dc healthytots act

OSSE

An Early Child Care Wellness Initiative
for CACFP Participants

Healthy Tots: Phase One

Enhanced CACFP Meal Reimbursements

Automatic participation

Add10

Optional participation

Local5

Full Day4

Enhanced CACFP Meal Reimbursements

Full Day4

Full Day4

3 Meals and **1 Snack** per **Day** per **Infant/Child**

or

2 Meals and **2 Snacks** per **Day** per **Infant/Child**

Breakfast

Lunch

Supper

Snack (a.m. or p.m.)

Full Day4

Which meal may we add?

- Facilities may add any additional meal.

The addition must:

- **benefit the infants/children**
- **total 3 meals and 1 snack or 2 meals and 2 snacks**

Breakfast a.m.Snack Lunch p.m.Snack Supper

Full Day4

Why should your facility offer Full Day4?

Breakfast → *All breakfasts served in the month are reimbursed at the free rate. (local funds)*

Lunch

Supper → *This could be a child's last meal of the day.*

Snack

Full Day4

Full Day4 Eligibility

Eligible children:

-children enrolled in full day child care

Eligible centers:

-75% of enrolled children are D.C. residents

-50% or more of enrolled children are eligible for child care subsidy

Full Day 4

Documenting Full Day4 Eligibility

Master Enrollment List (MEL)

- ✓ **Subsidy requirement**
  - Child care subsidy/TXX column already included
- ✓ **Residency requirement**
  - Yes/No column was added to the Master Enrollment List

Where residency information can be located:

- **CACFP Enrollment/Income Eligibility Form**
  - **Front – parent/guardian signature section**

Full Day 4

Meal and Snack Timing

- Maintain at least 1 hour between meals and snack service.

**unless a shorter timeframe is requested and approved.*

Full Day4

Benefit of adding another meal

- All breakfasts are reimbursed at the free rate.*
- Provide children with the nutrition they need for healthy growth.

**Reimbursed through local funds*

Full Day4

Is Full Day4 a good choice for your facility?

- ✓ Will adding a meal **benefit the infants/children** in my care?
- ✓ Is my facility **open long enough** to offer an additional meal?
- ✓ Does my facility have **enough staff to prepare or serve** another meal?
- ✓ Will adding another meal =
  - ❖ **3 meals and 1 snack being served per child per day**?

    or
  - ❖ **2 meals and 2 snacks being served per child per day**?
- ✓ Are the **children enrolled in full day child care** receiving the additional Full Day4 meal?
- ✓ *Each month,* is **75%** of my facility's enrollment **children who are D.C. residents**?
- ✓ *Each month,* is **50% or more** of my facility's enrollment **children eligible for child care subsidy**?

Enhanced CACFP Meal Reimbursements

Claiming Healthy Tots

Full Day4

Claiming **Full Day4**

- Sign-up to participate in Full Day 4.
- Record the number of breakfasts served in the "Full Day4-local breakfast" box.
  - *If participating in Full Day4, do not place breakfast count in "federal breakfast" box.*
- Record the number of the "additional" meal in the appropriate box.

$1.66 (federal free rate) for every breakfast served.

