

MENU AND MEAL COUNT REVIEW CHILD AND ADULT CARE FOOD PROGRAM

YOUR CLAIM _____ 19 _____

PROVIDER'S

Your claim: is ACCEPTABLE, no discrepancies
 has NOT been fully

DISALLOWED MEALS:

BRK AM SN LUN PM SUP EV SN

DATE(S)	MEAL/SNACK						Reason for
	B	A	L	P	S	E	

DATE(S) Did not effect claim reimbursement/errors noted:

Recommendations _____

APPEAL RIGHTS: You have the right to appeal any action taken by the CACFP that effects your CACFP claim. If non-reimbursement items are indicated above, you have 15 days from the date you sign this form to appeal to the review official listed to the right.

APPEAL OFFICIAL: COMMANDER, III CORPS & FORT HOOD
 ATTN: AFZF-CA-HSD-CYS
 Dixie Moffitt
 Program Operation Specialist
 Building #1802
 Fort Hood, Texas 76544

TOTAL REIMBURSEMENT _____

CACFP STAFF SIGNATURE: _____ DATE: _____

CACFP PROVIDER SIGNATURE: _____ DATE: _____