Reset

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

Child Care and Adult Care Centers: **Read instructions carefully before completing claim. If the claim is incomplete, your reimbursement will be delayed.**

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

1. Agreement Number:

2. Name and Address of Institution:

3. Federal ID#:

4. Month and Year Claimed: ☐☐ ☐☐☐☐

5. Total Number of Days Food Service was Provided for Month Claimed: ☐☐

FOR DSS USE ONLY

Y M M D D

	Free	Reduced	Paid	Total
6a. Enrollment This Month:				

6b. Proprietary Title XIX, Title XX or F/RP Centers Only: (Check One)	XIX,XX	F/RP	Total Center Enrollment	Total Title XIX, XX or F/RP Enrollment	Percentage Title XIX, XX or F/RP
1.	☐	☐			
2.	☐	☐			
3.	☐	☐			
4.	☐	☐			
5.	☐	☐			
6.	☐	☐			
7.	☐	☐			

Total Number of Meals Served to Participants in Care Centers

	A. Breakfasts	B. Lunches	C. Suppers	D. Supplements
7. Paid:				
8. Free:				
9. Reduced:				
10. Total:				

11. Average Daily Attendance:

12. Number of Centers This Claim Period for Which You are Claiming Meals:

13. Food Cost:

14. All Centers: Please check the box below if you have a change in staff involved with the Child and Adult Care Food Program:

☐ Cook ☐ Person Who Does CACFP Paperwork

☐ Director ☐ Other: ____________________

We will contact your center to do training with new staff on the Child and Adult Care Food Program.

15. Check New Address:
☐

16. 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.

17. Signature Authorized Representative:

18. Title:

19. Preparation Date:

MO	DA	YEAR

DSS Form 3321 (JUL 05) Edition of JUL 02 is obsolete.

INSTRUCTIONS FOR DSS FORM 3321

- Report data for one calendar month only.
- This claim will be returned, as payment cannot be made, if it is not properly completed. If you have any questions about how to complete this form, please contact the South Carolina Department of Social Services, Child and Adult Care Food Program (SCDSS CACFP) for assistance at (803) 734-9739.
- Sign and date this claim before mailing it. If your name is not on the “Statement of Authority” which you submitted to our office earlier, you may not sign this form.
- Submit the original and two copies to SCDSS. All claims must be received by the 15th of the month following the claim month. One copy must be kept by the center or sponsor.
- Please notify our office immediately in writing if your center or sponsorship is closing its business operation.

Specific Instructions:
Check the appropriate box to indicate “Original Claim,” “Revision 1,” “Revision 2” or “Revision 3.”

- A revised claim completely voids all previous claims for the same month. Therefore, when you do a revised claim, include all reporting data for the entire month’s operation. Also, be sure to maintain all records and documentation to support the claim for reimbursement.

  Any revised claim submitted after the legislatively mandated deadline of 90 days after the end of the claim month may not be paid.

1. and 2. Your agreement number and address as found in your approval letter.

3. Self-explanatory.

4. Enter, by number, the month and year this claim covers. Example: May 2002 05 2002

5. Self-explanatory.

6a. Enter the total number of enrolled participants in each applicable income eligibility category. This information will be taken from the Master Roster.

Total enrollment should include all enrolled participants that were in attendance at least one day during the month.

A current and complete income eligibility application must be filed for all participants included in the “Free” or “Reduced” category.

6b. This section is to be completed only by proprietary Title XIX and XX centers or sponsors and for proprietary free and reduced institutions. For each center with meals being reported for the claim month, indicate the total center enrollment, and Title XIX or XX enrollment or free and reduced enrollment. Divide the Title XIX, Title XX or free and reduced (F/R) enrollment by the total center enrollment to determine the Title XIX, Title XX or F/R percentage. Do not report meals for any Title XIX, Title XX or F/R center that does not have 25% or more participants receiving Title XIX, Title XX or F/R benefits enrolled for this claim month. The total center enrollment for all centers reported for the claim month in 6b should equal the “Total” enrollment in 6a.

Total meals served.

7. - 9. (Cols. A-D) To be completed by institutions which are reimbursed based on the actual count of eligible meals served by meal type and income category. Enter the total number of meals by income category (paid, free, reduced) actually served to eligible participants enrolled in all centers. Centers include regular child or adult care centers, OSHC centers and proprietary Title XX, Title XIX and F/R centers. If none, enter a “0.”

10. (Cols. A-D) To be completed by institutions using the claiming percentage method of reimbursement.

Complete only line 10. Leave lines 7, 8 and 9 blank. Enter the total number of meals served to eligible participants enrolled in centers. If none, enter a “0.”

11. Average daily attendance.

For each day during the claim period, count the number of eligible participants in attendance for each participating center. To arrive at the average daily attendance, divide the centers total monthly attendance by the number of operating days. Add the average for each center and insert the number.

12. Number of centers this claim period for which you are claiming meals.

Only enter the number of participating centers that are operating this claim month which have met the eligibility and reimbursement requirements as cited in the applicable program regulations.

13. Enter the total food cost for the center(s) for this claim month. Food cost includes expenses for food and milk purchased for center participants.

14. Self-explanatory.

15. Self-explanatory.

16. Remarks.

Enter any remarks you would like.

17. and 18. Signature and title of authorizing representative.

This signature must be that of the individual designated to sign the claim for reimbursement on the statement of authority. If this person has changed, a new statement of authority must be submitted prior to SCDSS processing the claim.

19. Preparation date.

Date the claim for reimbursement is prepared. This date must be after the last calendar day of the claim month.

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 (7 CFR226).

Agreement Number: ______________________

Name of Institution: ______________________ Claim Month: ______________________

Center Name	County	Enrollment				Meals				ADA
		Free	Reduced	Paid	Total	Breakfast	Lunch	Supper	Supplement	
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