ED-103
Schedule D
Rev. 12/10
7 CFR 226.11(b)

CONNECTICUT STATE DEPARTMENT OF EDUCATION
Bureau of Health/Nutrition, Family Services and Adult Education
25 Industrial Park Road
Middletown, Connecticut 06457-1543

Reimbursement Claim for Day Care Centers

Instructions

1. ***Complete all items; use zero or N/A where appropriate.***
2. ***Retain all records to support the claim for three years after the date of submission of the final claim for the fiscal year to which they pertain, or longer for unresolved audit findings.***
3. ***Return on or before the 15th of the month following the claim month to the address above.***

Name of Institution	Agreement Number	Claim Month & Year
Prepared By (Name, Title, Telephone Number)	Date Prepared	Check One ☐ Original ☐ Revision 1 ☐ Revision 2 ☐ Revision 3

Name of Site	**Number of Operating Days**	**Total Attendance**	**No. of Participants Enrolled by Category**				**No. of Meals Served to Enrolled Participants**			
			Free	Reduced	Over Income	Total	Breakfasts	Lunches	Suppers	Snacks
A	B	C	D	E	F	G	H	I	J	K
GRAND TOTALS Total on last page only										

At-Risk Afterschool Care Program *Only*				
Name of Site	**No. of Operating Days**	**Total Attendance**	**No. of Snacks**	**No. of Suppers**

Sign on last page only

I CERTIFY that the information supplied above is correct to the best of my knowledge, that records are available to support this claim, that this claim is in accordance with the terms of existing Agreement(s), and that payment has not been received.

Signature of Authorized Representative *Title* *Date*