

**List children alphabetically by last name if possible

CACFP Daily Meal Count

Early Years - Agreement 7119

Program Name		Provider's Name							License Number							License Capacity							Claim Month/Year													
A t t e n d		First Name							First Name							First Name							First Name							First Name						
		Last Name							Last Name							Last Name							Last Name							Last Name						
Date	B	AS	L	PS	S	LS	B	AS	L	PS	S	LS	B	AS	L	PS	S	LS	B	AS	L	PS	S	LS	B	AS	L	PS	S	LS						
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B=Breakfast AS=AM Snack L=Lunch PS=PM Snack S=Supper LS=Evening Snack

I certify that this claim is true and correct; that it is in accordance with the terms of existing Agreement(s); that records are available to support this claim; and that payment has not been previously received. I further understand that this information is being given in connection with the receipt of Federal funds and that deliberate misrepresentation may subject me to prosecution under applicable State and Federal statutes.

Provider's Signature _____