MONTHLY TOTAL SHEET

PROVIDER NAME: _____CACFP #:_____

TOTALS FOR THE MONTH OF:_____

PLEASE CIRCLE ONE: FAMILY DAY CARE OR GROUP DAY CARE OR INFORMAL

TOTAL ENROLLMENTS:_____

#BREAKFAST: _____ **COMMENTS:**

#AM SNACK: _____

#LUNCH: _____

#PM SNACK: _____

#DINNER: _____

#LATE NIGHT SNACK: _____

PLEASE LIST "NO SCHOOL" DAYS AND SCHOOL DISTRICT, DAYCARE CLOSINGS AND HOLIDAYS.

I certify that the claim information is true and correct. I understand this information is being given in connection with the receipt of Federal funds. CACFP officials may verify information and that deliberate misrepresentation may subject me to prosecution under applicable State and Federal criminal statutes. I understand that part of or my entire monthly claim can be disallowed for noncompliance reasons by CACFP officials or its designated sponsoring organization.

I understand that I cannot claim beyond my license capability.

Provider's Signature_____ Date_____

OFFICE USE ONLY (REVISED 8/2020)

- ☐ Enrollments
- ☐ Site visit
- ☐ Capacity
- ☐ 6 month infant menu
- ☐ Weekly menu
- ☐ Attendance Sheet
- ☐ Resident child