CACFP Claim Revision

Agreement #:____

Institution/Site Name: ____

Please provide the revised counts

Claim Month/Year:______________

Number of days in operations: ________

Total enrollment: ________

At-Risk number of days in operation, if applicable: ________

At-Risk total enrollment, if applicable: ________

Participation Data:

Title XX/XIX, if applicable: ________

Number free eligible: ________

Number reduced eligible: ________

Number not eligible: ________

	Child Care	At-Risk	Adult Care
Number of Breakfasts			
Number of Lunches			
Numbers of Suppers			
Number of Snacks			

Reason for revision: ____

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