Nutrition Services

Administrative Resource Materials

Adult Care Centers

Fiscal Year 2027

July 1, 2026 – June 30, 2027

These resources you can photocopy for use in your center.
Other resources are available at the Nutrition Services website:
https://www.education.ne.gov/ns/forms-resources/child-and-adult-care-food-program

Adult Care Centers/Sponsors of Centers

- Income Eligibility Guidelines FY2027 (NS–402-G)
- Fiscal Year 2027 Income Eligibility & Enrollment Form – Adults (NS–200–G)
- Tip Sheet for CACFP Income Eligibility & Enrollment Form (NS–201–A)
- Claim for Reimbursement Worksheet (NS–401–G)
- Reimbursement Claim – Adult Care Centers
- State Treasurer ACH/W-9 Form (Direct Deposit application)
- CACFP Time-Certification Worksheet (NS–405–G)
- CACFP Site Review Form for sponsored centers (NS–406–G)
- CACFP Training Log (Sample) (NS–412–G)
- CACFP Monthly Expenditures Worksheet (NS–413–G)
- CACFP Procurement Log
- Nutrition Services Computer Access Application & Agreement for on-line Application & Claim Systems (NDE 01-033)

NEBRASKA DEPARTMENT OF EDUCATION

Nebraska Department of Education
Nutrition Services
Mailing Address:
P.O. Box 94987 Lincoln, Nebraska 68509
Physical Address:
500 S 84th Street Lincoln, Nebraska 68510
Toll Free: 800-731-2233
In Lincoln: 402-471-2967
Fax: 402-471-4407
http://www.education.ne.gov/NS/

NUTRITION SERVICES
INCOME ELIGIBILITY GUIDELINES

JULY 1, 2026 - JUNE 30, 2027

Household Size	Free Meals					Reduced Price Meals				
	Annual	Monthly	Twice per Month	Every Two Weeks	Weekly	Annual	Monthly	Twice per Month	Every Two Weeks	Weekly
1	20,748	1,729	865	798	399	29,526	2,461	1,231	1,136	568
2	28,132	2,345	1,173	1,082	541	40,034	3,337	1,669	1,540	770
3	35,516	2,960	1,480	1,366	683	50,542	4,212	2,106	1,944	972
4	42,900	3,575	1,788	1,650	825	61,050	5,088	2,544	2,349	1,175
5	50,284	4,191	2,096	1,934	967	71,558	5,964	2,982	2,753	1,377
6	57,668	4,806	2,403	2,218	1,109	82,066	6,839	3,420	3,157	1,579
7	65,052	5,421	2,711	2,502	1,251	92,574	7,715	3,858	3,561	1,781
8	72,436	6,037	3,019	2,786	1,393	103,082	8,591	4,296	3,965	1,983
For each additional family member add:	7,384	616	308	284	142	10,508	876	438	405	203

If households report multiple frequencies of pay, total income must be calculated on an annual basis. Use the following conversions:
Annual Income Conversion: Weekly X 52; Every 2 Weeks X 26; Twice a Month X 24; Monthly X 12

Dear Participant or Adult Family Member or Guardian:
Our adult care institution has been approved by the Nebraska Department of Education for participation in the Child and Adult Care Food Program (CACFP). The CACFP reimburses our institution for the partial cost of meals. We are requesting your help to receive the maximum benefits from the CACFP by completing the attached form (NS)200-C. All information contained on this form is ***confidential.***

The participant/adult family member/guardian must complete Parts 1 and 4 and one of the following options*:* Part 2, Part 3A or Part 3B, to determine the amount of CACFP funds the center will be eligible to receive. This form will be placed in our files and treated as confidential information. **Note:** No ***white out*** or ***eraser ink*** should be used**.** If there is an error cross through, correct, and initial.

Part 1 – PARTICIPANT ENROLLMENT
- Participant's Name: List the first and last name of participant.
- Date of Birth: List participant's date of birth.
- Enrollment Date: List participant's enrollment date with organization.

Optional: Check the boxes of all appropriate race(s) and ethnicities regarding the participant being enrolled.

Part 2 - Households receiving *benefits* from the Supplemental Nutrition Assistance Program **(SNAP),** Temporary Assistance for Needy Families **(TANF),** Food Distribution Program on Indian Reservations **(FDPIR), SSI or Medicaid:**
- Complete Parts 1, 2 and 4 on the attached form.
- Provide the name and case number for the program from which benefits are received.

Part 3A - Household **exceeding** the income guidelines listed on the chart below:
- Complete Parts 1, 3A and 4 on the reverse side.

TO CALCULATE ANNUAL INCOME

Weekly Income X 52 ♦ Every 2 Weeks Income X 26 ♦ Twice a Month Income X 24 ♦ Monthly Income X 12

Household Size:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	Each Additional Family Member
Annual Income:	$29,526	$40,034	$50,542	$61,050	$71,558	$82,066	$92,574	$103,082	+ $ 10,508

Part 3B - Household **below** the income guidelines listed complete as follows - Complete Parts 1, 3B and 4 on the attached form with the additional information below:
- HOUSEHOLD NAMES: Write the names of everyone in the household. Include participant, participant's spouse, and/or any other individuals who reside with the participant and depend on the participant for economic support. Functionally impaired adults living with their parents are considered a "family" separate from their parents.
- GROSS INCOME BEFORE DEDUCTIONS: Write the amount of income each person gets on the same line as their name. Use the appropriate column(s): Earnings from Work, Welfare/Child Support/Alimony, Pensions/Retirement/Social Security or Other Income (see list below). Next to the amount of income write how often the income is received. Income is all money before taxes or anything else is taken out. If a person does not have income, check the box for zero income.
  OTHER INCOME: Strike benefits, unemployment compensation, workman's compensation, disability benefits, interest/dividends, cash withdrawn from savings, income from estates/trusts/investments, royalties/annuities/rental income, regular contributions from person not living in the household.
  MILITARY HOUSING BENEFITS: Report off-base housing allowance as income. If the housing is part of the Military Housing Privatization Initiative, do not include as income.
  SELF-EMPLOYMENT: Report income derived from the business venture less operating costs for net income. The loss from the business cannot be deducted from a positive income earned in other employment. The least possible income is zero.
- SOCIAL SECURITY NUMBER: Write the last four (4) digits of the social security number of the participant or adult family member or guardian who signs the forms. If the participant or adult family member or guardian does not have a social security number, check the box. Use of this information is for CACFP use only and is required.

Part 4 SIGNATURE AND CONTACT INFORMATION:
- Sign and date the application. The form must be signed by the participant or an adult family member or guardian.
- Complete the contact information – name, address, telephone number, and employer information.

Privacy Act Statement:
The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, the funds your adult care center receives may be impacted. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-Discrimination Statement:
In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20PComplaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **Mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW Washington,
   D.C. 20250-9410; or
2. **Fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **Email:**
   program.intake@usda.gov

This institution is an equal opportunity provider.

As stated above, all protected bases do not apply to all programs, "*the first six protected bases of race, color, national origin, age, disability and sex are the six protected bases for applicants and recipients of the Child Nutrition Programs.*"

For assistance completing this form, contact the center:

Center Name:_____

Address: _____

City, State, Zip:_____

Center Contact Person:_____

Telephone: _____

The State Agency administering the Child and Adult Care Food Program is:
Nebraska Department of Education
Nutrition Services
P.O. Box 94987
Lincoln, NE 68509
Telephone: 402-471-2488
Web site: http://www.education.ne.gov/NS

REVISED 4/2026

INCOME ELIGIBLITY AND ENROLLMENT FORM FOR ADULT CARE CENTERS

July 1, 2026 THROUGH June 30, 2027

Part 1. PARTICPANT: Complete the participant's name, date of birth, it is optional to complete the ethnicity, and race.

Last Name, First Name	Date of Birth	Enrollment Date

OPTIONAL: Please check the ethnicity and race of the participant you are enrolling.

Ethnicity (select one or more): ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Race (select one or more): ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ White or Caucasian ❑ Native Hawaiian or other Pacific Islander

Part 2. Households receiving *benefits* from the Supplemental Nutrition Assistance Program (**SNAP**), Temporary Assistance for Needy Families (**TANF**), Food Distribution Program on Indian Reservations (**FDPIR**), Supplemental Security Income (**SSI**), or **Medicaid.** Complete Part 1, 2 and 4.

Check Applicable Program(s): ❑ **SNAP** ❑ **TANF** ❑ **FDPIR** ❑ **SSI** ❑ **Medicaid** **Master Case #**_____

Part 3A Households **exceeding** the income guidelines (listed on the attached letter), check this box. ❑

Part 3B. ALL OTHER HOUSEHOLDS - If you do not receive SNAP, TANF, PDPIR, SSI or Medicaid household benefits, complete Parts 1, 3B and 4.

	REPORT GROSS INCOME BEFORE ANY DEDUCTIONS (Net for Self Employed) **Frequency of pay codes: W**=Weekly **E2**=Every 2 weeks **2M**=Twice a month **M**=Monthly **Y**=Yearly								
List the Names of All Household Members *including* participant.	**Earnings from Work**		**Welfare, Child Support, Alimony**		**Pensions, Retirement, Social Security**		**All Other Income** (see instructions)		Check if **Zero** Income
	How much?	How Often?	How much?	How Often?	How much?	How Often?	How much?	How Often?	
1									❑
2									❑
3									❑
4									❑

Last four digits of Social Security Number: XXX-XX _____ If you do not have a Social Security Number, check this box ❑

Part 4. Signature and Contact Information

I certify that all information on this form is true and that all income is reported. I understand that the facility will receive Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose their meal benefits, and I may be prosecuted.

_____ _____
Signature of Participant or Adult Family Member or Guardian Date of Signature

***OPTIONAL**: Guardian Contact Information:*

_____
Print Name

_____
Address City State Zip

Email address: _____ *Telephone #:* _____

Center Use Only

_____ SNAP/TANF/FDPIR/SSI/MEDICAID - Household (must have a master case #)

_____ Annual Income: $ _____ Household Size _____

_____ _____
Center Official Signature Date of Signature

_____ _____
Effective Date Expiration Date

Household Meal Benefit Category:
- ❑ Free
- ❑ Reduced
- ❑ Paid
- ❑ Incomplete

Among the most common problems found at centers during monitoring reviews and audits are enrollment forms not on file or updated and incomplete or incorrectly classified Income Eligibility Forms (IEFs). By following the instructions in this tip sheet, centers can avoid costly errors that could result in paying money back to the State.

