement**

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|--|-----------------------------------|
| 1. ADA Total: _____
(Item #7 + #11 of claim) | 4. Sponsor's Name: _____ |
| 2. Homes Claimed Total _____
(Item #10 + #14 of claim) | 5. Provider ID#: _____ |
| 3. Expenses for Month: _____
(Item #11Ci of wksht) | 6. Claim Month/Year: _____ |

<u>Tier I Homes Data</u>		<u>Signature</u>	<u>Date</u>	<u>Signature</u>	<u>Date</u>
	Claim	Adj. #1	Total	Adj. #2	Total
7. ADA (Item 5b of wksht)	_____	_____	_____	_____	_____
8. Participated (Item #5a of wksht)	_____	_____	_____	_____	_____
9. Number of Meals (Item #7 of wksht)					
a. Breakfast	_____	_____	_____	_____	_____
b. Lunch	_____	_____	_____	_____	_____
c. Supper	_____	_____	_____	_____	_____
d. Snack	_____	_____	_____	_____	_____
10. Homes (Item #5c of wksht)	_____	_____	_____	_____	_____

<u>Tier II Homes Data</u>					
11. ADA (Item #6b of wksht)					
a. Tier II Hi	_____	_____	_____	_____	_____
b. Tier II Lo	_____	_____	_____	_____	_____
c. Tier II Mixed	_____	_____	_____	_____	_____
12. Participated (Item #6a of wksht)					
a. Tier II Hi	_____	_____	_____	_____	_____
b. Tier II Lo	_____	_____	_____	_____	_____
c. Tier II Mixed	_____	_____	_____	_____	_____
13. Number of Meals (Item #8 wksht)					
a. Breakfast at Tier II Hi Rates	_____	_____	_____	_____	_____
b. Lunch at Tier II Hi Rates	_____	_____	_____	_____	_____
c. Supper at Tier II Hi Rates	_____	_____	_____	_____	_____
d. Snack at Tier II Hi Rates	_____	_____	_____	_____	_____
e. Breakfast at Tier II Lo Rates	_____	_____	_____	_____	_____
f. Lunch at Tier II Lo Rates	_____	_____	_____	_____	_____
g. Supper at Tier II Lo Rates	_____	_____	_____	_____	_____
h. Snack at Tier II Lo Rates	_____	_____	_____	_____	_____
14. Homes (Item #6c wksht)					
a. 100% Tier II Hi Rates	_____	_____	_____	_____	_____
b. 100% Tier II Lo Rates	_____	_____	_____	_____	_____
c. Tier II Mixed	_____	_____	_____	_____	_____
d. Subtotal Tier II	_____	_____	_____	_____	_____

I certify that, to the best of my knowledge and belief, this claim is true and correct. There are records to support this claim; it is in accordance with an existing agreement, and payment has not been received.

Signature/Title	Date	Phone Number
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Note: During any fiscal year, administrative cost payments may not exceed 30% of the total amount of administrative cost payments and food service payments. Attached to this claim is the Financial Spreadsheet and list of the names, addresses, and amount of reimbursement for each day care home covered by this claim. Submit claims by the 10th day of the month following the month covered to: Child and Adult Care Food Program, Department of Public Health and Human Services, 111 N Jackson St 5th Floor, PO Box 202925, Helena, MT 59620-2925. Toll Free 888-3-7-9333. Please retain a copy for your file.