

**South Carolina Department of Social Services
At-Risk Afterschool Snack 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: _____ FEIN: _____																				
2. Name and Address of Institution:	FOR SCDSS USE ONLY: Y M M D D																				
3. Month and Year Claimed:	4. Total Number of Snack Service Days for Month Claimed																				
5. Average Daily Attendance	6. Number of Sites Operating for Month Claimed:																				
7. Total Number of Snacks Served to Children for Month Claimed:																					
8. ABC VOUCHER CENTERS ONLY	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 45%;"></th> <th style="width: 15%; text-align: center;">Total Center Enrollment</th> <th style="width: 20%; text-align: center;">Total ABC Voucher Enrollment</th> <th style="width: 20%; text-align: center;">Percentage ABC Voucher</th> </tr> </thead> <tbody> <tr> <td>1. _____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>2. _____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>3. _____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>4. _____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>		Total Center Enrollment	Total ABC Voucher Enrollment	Percentage ABC Voucher	1. _____	_____	_____	_____	2. _____	_____	_____	_____	3. _____	_____	_____	_____	4. _____	_____	_____	_____
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2. _____	_____	_____	_____																		
3. _____	_____	_____	_____																		
4. _____	_____	_____	_____																		
9. Please indicate if you have had a change in staff involved with meal service and/or recordkeeping for this program that would require training. A technical assistance visit will be scheduled.																					
10. Remarks:																					
10. I certify 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, and that it is in accordance with the terms of the existing agreement. 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 reimbursement 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.																					
11. Signature of Authorized Representative	12. Title:	13. Preparation Date:																			
All receipts, invoices and other evidence of purchases must be retained and available for future audit for a period of three (3) 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 (7CFR 226).																					