The information that each center must give to households includes three items. These are:

Page 1 – Cover Letter to Households & Instructions

Page 2 – Civil Rights and Center Contact Information

Page 3 – Adult Enrollment and Income Eligibility Form

The Nebraska Department of Education Nutrition Services (NDE) provides each institution with an original of the items listed above. Institutions must fill in the center contact information on Page 2 of the Form (NS-200-C) before photocopying them. This includes the center's name, address, phone number and contact information, such as center name and director's signature. Each institution will need to make enough photocopies to distribute to the households of all participant enrolled at the center.

Enrollment and Income Eligibility Form (IEF) – Adult Care Centers (NS-200-C)
All participants who are being claimed for meals for reimbursement in the free or reduced category must have a current *Enrollment and Income Eligibility Form* completed by the household and on file with your institution.

Part 1 – PARTICIPANT ENROLLMENT
Participant's Name: List the first and last name including nicknames and hyphenated last name for all participant enrolled at this center. Nicknames, abbreviations, initials, etc. are not acceptable.
Date of Birth: List participants' date of birth.
Enroll Date: List participants' enrollment date with the organization.
Ethnicity/Race: Using the codes provided, enter the codes for ethnicity and race.

Racial/Ethnic Identity of Participant
Households are asked to report the ethnicity and race of the participant enrolled for care. This is optional for households, however, centers are required to gather and report this information each year. If the household did not mark this section, the center may fill this section out to the best of their ability and initial this section in the margin to document they completed this section.

Definitions Ethnicity:
1. Hispanic or Latino. An individual of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino."
2. Not Hispanic or Latino.

Definitions Race:
1. American Indian or Alaskan Native. A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
2. Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
3. Black or African American. A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to 'Black or African American.
4. Native Hawaiian or Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
5. White. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Part 2 - Benefit Information
If the household receives benefits from Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Food Distribution Program on Indian Reservations (FDPIR), Social Security Income (SSI) or Medicaid this information is to be recorded on Part 2 of the Adult Enrollment and Income Eligibility Form.

In addition to providing Part I with the general information for each participant, the household must check (✓) what benefits they are currently receiving and their master case number on the line provided.

The master case number must be listed. **SNAP, TANF FDPIR, SSI and Medicaid** are the **only** programs that qualify for automatic eligibility in the Free category in adult care centers.

Part 3A – Household **exceeding** the income guidelines provided - Complete Parts 1, 3A and 4 on the attached Enrollment and Income Eligibility form. Households are not required to provide adult care centers with their household income. If centers are using this as an enrollment form an adult/guardian is still required to sign and date the form.

Part 3B - Household **below** the income guidelines provided in the cover letter are to complete Parts 1, 3B and 4 on the Enrollment and Income Eligibility Form.

HOUSEHOLD NAMES: Write the names of all household members not listed in Part 1. All individuals residing in the household are to be listed spouses, children, other relatives and unrelated people in the household who are living as an economic unit.
GROSS INCOME BEFORE DEDUCTIONS: The amount of income each person receives is to be documented on the same line as their name. Columns are provided for different sources of income: Earnings from Work, Welfare/Child Support/Alimony, Pensions/Retirement/ Social Security or Other Income (see list). Next to the amount of income households need to identify how often the income was received. Income is all money before taxes or deductions. If a person does not have income, check the box for zero income.

- OTHER INCOME: Strike benefits, unemployment compensation, worker's compensation, disability benefits, interest/dividends, cash withdrawn from savings, income from estates/trust/investments, royalties/annuities/rental income, and regular contributions from persons not living in the household.
- MILITARY HOUSING BENEFITS: Report on off-base housing allowance as income. If the housing is part of the Military Housing Privatization Initiative, do not include as income.
- SELF-EMPLOYMENT: Report income derived from the business venture less operating costs for net income. The loss from the business cannot be deducted from a positive income earned in other employment. The least possible income is zero.

SOCIAL SECURITY NUMBER: Write the last four (4) digits of the social security number of the adult household member who signs the form. If the adult household member does not have a social security number, check the box. Use of this information is for CACFP use only and is required.

For Center Use Only
Every application that is returned to the adult care center must be determined by center personnel. The section "For Center Use Only" must be completed for every IEF returned to the center.

The application will be based either on 1) categorical eligibility (case number and benefits) reported in Part 2, or 2) household size and income reported in Part 3b. The eligibility determination must be made by the center, indicating the application is determined 1) Free, 2) Reduced or 3) Paid.

Participants receiving benefits from SNAP, TANF, FDPIR, SSI or Medicaid should be determined in the free category if a master case number for one of those programs is listed. If Part 2 is complete, it is not necessary for the household to complete Part 3b.

When determining eligibility based on household income, indicate the total number of household members listed on the application and the total annual household income from Part 3b. The total number of persons in the household should equal the number of names listed on the IEF. Make sure names in Part 3b are not duplicated from Part 1 or Part 3b.

Income Conversions
Income calculations are made based on the following formulas:

- Monthly (M) income is calculated by **multiplying** the income by 12;
- Twice monthly (2M) income is calculated by **multiplying** by 24;
- Every two weeks (E2) is calculated by **multiplying** by 26;
- Weekly (W) income is calculated by **multiplying** the income by 52.

