ED-103
Schedule C
Rev. 07/09
7 CFR 226.12 (a)
7 CFR 226.13 (c)

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

REIMBURSEMENT CLAIM FOR DAY CARE HOMES

INSTRUCTIONS

1. Complete all items, use zero or N/A where appropriate.
2. Retain a copy in your file for three years.
3. Return on or before the 15th of the month, following the claim month, to the address above.

1. Name of Institution:	2. Agreement Number:
3. Claim Sequence (check one): ___ Original ___ Original Corrected ___ 1st Revision ___ 2nd Revision ___ 3rd Revision	4. Claim Month /Year: _____/_____ month year

5. Total Administrative Costs for the Month:	6. Total Operating Days:
7. Income to the Program:	

Category	Number of homes served during the month:	Enrollment:	Average Daily Attendance:
8. Tier I			
9. Tier II (Higher Rate)			
10. Tier II (Lower Rate)			
11. Tier II Mixed			
TOTALS:			

Number of Meals				
Category	Breakfast	Lunch	Supper	Supplements
12. **Tier I** Children in Tier I Homes				
13. **Tier I** Children in Tier II Homes				
14. Total Meals served to **Tier II** Children				

Certification By Authorized Representative

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 Only	Title	Date Signed

This form was prepared by:

Name: Title: Telephone: