

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	Relation	Sp Needs	Sp Diet	Pay Source	School Level	Formula	Sex
1						<input type="checkbox"/>	<input type="checkbox"/>				
2						<input type="checkbox"/>	<input type="checkbox"/>				
3						<input type="checkbox"/>	<input type="checkbox"/>				
4						<input type="checkbox"/>	<input type="checkbox"/>				
5						<input type="checkbox"/>	<input type="checkbox"/>				
6						<input type="checkbox"/>	<input type="checkbox"/>				
7						<input type="checkbox"/>	<input type="checkbox"/>				
8						<input type="checkbox"/>	<input type="checkbox"/>				
9						<input type="checkbox"/>	<input type="checkbox"/>				
10						<input type="checkbox"/>	<input type="checkbox"/>				
11						<input type="checkbox"/>	<input type="checkbox"/>				
12						<input type="checkbox"/>	<input type="checkbox"/>				
13						<input type="checkbox"/>	<input type="checkbox"/>				
14						<input type="checkbox"/>	<input type="checkbox"/>				
15						<input type="checkbox"/>	<input type="checkbox"/>				
16						<input type="checkbox"/>	<input type="checkbox"/>				
17						<input type="checkbox"/>	<input type="checkbox"/>				
18						<input type="checkbox"/>	<input type="checkbox"/>				
19						<input type="checkbox"/>	<input type="checkbox"/>				
20						<input type="checkbox"/>	<input type="checkbox"/>				
21						<input type="checkbox"/>	<input type="checkbox"/>				
22						<input type="checkbox"/>	<input type="checkbox"/>				
23						<input type="checkbox"/>	<input type="checkbox"/>				
24						<input type="checkbox"/>	<input type="checkbox"/>				
25						<input type="checkbox"/>	<input type="checkbox"/>				
26						<input type="checkbox"/>	<input type="checkbox"/>				
27						<input type="checkbox"/>	<input type="checkbox"/>				
28						<input type="checkbox"/>	<input type="checkbox"/>				
29						<input type="checkbox"/>	<input type="checkbox"/>				
30						<input type="checkbox"/>	<input type="checkbox"/>				
31						<input type="checkbox"/>	<input type="checkbox"/>				
32						<input type="checkbox"/>	<input type="checkbox"/>				

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 : ____/____/____

<i>Legend</i>	
Relation	School Level
O - Own Children	A - A.M. Kindergarten
F - Foster Children	D - A.M. Head Start
R - Related,	H - Home School
Non-Resident	K - Kindergarten
N - Not Related	L - All Day Head Start
H - Helpers Child	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: ____/____/____