All numbers are rounded upward to the next whole dollar.

If households indicate $0 income OR check (✓) the "Zero Income Box" the IEF is determined in the Free category. (NOTE: If Part 3b income is left blank, the IEF is incomplete and determined Paid.)

The person who made the eligibility determination must sign the application and indicate the date the determination was made and signed (Date of Signature). The date determined by the center's determining official must be the same or later than the date signed by the adult household member or guardian. An effective date of the application must be given. The effective date may be dated as early as the first of the month in which the center official made the eligibility determination. This will allow the center to claim meals served to eligible participants in the free or reduced price categories at the beginning of the month in which the application was determined to be free or reduced price, if the center has enrollment documentation to show the participant was enrolled at the center on that date and was served a creditable meal**. Meals may not be claimed in the free or reduced price categories before the effective date of the application.**

Each spring NDE issues new Enrollment and IEFs to be used by centers for the period July 1 through June 30 of the following fiscal year.

Expiration date - All IEFs are valid for one year. NDE encourages all centers to solicit new IEFs annually during June and July, to coincide with the effective dates of the income eligibility guidelines. IEFs should be considered current and valid until the last day of the month in which the IEF was made effective one year earlier. This means that if an IEF was effective on September 12th, 2026, it is considered valid until September 30, 2027. IEFs must be kept on file for four years for all participants whose meals are being claimed on the program.

Review the information provided by the household in making your eligibility determination. If you are doubtful about the accuracy or completeness of any information provided by a household, contact them for additional information or clarification. If you obtain additional information from households via telephone or other means, indicate the date, the information received and initial the clarification on the IEF.

Service Provider Agreements (Title XX or other payment authorizations) do not qualify participants for free or reduced price meal rates. The only document that may be used for determining eligibility is the IEF.

For more information contact*:*
Nutrition Services
Nebraska Department of Education
P.O. Box 94987
Lincoln, Nebraska 68509
Telephone: (402) 471-2967 or (800) 731-2233

NON-DISCRIMINATION STATEMENT:

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf , from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. Mail:
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or

2. Fax:
   (833) 256-1665 or (202) 690-7442; or

3. Email:
   program.intake@usda.gov

This institution is an equal opportunity provider.

As stated above, all protected bases do not apply to all programs, *"the first six protected bases of race, national origin, age, disability and sex are the six protected bases for applications and recipients of the Child Nutrition Programs."*

CACFP Claim Deadline

Month	**Last day for submission (60th day)**
January	April 1 (Leap Year—March 31)
February	April 29
March	May 30
April	June 29
May	July 30
June	August 29
July	September 29
August	October 30
September	November 29
October	December 30
November	January 29
December	March 1 (Leap Year—February 29)

Claim for Reimbursement Worksheet
NS-401-G
Revised April 2009

Center:	Agreement Number:	Month, Year:

	NUMBER OF MEALS SERVED																		**ATTENDANCE***
	Breakfast			AM Snack			Lunch			PM Snack			Supper			EV Snack			How many participants were served?
Date	F	R	P	F	R	P	F	R	P	F	R	P	F	R	P	F	R	P	
1																			
2																			
3																			
4																			
5																			
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31																			
TOTAL																			
	A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**	**M**	**N**	**O**	**P**	**Q**	**R**	**S**

*** Daily Attendance** is the total number of different participants who were served at least one meal during the day. Column S is the number of participants present during the day, not a total of the number of meals served.

Calculating Average Daily Attendance (ADA)

_____ ÷ _____ = _____
Total in column S ÷ Days served = ADA

Round ADA up to the next highest number.

Before submitting your claim, review these Edit Checks

1. Is the center approved to claim the meals noted above?
2. The total meal count for any meal may not exceed the total attendance for the month.
3. The same number of meals claimed for one or more meal types is not identical for 15 consecutive days in the month; this is block claiming. If the number of meals claimed for one or more meal types is identical for 15 consecutive days, follow-up by the center sponsor is required. Follow-up must be documented for each center.

Return to:
Nebraska Department of Education
Financial Services
P.O. Box 94987
Lincoln, Nebraska 68509-4987
Fax Number (402) 471-0117 or (402) 471-4407

NDE 28-017
(Revised 1/2011)
Date Due: 10th day of the month following the Month Being Reported

Date Received by NDE	

RESET FORM

Reimbursement Claim: Adult Care Centers

Sponsor/Center Fax Number: ( ) _____ Submission Type: Original ☐ Revised ☐

Sponsor Information			
Sponsor's Name	**Sponsor Number**	**Site Name**	**Month/Year Claimed**

Attendance Reporting	
Number of Days Meals were Provided	
Average Daily Attendance	
Title XX Participants (For Profit Centers only)	

Eligibility			
Number of Free	**Number of Reduced Price**	**Number of Paid**	**Total Eligible**
			0

Regular Meals Served Only (Do not include At-Risk Meals)				
Meal Type	**Free Meals (A)**	**Reduced Meals (B)**	**Paid Meals (C)**	**Total Meals (A+B+C)**
Regular Breakfasts				0
Regular A.M. Snacks				0
Regular Lunches				0
Regular P.M. Snacks				0
Regular Supper				0
Regular Evening Snack				0

At-Risk Meals Only
(Meals claimed At-Risk cannot be claimed above in Regular Meals)
Do not include any meals that are claimed above. Breakfasts and Lunches may be claimed only on school's out days, vacation days (e.g., winter and springs break) and weekends during the school year.

Meal Type	Number Days Served	Number of At-Risk Participants	Average Daily Attendance	Meals Served
At-Risk Breakfasts				
At-Risk A.M. Snacks				
At-Risk Lunches				
At-Risk P.M. Snacks				
At-Risk Supper				
At-Risk Evening Snack				

I certify that to the best of my knowledge and belief, this claim is true and correct in all aspects; records are available to support the claim; the claim is in accordance with existing agreement; and payment has not been received or requested. I further certify that claims submitted for meals served in For-Profit Centers are submitted for those centers having 25% or more participants receiving Title XX benefits or eligible for Free or Reduced meals for this claim period.

Date of Preparation _____ Title _____ Signature of Authorized Representative _____

INSTRUCTIONS – ADULT CARE CENTERS

If you are submitting the claim via the WEB, you do not need to send a claim form to the Department of Education. However, you must retain the original on file with the Authorized Representatives signature. If you are submitting the claim via the WEB, you have until the 10th day of the month to input and submit the claim on line.

Claims not submitted via the WEB, are due the 10th day of the month following the reporting month and must be submitted by the calendar month. No month's meal counts can be combined with another month's counts regardless of the number of days served.

Sponsor Information

Complete the Sponsor's Name, the correct 6-digit agreement number (county-district number), the Month and Year of the claiming month. Check the type of submission of claim, either original claim or revised claim. If you are not submitting the claim via the WEB, report the fax number under the "Date Received by NDE".

Attendance Reporting

Report the Number of days meals are provided for the month being reported.
Report the Average Daily Attendance.
For-Profit Centers must report the Number of Title XX Participants.

For-Profit Sites Only

The following calculation for the Title XX participants: Divide the number of Title XX participants or Eligible Free and Reduced participants by the lessor of the License Capacity or Total Enrollment. If the resulting percentage is **LESS** than 25%, you cannot claim the meals served at that site.

Eligibility

Report the number of children enrolled that are eligible for Free meals, Reduce priced meals, and Paid meals. Report the Total number of children enrolled. Must equal the sum of eligible Free plus Reduce plus Paid.

Regular Meals Served

Report the number of meals served to children by meal type (breakfast, a.m. snack, lunch, p.m. snack, supper, and evening snack) and by eligibility type (Free, Reduced Price, or Paid).

Report the Total number of Breakfasts, A.M. Snacks, Lunches, P.M. Snacks, Suppers, and Evening Snacks. Must equal the sum of Free plus Reduced Price plus Paid.

P.M. Snacks means snacks served in the afternoon.

At-Risk Meals

Do not include any meals that are claimed above. Breakfasts and Lunches may be claimed only on school's out days, vacation days (e.g., winter and spring break) and weekends during the school year.

The Authorized Representative must sign and date the claim form.

(Rev. November 2024) Clear Form

STATE OF NEBRASKA W-9 & ACH ENROLLMENT FORM

PLEASE SUBMIT FORM TO INVOICED AGENCY

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following boxes:

☐ Individual ☐ Sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/Estate

☐ Non-Profit Entity ☐ Government (Local, State or Federal)

☐ Limited Liability Company. Enter the tax classification (C = C Corporation, S = S Corporation, P = Partnership) ____

☐ Other (see instructions) _____

Note: Enter the owner's name on line 1 and mark the appropriate federal tax classification box for disregarded entities.

4 Exemptions (see instructions): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____

5 Address:

Remit Address (if different):

6 City, state, and ZIP code

City, state, and ZIP code

Taxpayer Identification Number (TIN):

Social Security Number (SSN): _____-_____-_____ **OR** Employer Identification Number (EIN): _____-_____

Month & Year Tax Id/Name changed

Certification:

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding due to failure to report interest and dividend income, and
3. I am a U.S. citizen or other U.S. person (defined in the instructions), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

For additional instructions please refer to http://www.irs.gov/pub/irs-pdf/fw9.pdf to obtain a copy of the IRS Form W-9 General Instructions.

Signature of US Person:_____ Date: _____

Printed Name: _____ Contact Phone:_____

Comments or Business/Entity Notes:

ACH Enrollment: ☐ Initial Setup ☐ Change ☐ Close Account

This information is REQUIRED to process ACH payments. Without this information, your payment may be delayed.

Financial Institution Name:	Nine Digit Routing Number:	Prior Routing Number: *	☐ Check here if the bank is outside of the United States.
Address:	Depositor Account Number:	Prior Account Number: *	☐ Check here if our payments to you are being forwarded from a U.S. financial institution to a financial institution in another country
City, state and ZIP code:	Type of Account: ☐ Checking ☐ Savings	* Prior ACH instructions are required to be completed if changing/updating your ACH instructions with the State of Nebraska.	

This account will be used for all payments by the State of Nebraska unless specified here: _____

E-mail:_____

(Used for ACH payment notifications.)

