The University of the State of New York
THE STATE EDUCATION DEPARTMENT

Child Nutrition Reimbursement Unit
510 West, Education Building
Albany, New York 12234
(518) 474-3926

MONTHLY CLAIM FOR REIMBURSEMENT
(7/00)

SFA Name _____

SFA Code

LEA Code

Agreement Number

Claim Period Month Year

☐ **BREAKFAST** ☐ **LUNCH** ☐ **SNACK**

RA Name	RA Code	Enrollment	Days	Eligibles		Meals Served			Total
				Free	Reduced	Free	Reduced	Paid	

CONTACT

Name _____ Telephone Number _____

CERTIFICATION

I hereby certify that the information contained in this claim is accurate and the supporting documentation is available for review.

Signature of Authorized Person _____ Date _____