Claim Information Form (CIF)

Provider Name: *You must return this with your claim forms each month*

_______________________________ Monitor: _________________ **Provider ID:** ___________ Tier: _______

_______________________________ License: _________________ Phone: (____)________ Capacity: _______

_______________________________ License Exp: _________________ County: _____________ Tier Exp: ___/___/___

		Status	DOB	DOE	Age	Relation	Sp Needs	Sp Diet		School Level	Formula	Sex
1												
2												
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Open on Holiday: Date(s) : ___________________ Holiday(s) : ____________ Child(ren) now w/Doctor's Statement: # ____________

Children Starting Kindergarten/1st Grade: # ________ Grade : ____ # ________ Grade : _____ # ________ Grade : _____

Children leaving your care:

Name: ___________________________ # _____ Last Day in Care : ___ /___ /____

Name: ___________________________ # _____ Last Day in Care : ___ /___ /____

List all school aged children who attended AM Snack or Lunch:

____ Reason : ________________________________ Date : ____ /____ /_____

____ Reason : ________________________________ Date : ____ /____ /_____

____ Reason : ________________________________ Date : ____ /____ /_____

Legend

Relation

- O - Own Children
- F - Foster Children
- R - Related, Non-Resident
- N - Not Related
- H - Helpers Child

Status

- A - Active
- P - Pending
- W - Withdrawn

School Level

- A - A.M.
- D - A.M. Head Start
- H - Home School
- K - Kindergarten
- L - All Day Head
- M - P.M.
- N - No School
- P - P.M. Head Start
- S - School Age
- Y - Year Round School

Signature: ____________________________________ Date: ___ /___ /______