Authorized Individual or Entity Signature:	**Attachment Required!** (Select and attach **one** of the following items for verification):
Printed Name:	☐ Blank check (voided) or ☐ Photocopy of a cleared check
Date	☐ Letter from your financial institution
	☐ Vendor invoice or letter which contains printed ACH instructions

AGENCY APPROVAL #1 -Signature: **DATE:**

AGENCY APPROVAL #2 -Signature: **DATE:**

CACFP Time Certification Documentation Worksheet

INSTRUCTIONS: This worksheet must be completed for staff performing Child and Adult Care Food Program duties if any CACFP funds are used for salaries. Indicate the total number of hours per day spent on activities related to the CACFP. *Staff must be listed in the staff profile on the CNP online system.*

Examples of CACFP Food Service activities: menu planning, menu production records, grocery shopping, cooking and serving meals, clean-up after meals, point of service meal counts, attending in-services related to nutrition and food safety, maintaining commodity inventory, etc.

Examples of CACFP Administrative activities: application process, claims, IEF/enrollment forms, attendance records, printing, copying, data processing, etc.

This entire form must be completed if you are using time certification to document a nonprofit food service operation.

Employee Name (please print legibly) _____ Month/Year:_____

Date	Hours Worked on CACFP		Total Day Care Hours Worked	Date	Hours Worked on CACFP		Total Day Care Hours Worked
	Food Service	CACFP Administrative			Food Service	CACFP Administrative	
1				17			
2				18			
3				19			
4				20			
5				21			
6				22			
7				23			
8				24			
9				25			
10				26			
11				27			
12				28			
13				29			
14				30			
15				31			
16				**TOTAL**			

I certify that this is an accurate record of the number of hours worked on the Child and Adult Care Food Program.

_____

Employee Name (please print legibly) Employee's Signature Date

MUST BE COMPLETED BY CENTER DIRECTOR/CACFP AUTHORIZED REPRESENTATIVE

A. (HOURLY PAID STAFF)

Total hours worked on **FOOD SERVICE** _____ x $_____ (hourly wage) = $_____ (Total CACFP salary)

Total hours worked on **CACFP ADMINISTRATION** _____ x $_____ (hourly wage) = $_____ (Total CACFP salary)

B. (SALARIED STAFF)

Total hours worked on **FOOD SERVICE** _____ ÷ Total hours worked _____ = _____%

↕

Total Salary for month $_____ x _____% = $_____(Total CACFP salary)

Total hours worked on **CACFP ADMINISTRATION** _____ ÷ Total hours worked _____ = _____%

↕

Total Salary for month $_____ x _____% = $_____(Total CACFP salary)

I certify that payroll records are on file that verify the total wages as listed above.

Signature of Center Director/Authorized Representative_____ Date _____

CACFP Training Log

Name of Sponsor: _____ Agreement #:_____

Topic/Description:

_____

_____

_____

_____

_____

_____

Presenter(s): _____

Date: _____

Signature of Participants:

_____

_____

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_____

_____

Attach copies of agenda, meeting minutes, handouts, summary, etc.

Child and Adult Care Food Program
SPONSOR MULTI-SITE REVIEW FORM

Date of Review		**Time In**		**Time Out**	
Sponsor Name					
Site Name					
Site Address			**Telephone #**		
City, State, Zip Code					
Site Contact					
Reviewer					

Each site must be reviewed at least three times annually. At least two of the three reviews must be unannounced and at least one unannounced review must include the observation of a meal service. Reviews cannot be more than six months apart. *Preapproval visits* must be conducted at new sites prior to the beginning of program participation and reviewed again within the first four weeks of CACFP operation.

Type of Review ☐ Pre-Approval ☐ First Four Week ☐ Regular Review ☐ 1 ☐ 2 ☐ 3 ☐ Follow-Up: _____	☐ Announced ☐ Unannounced ☐ Meal Visit ☐ Non-Meal Visit **BR AM LU PM SU EV** Circle Meal Observed

Summary of previous review - identify the errors and concerns observed
Identify how errors were corrected and resolved from the previous review
If applicable, summary of the computer system error report

*Denotes responses included in the Report Summary

SECTION I. Recordkeeping	YES	NO	*
1. Income Eligibility Forms (IEF) are current and complete for all participants whose meals are claimed in the Free and Reduced meal benefit categories			
Number of IEF's Reviewed			
Number of IEF's in Error /Missing			
2. Enrollment forms are current and complete for all claimed participants			
Number of Enrollments Reviewed			
Number of Enrollments in Error/Missing			
3. Attendance records match the number of children observed by the reviewer			
Number of Children in Attendance			
4. Meal count records are up to date through the current meal service			
5. Meal count records are not pre-recorded or marked for meals that have not occurred			
6. Menu Production Records are up to date and/or delivery tickets are current through the last meal service			

Section I Recordkeeping - Report Summary

(Provide specific errors identified such as names of children with missing IEF's, meal count errors, etc., and how the errors were deducted prior to claiming if applicable.)

