Department of Elder Affairs
Adult Care Food Program
Food and Nutrition Management
Monthly Reimbursement Claim

Instructions: Return to the above address no later than the 15th of the month following the month covered by this claim. If more than one center is operated under an approved sponsor, consolidate all data from the centers on one reimbursement claim. Refer to detailed instructions. All monetary figures must be rounded to the nearest dollar. Do not show cents.

Example: indicate $150.75 as 1 5 1

1. Name and address of sponsor:
   Name:______________________________________________________
   Address:_____________________________________________________
   City:_________________ State:_______ Zip:______________________
   FEID#:______________________________________________________
   Last Name:_____________ First Name:____________________
   Phone:___________________

2. Agreement Number:________________________________________

3. Report Period: Month_______ Year_______

4. Number of Operating Days:_____________________

5. Average Daily Attendance:__________________________

6. Total Number Centers Operated:_________________________
   Proprietary Title XIX___________________
   All Others_____________________

7. Number of Enrolled Adults by Category: Free___________________ Reduced___________________ Non needy_____________________

8. Number of Meals Served by Type:

<table>
<thead>
<tr>
<th></th>
<th>Title XIX</th>
<th>Adult Day Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A.M. Supplement</td>
<td></td>
<td></td>
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<tr>
<td>Lunch</td>
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<tr>
<td>P.M. Supplement</td>
<td></td>
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<tr>
<td>Supper</td>
<td></td>
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</tbody>
</table>

9. Program Expenditures and Income:
   Operating Expenditures:________________________ Administrative Expenditures:____________________________ Income:________________________

10. 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); that payment has not been received; that meals listed on this claim have not and will not be claimed for reimbursement under Part C of Title III of the Older Americans Act of 1965.

   Title:_______________________________________________________
   Signature:_________________________________________________ Print Name:________________________________________
   Preparation Date:___________________________________________