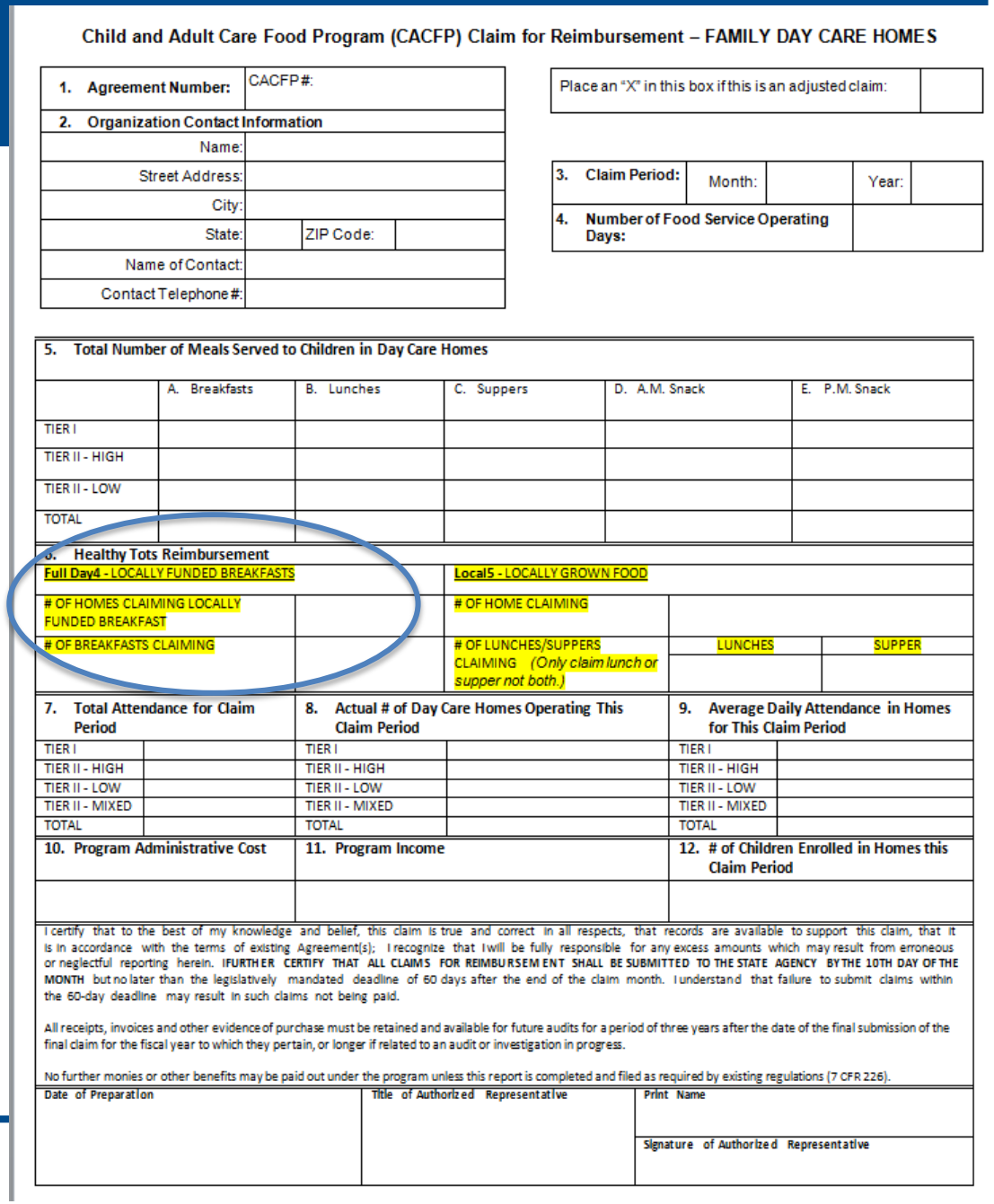
Additional meal reimbursement paid according to children's eligibility rate.

Full Day4

Family Day Care Home Sponsor Claim Form

Claiming **Full Day4**

- Record the number of breakfasts served in the "Full Day4 local breakfast" box.
- Record the number of the "additional" meal in the appropriate box.



Child and Adult Care Food Program (CACFP) Claim for Reimbursement – FAMILY DAY CARE HOMES

1. Agreement Number:	CACFP#:
2. Organization Contact Information	
Name:	
Street Address:	
City:	
State:	ZIP Code:
Name of Contact:	
Contact Telephone #:	

Place an "X" in this box if this is an adjusted claim:

3. Claim Period:	Month:		Year:	
4. Number of Food Service Operating Days:				

5. Total Number of Meals Served to Children in Day Care Homes

	A. Breakfasts	B. Lunches	C. Suppers	D. A.M. Snack	E. P.M. Snack
TIER I					
TIER II - HIGH					
TIER II - LOW					
TOTAL					

6. Healthy Tots Reimbursement

Full Day4 - LOCALLY FUNDED BREAKFASTS		Local5 - LOCALLY GROWN FOOD		
# OF HOMES CLAIMING LOCALLY FUNDED BREAKFAST		# OF HOME CLAIMING		
# OF BREAKFASTS CLAIMING		# OF LUNCHES/SUPPERS CLAIMING *(Only claim lunch or supper not both.)*	LUNCHES	SUPPER

