Submit no later than the 15th of the month following the month covered by this claim to:

Adult Care Food Program

Florida Department of Elder Affairs

4040 Esplanade Way, Bldg B

Tallahassee, Florida 32399-7000

(850)414-2048 Fax (850)414-2348

Department of Elder Affairs

Adult Care Food Program

Food and Nutrition Management

Monthly Reimbursement Claim

Elder Affairs FLORIDA

If this is a revised claim,

Mark "X" in this box: ☐

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:

	Title XIX	Adult Day Care
Breakfast		
A.M. Supplement		
Lunch		
P.M. Supplement		
Supper		

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:_____