SECTION II. MEAL OBSERVATION

Type of Food Service (check one)

☐ Vended. Name of vendor(s): _____

Meal Types that are vended: ☐ BR ☐ LU ☐ SN ☐ SU

☐ All meals are self-prepared

☐ Prepared by the sponsoring organization at a central location and delivered to this site

☐ Combination of vended and self-preparation. (Indicate vended meals above)

MEAL OBSERVED: ☐ Breakfast ☐ Lunch ☐ Snack AM/PM/EV ☐ Supper

Ages & Number of Participants Observed:

1 Year: _____ 2 Years: _____ 3 – 5 Years: _____ 6 Years & Above: _____ Total Number: _____

Component	Food Prepared	Quantity Prepared
Meat/Meat Alternate		
Vegetable		
Vegetable/Fruit		
Grains/Bread		
Milk (Identify fat content)		
Other		

SECTION II. MEAL OBSERVATION (continued)	YES	NO	*
1. The meal observed met the CACFP meal pattern (Attached copy of Menu Production Record/Vendor Ticket)			
2. The site served the minimum CACFP portions to each participant			
3. The meal counts were made at the point of meal service			
4. The number of meals recorded match the number of meals observed by the reviewer			
5. Meals were served according to the mealtimes listed on the site application			
6. The site served the required fat content of milk to each age group			
7. *Identify the meal/snack a whole grain-rich was served on day of review:*			
8. Water is offered and made available to the participants throughout the day			
11. Sanitary conditions are maintained in the food preparation and service area			
12. Participants wash their hands before the mealtime with soap and running water			

SECTION III. MEAL PATTERN REVIEW	YES	NO	*
1. The site served at least one whole grain-rich item daily based on current month menus			
2. The site served ready to eat cereals that met the sugar limits			
3. The site served yogurt that met the sugar limits			
4. Labels for whole-grains, ready to eat cereals and yogurt were available for review			
4. The sited served commercially prepared, or combination foods based on current month menus			
4a. Supporting documentation is on file for these foods (Child Nutrition Label or Product Formulation Statements). Please refer to USDA Crediting Handbook.	`		
5. The site has participants with special diets or meal modifications			
5a. Medical statement(s) or meal accommodation forms are on file for these participants			

Section II & III Meal Pattern Review & Meal Observation - Report Summary

(Provide specific errors identified such as dates and meals missing production records, failing to meet meal pattern, no labels on file, etc., and how the errors were deducted prior to claiming if applicable.)

SECTION IV. CIVIL RIGHTS	YES	NO	*
1. The "And Justice For All" civil rights poster is displayed in a prominent location			
2. Admission and placement criteria/procedures are nondiscriminatory			
3. Participants are not separated by race, color, national origin, sex, age, or disability in the following areas: eating area, serving lines, seating arrangements, assignment of eating period			
4. All services and facilities are routinely used by all persons regardless of race, color, national origin, sex, age, or disability			
5. The non-discrimination statement and the procedure for filing a complaint has been provided to all participants and beneficiaries concerning the program and program activities. (The reviewer needs to ensure all households receive a copy of the non-discrimination statement that is located on Page 2 of parent letter of the IEF packet.)			

Section IV Civil Right - Report Summary

SECTION VI. INFANT PROGRAM (Complete if site has infants in care)	YES	NO	*
Name of Formula offered by the Sponsor:			
1. Each enrolled infant has a complete Infant Formula Selection Form on file which includes: • Name of Formula offered • Parent/Guardian has accepted or declined formula offered • Parent/Guardian signature and date			
2. Infants who are developmentally ready for service of solid foods have documentation of parental/guardian approval for the service of specific solid foods (The reviewer is responsible to assure this information is **current)**			
3. USDA Infant Meal Pattern is met based on each infants' nutritional needs and documentation of approved foods to be served by parent/guardians (The reviewer is responsible to conduct a comparison between the approval of solid food permission for each infant against the foods provided & meals claimed)			
4. Infant production records are complete for all meals claimed through the current meal service			
5. Meal count records are up to date for infants			

Section IV Infant Program - Report Summary

(Provide specific errors identified such as infant production errors, missing formula selection forms, foods served do not correspond to solid permission form, etc., and how the errors were deducted prior to claiming if applicable.)

General Comments

Section V Five Day Reconciliation – Report Summary (Page 5-6)

(Outline the errors identified and how the errors were deducted prior to claiming.)

Signature of Site Representative: _____ Date: _____

Signature of Reviewer: _____ Date: _____

5-Day Reconciliation (complete attached worksheet - copy additional pages as needed).

A reconciliation of meal counts for five consecutive days must be included as a part of each facility review conducted by a sponsor. Five-day reconciliation is completed on **10 percent** of the center's enrolled participants, with a minimum of five participants being included in the reconciliation.

1. Gather meal counts, current enrollment forms and attendance records.
2. Choose five consecutive operating days from the meal count records.
3. **Choose a 10 percent** sample of enrolled participants (or a least five participants) and record each participant's full name and usual days/times and meals from the enrollment form.
4. Evaluate the center's enrollment records to ensure that they are current and accurate.
    a. Enrollment records include
        - Participant's name
        - Date of birth
        - Date care began
        - Signature of adult household member
        - Usual times in care and days in care (childcare centers only; optional if parent check child in and out)
        - Usual meals served while in care (childcare centers only; optional if parent checks child in and out).
    b. Enrollment records must be complete and signed and dated by the adult household member within the past 12 months (childcare centers only; one time enrollment for adult care centers)
5. Check to see that time in/out attendance records are on file for every participant.
6. Record all meals claimed for the sample during the identified five-day time period.
7. Compare usual days/times in care and attendance records with the meals claimed for reimbursement for your participant sample. Note any discrepancies.
8. If meal counts and attendance cannot be reconciled, the regulations require the reviewer to determine whether the establishment of an overclaim is necessary.

