Reset

South Carolina Department of Social Services
Child and Adult Care Food Program

CLAIM FOR REIMBURSEMENT

Read instructions carefully before completing this claim.
If the claim is incomplete, your reimbursement will be delayed.

Check One
Original Claim: ☐
Revision: ☐ 1. ☐ 2. ☐ 3.

1. Agreement Number:

2. Name and Address of Institution:

3. Month and Year Claimed:
☐☐ ☐☐☐☐

4. Total Number of Days Food Service Was Provided for Month Claimed: ☐☐

For DSS Use Only: Y M M D D

5. Average Daily Attendance:
Tier I: ☐☐☐☐☐☐
Tier II (H): ☐☐☐☐☐☐
Tier II (L): ☐☐☐☐☐☐
Tier II (M): ☐☐☐☐☐☐

6. Actual No. of Day Care Homes Operating This Claim Month:
Tier I: ☐☐☐☐
Tier II (H): ☐☐☐☐
Tier II (L): ☐☐☐☐
Tier II (M): ☐☐☐☐

7. Total Number of Eligible Meals Served to Children in Day Care Homes:

	A. Breakfasts	B. Lunches	C. Suppers	D. Supplements
Tier I:	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐
Tier II (H):	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐
Tier II (L):	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐

8. Program Income:

9. ☐ Check New Address:

10. Remarks:

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); 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 all claims for reimbursements shall be submitted to the South Carolina Department of Social Services within the time frame prescribed by the department. I understand that failure to submit claims within the prescribed time frame may result in such claims not being paid.

12. Signature of Authorized Representative:

13. Title:

14. Preparation Date:
MO DA YR
☐☐ ☐☐ ☐☐☐☐

All receipts, invoices and other evidence of purchases must be retained and available for future audit for a period of three years after the end of the fiscal year to which they pertain. No further monies or other benefits may be paid out under this program unless this report is completed and filed as required by existing regulations (7CFR226).

DSS Form 3320 (JAN 02) Edition of MAR 98 is obsolete.

South Carolina Department of Social Services
Child and Adult Care Food Program

ADMINISTRATIVE COSTS

Read instructions carefully before completing this claim. If the claim is incomplete, your reimbursement will be delayed.	**Check One** Original Claim: ☐ Revision: ☐ 1. ☐ 2. ☐ 3.

Sponsor: _____ Date: _____
Month Year

Enter the claim month's summary of expenses for each category of administrative costs. The amount may not be greater than 10 percent of each approved budget category. Documentation must be on file to support each cost entered on the claim. Any claim that exceeds 10 percent of an approved budgeted category or exceeds the total budgeted amount will not be processed. A budget may be revised at any time during the fiscal year until the August cut off date. The maximum budget amount available is based on the sum of the number of providers approved to participate each month from the beginning month sponsor participation.

Budget Categories	**Amount This Month**
I. Administrative Labor (Pages 2 and 3)	
II. Travel Expenses (Page 3)	
III. Office Supplies, Equipment, Publications and Postage (Page 4)	
A. Office Supplies, Materials, Printing, Publications, Postage, etc. (In-Office ONLY)	A.
B. Equipment Purchases, Rental or Depreciation	B.
IV. Office Rental, Maintenance and Utilities (Page 5)	
V. Other – All Must Be Approved Budgeted Items (Specify) (Pages 6 and 7)	
Indirect Costs	
Insurance (Tort, Liability, Data Processing, etc.)	
Bonding	
Auditor Services	
Temp Agency Services	
Technical Assistance/Support	
Equipment Maintenance (Purchasing or Improving – Specify Which)	
Advertisement	
Membership Fees (Program Related ONLY)	
Recruiting Fees	

V. Other (Continued) – All Must Be Approved Budgeted Items (Specify) (Pages 6 and 7)	
Speakers (For CACFP Workshops)	
Vehicle Supplies and Maintenance (Please Explain)	
Bank Account Service Charges	
Participant Costs (Any items not used in the office – for provider use.)	
A. Printing/Publications	A.
B. Workshops	B.
C. Materials and Supplies	C.
D. Other Participant Costs (Please Explain)	D.
_____	
Other: (Please specify and explain those costs.)	
_____	
_____	
_____	
_____	
_____	
_____	
* Contracted Services (Services rendered by outside agencies that involve signing a contract.) Indicate specific services provided. Use separate sheet of paper if more space is needed. A copy of the current contract must be on file at SCDSS.	
_____	
_____	
_____	
_____	
Grand Total	_____
Signature of Person Designated on Statement Authority:	Date: