

Claim Information Form (CIF)

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	Rela tion	Pay Source	Parent Signature	Sex
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
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24								
25								
26								
27								
28								
29								
30								
31								
32								

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 Breakfast or Lunch:
 # _____ Reason : _____ Date : ____/____/____
 # _____ Reason : _____ Date : ____/____/____
 # _____ Reason : _____ Date : ____/____/____

Relation	School Level
O - Own Children	A - A.M. Kindergarten
F - Foster Children	D - A.M. Head Start
R - Related, Non-Resident	H - Home School
N - Not Related	K - Kindergarten
H - Helpers Child	L - All Day Head Start
	M - P.M. Kindergarten
	N - No School
	P - P.M. Head Start
	S - School Age
	Y - Year Round School
Status	
A - Active	
P - Pending	
W - Withdrawn	

Signature: _____ Date: ____/____/____