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| TENNESSEE DEPARTMENT OF HUMAN SERVICES**CLAIM FOR REIMBURSEMENT** CHILD AND ADULT CARE FOOD PROGRAM(HOMES ONLY) | 1. Check Appropriate Claim Type[ ]  Original Claim[ ]  Revised Claim | 2. AGREEMENT NUMBER

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3.NAME AND ADDRESS OF INSTITUTION |
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| 4. MONTH AND YEAR CLAIMED 5. TOTAL NUMBER OF DAYS FOOD  SERVICE WAS PROVIDED FOR PERIOD CLAIMED  |
| MONTH YEAR  [ ]  [ ]  [ ] [ ] [ ] [ ]  [ ] [ ]  |
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| **6. A. BREAKFAST B. LUNCHES C. SUPPERS D. SUPPLEMENTS** **A. TIER I (Only)**

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 **B. TIER II (Only)**

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 **C. TIER II Mixed (Only)****TIER I Rates**

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**TIER II Rates**

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| **7. TOTAL ATTENDANCE FOR CLAIM PERIOD**  |  **A. TIER I (ONLY)**

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 |  **B. TIER II (ONLY)**

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 | **TIER I****TIER II** | **C. MIXED**

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|  | **D. GRAND TOTAL****(TIER I (ONLY) + TIER II (ONLY) + MIXED)** |

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| **8. PROGRAM ADMINISTRATIVE COSTS**  | **9. PROGRAM INCOME**  | **10. ACTUAL NO. OF DAY CARE HOMES OPERATING THIS CLAIM PERIOD**  |
| **[ ] [ ] [ ] [ ] [ ] [ ]  .** **[ ]** **[ ]**  | **[ ] [ ] [ ] [ ] [ ] [ ]  . [ ] [ ]**  | **TIER I (ONLY)**  | **TIER II (ONLY)**  | **MIXED** | **TOTAL** |
|  |  | **[ ]** **[ ]** **[ ]** **[ ]**  | **[ ]** **[ ]** **[ ]** **[ ]**  | **[ ]** **[ ]** **[ ]** **[ ]**  | **[ ]** **[ ]** **[ ]** **[ ]** **[ ]** **[ ]**  |
| **11. CHILDREN ENROLLED IN HOMES FOR THIS CLAIM PERIOD**  |  **A. TIER I (ONLY)**

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 |  **B. TIER II (ONLY)**

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 | **TIER I****TIER II** | **C. MIXED**

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|  | **D. GRAND TOTAL****(TIER I (ONLY) + TIER II (ONLY) + MIXED)** |

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| 1. **REMARKS**

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| **I CERTIFIY 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 claims submitted for meals served in proprietary centers meet the requirements for reimbursement as established by the Federal Regulations as 7CFR Part226. I further certify that all claims for reimbursement shall be submitted to the State Office no later than 30 days after end of the claim month. I understand that failure to submit claims within the 30 day deadline may result in such claims not being paid.** |
| 1. **SIGNTURE OF AUTHORIZED REPRESENTATIVE**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | 1. **TITLE**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | 1. **PREPARATION DATE**

 **MO DAY YEAR**

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| **All receipts, invoice and other evidence of purchase must be retained and available** | **No further reimbursement shall be paid under the CACFP for the period covered by this claim unless this is completed and filed as required by the Tennessee Department of Human Services and the Federal Regulations at 7 CFR Part 226** |

**HS-3083 8-2014**