ANGELS CHILD CARE FOOD PROGRAM

13200 Crossroads Parkway North, Suite 155
City of Industry CA 91746-3423
888/ 375-5155 -NEW Fax 562/ 908-0501

CLAIM COVER SHEET

PROVIDER NAME ____

PROVIDER ADDRESS ______________________________ CITY ________________ ZIP CODE__________

PROVIDER PHONE NUMBER _______________________ CELL NUMBER___________________________

E-MAIL ADDRESS: ____

CLAIM MONTH/YEAR________________________

LIST OF CHILDREN CLAIMED

Please list children by **assigned enrollment number** that represents them on your claim

First & Last Name	First & Last Name
1______________	15______________
2______________	16______________
3______________	17______________
4______________	18______________
5______________	19______________
6______________	20______________
7______________	21______________
8______________	22______________
9______________	23______________
10______________	24______________
11______________	25______________
12______________	26______________
13______________	27______________
14______________	28______________

MEAL SERVICE TIME

A minimum of 2 hours shall elapse between the Beginning of one meal service and the beginning of another meal service when supplements (snacks) are served.

Breakfast: __________ **to** __________

AM Snack: ____________________

Lunch: ___________**to**____________

PM Snack: ____________________

Dinner: ___________ **to** ___________

CLAIM ATTACHMENTS

Make sure you have enclosed all forms necessary to receive full reimbursement

Drop Notice: ________________

Enrollments: ________________

Enrollment Update: ____________

Menu Plan Ledger: ____________

School-Age Form: _____________

Sign In & Out Sheets: __________

REGULAR ATTENDANCE MENU'S

NUMBER OF PAGES_____________

NOTES

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INFANT ATTENDANCE MENU'S

NUMBER OF PAGES_____________

NOTES

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I certify that this information is true and correct in all respects. I understand that this information is being given in connection with the receipt of federal funds and that a deliberate misrepresentation or withholding of information may result in prosecution under applicable state and federal statues.

______________________________ ______________________________

PROVIDER SIGNATURE – PRINTED NAME PROVIDER NUMBER DATE