7. Total Attendance for Claim Period		8. Actual # of Day Care Homes Operating This Claim Period		9. Average Daily Attendance in Homes for This Claim Period	
TIER I		TIER I		TIER I	
TIER II - HIGH		TIER II - HIGH		TIER II - HIGH	
TIER II - LOW		TIER II - LOW		TIER II - LOW	
TIER II - MIXED		TIER II - MIXED		TIER II - MIXED	
TOTAL		TOTAL		TOTAL	

10. Program Administrative Cost	11. Program Income	12. # of Children Enrolled in Homes this Claim Period

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 REIMBURSEMENT SHALL BE SUBMITTED TO THE STATE AGENCY BY THE 10TH DAY OF THE MONTH** but no later than the legislatively mandated deadline of 60 days after the end of the claim month. I understand that failure to submit claims within the 60-day deadline may result in such claims not being paid.

All receipts, invoices and other evidence of purchase must be retained and available for future audits for a period of three years after the date of the final submission of the final claim for the fiscal year to which they pertain, or longer if related to an audit or investigation in progress.

No further monies or other benefits may be paid out under the program unless this report is completed and filed as required by existing regulations (7 CFR 226).

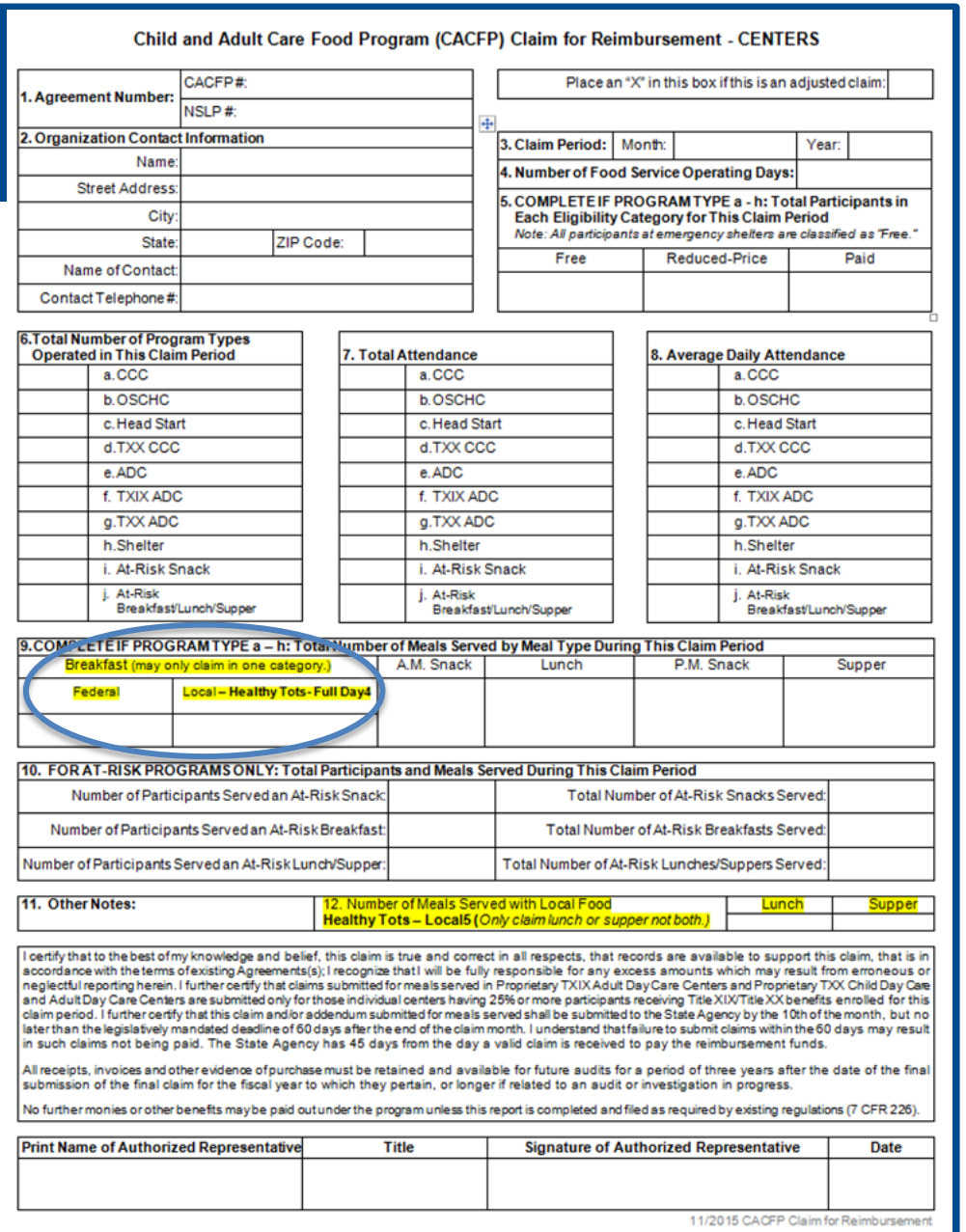
Date of Preparation	Title of Authorized Representative	Print Name
		Signature of Authorized Representative

Full Day4

Center Claim Form

Claiming **Full Day4**

- Record the number of breakfasts served in the "Full Day4 local breakfast" box.
  **only claim local breakfasts*
- Record the number of the "additional" meal in the appropriate box.



Child and Adult Care Food Program (CACFP) Claim for Reimbursement - CENTERS

1. Agreement Number:	CACFP #:
	NSLP #:
2. Organization Contact Information	
Name:	
Street Address:	
City:	
State:	ZIP Code:
Name of Contact:	
Contact Telephone #:	

Place an "X" in this box if this is an adjusted claim:

3. Claim Period:	Month:		Year:
4. Number of Food Service Operating Days:			

5. COMPLETE IF PROGRAM TYPE a - h: Total Participants in Each Eligibility Category for This Claim Period
Note: All participants at emergency shelters are classified as "Free."

Free	Reduced-Price	Paid

6. Total Number of Program Types Operated in This Claim Period	
	a. CCC
	b. OSCHC
	c. Head Start
	d. TXX CCC
	e. ADC
	f. TXIX ADC
	g. TXX ADC
	h. Shelter
	i. At-Risk Snack
	j. At-Risk Breakfast/Lunch/Supper

7. Total Attendance	
	a. CCC
	b. OSCHC
	c. Head Start
	d. TXX CCC
	e. ADC
	f. TXIX ADC
	g. TXX ADC
	h. Shelter
	i. At-Risk Snack
	j. At-Risk Breakfast/Lunch/Supper

8. Average Daily Attendance	
	a. CCC
	b. OSCHC
	c. Head Start
	d. TXX CCC
	e. ADC
	f. TXIX ADC
	g. TXX ADC
	h. Shelter
	i. At-Risk Snack
	j. At-Risk Breakfast/Lunch/Supper

9. COMPLETE IF PROGRAM TYPE a – h: Total Number of Meals Served by Meal Type During This Claim Period

Breakfast (may only claim in one category.)		A.M. Snack	Lunch	P.M. Snack	Supper
Federal	Local – Healthy Tots - Full Day4				

10. FOR AT-RISK PROGRAMS ONLY: Total Participants and Meals Served During This Claim Period

Number of Participants Served an At-Risk Snack:		Total Number of At-Risk Snacks Served:	
Number of Participants Served an At-Risk Breakfast:		Total Number of At-Risk Breakfasts Served:	
Number of Participants Served an At-Risk Lunch/Supper:		Total Number of At-Risk Lunches/Suppers Served:	

11. Other Notes:	12. Number of Meals Served with Local Food **Healthy Tots – Local5** (*Only claim lunch or supper not both.*)	Lunch	Supper

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 is in accordance with the terms of existing Agreements(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 claims submitted for meals served in Proprietary TXIX Adult Day Care Centers and Proprietary TXX Child Day Care and Adult Day Care Centers are submitted only for those individual centers having 25% or more participants receiving Title XIX/Title XX benefits enrolled for this claim period. I further certify that this claim and/or addendum submitted for meals served shall be submitted to the State Agency by the 10th of the month, but no later than the legislatively mandated deadline of 60 days after the end of the claim month. I understand that failure to submit claims within the 60 days may result in such claims not being paid. The State Agency has 45 days from the day a valid claim is received to pay the reimbursement funds.

All receipts, invoices and other evidence of purchase must be retained and available for future audits for a period of three years after the date of the final submission of the final claim for the fiscal year to which they pertain, or longer if related to an audit or investigation in progress.

No further monies or other benefits may be paid out under the program unless this report is completed and filed as required by existing regulations (7 CFR 226).

Print Name of Authorized Representative	Title	Signature of Authorized Representative	Date

11/2015 CACFP Claim for Reimbursement