Additional edit checks if discrepancies are observed: (REF: MEMO CACFP 10-2018: Conducting Five-Day Reconciliation)

- Determine number of children in attendance during the five-day period.
- Compare each day's total meal counts to daily attendance to ensure meal counts do not exceed number in attendance for each day.
- Compare total enrollment to daily attendance to ensure attendance did not exceed enrollment for any day in the five-day period (in facilities where enrollment forms are required). If attendance does exceed enrollment, for any day or any shift (if shift care is provided), the reviewer must determine the source of the error (e.g., inaccurate attendance records, missing enrollment forms) before a five-day reconciliation can be completed.
- Compare the center's total meal counts to its licensed capacity. Meal counts for any day or any shift (if shift care is provided) should never exceed licensed capacity.

FIVE-DAY RECONCILIATION WORKSHEET
CACFP SITE REVIEW

Name of Site:____________________________________ **Week of** ______________________

Child's Name	Enrollment Form			Week of:____________		Circle Meals Claimed
	Meals	Days in Care	Times	Days & Times in Attendance		
John Doe	B A L P S E	M-F	8am-5pm	1/1/17	8:00am-5:00pm	B A L P S E
				1/2/17	8:00am-5:00pm	B A L P S E
				1/3/17	8:00am-5:00pm	B A L P S E
				1/4/17	8:00am-12:00pm	B A L P S E
				1/5/17	Absent	B A L P S E
	B A L P S E					B A L P S E
						B A L P S E
						B A L P S E
						B A L P S E
						B A L P S E
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						B A L P S E

CACFP MONTHLY EXPENSES NS-413-G Rev. April 2017

MONTH/YEAR_____ Page ___ of ____

Check No.	Date	Name of Payee/Vendor	Food	Non food Supplies	Unallowable Costs	Food Service Labor	Admin Labor	Admin Costs	Food Service Equipment	Other		
										Description	Amount	Grand Total
		TOTAL										
											Less Unallowable Costs	
											Total CACFP	

CACFP reimbursement $ _____ Nonprofit food service? YES NO

Percentage of CACFP reimbursement used for food/nonfood supplies $_____

Reminder: All centers need to report their CACFP monthly expenses to NDE when submitting their claim on the online system.

INFORMAL PROCUREMENT LOG

Institution Name:_____

Items typically Purchased	Quantity Expected to Buy	Vendor:		Vendor:		Vendor:	
		Unit Price	Extended Price (Quantity x Unit Price)	Unit Price	Extended Price (Quantity x Unit Price)	Unit Price	Extended Price (Quantity x Unit Price)
TOTAL			$		$		$
✓ Vendor Selected		☐		☐		☐	
Date and Method of Contact							
Additional Notes:							
✓ Purchasing Plan (Frequency): ☐ Bi-Weekly ☐ Weekly ☐ Bi-Monthly ☐ Monthly							
Signature of person completing this form:						Date:	

NEBRASKA DEPARTMENT OF EDUCATION

Revised 2/2016

Adapted from Michigan Department of Education

Nebraska Department of Education
Nutrition Services
301 Centennial Mall South
P.O. Box 94987
Lincoln, NE 68509-4987

Nutrition Services Computer Access Application and Agreement

This application and agreement requests the assignment of a User ID and Password to be used as an electronic signature by the person named as Authorized Representative/Responsible Individual on page 2 of this form for the specified Sponsor/System. The Authorized Representative/Responsible Individual is authorized to attest, by electronic signature, as to the accuracy of the data reported to the Nebraska Department of Education (NDE) Nutrition Services System until NDE receives written notice to revoke the rights of access.

The Authorized Representative/Responsible Individual agrees that the use of the electronic signature (User ID and Password) attests to the accuracy of the data transmitted as an electronic version of each designated form. The Authorized Representative/Responsible Individual further agrees that the electronic signature (User ID and Password) is equivalent to, and has the full legal binding force of his/her written signature and is legally valid and enforceable.

The Authorized Representative/Responsible Individual also agrees to all terms of the pertinent application and agreement, related forms and claims and responsibility for the program(s) listed below in which you participate. On page 2, item 15 of this form (NDE-01-033) mark the box for each program in which you participate. The Authorized Representative/ Responsible Individual is legally and financially bound by all terms and conditions contained in such agreements.

- **National School Lunch Program, School Breakfast Program and Special Milk Program**: Program Application, Form NDE 01-014; Site Application, Form NDE 01-015; Claim, Form NDE 28-036; and the following as applicable: Annual Financial Statement, Form NDE 01-003 (for Non-Public Schools), and Fruit/Vegetable Claim.

- **Child and Adult Care Food Program:** Application and Agreements, as applicable, NS-407-G, NS-304-H; Form NDE 01-017; Form NDE 01-018, Site Information Sheet; and the following, as applicable: Proprietary For Profit Statement, Form NDE 01-030; Pricing Program Policy Statement, Form NDE 01-036; Adult Center Attachment, Form NDE 01-026; Child Care Claim Form, NDE 28-017; Adult Care Claim, Form, NDE 28-018; Day Care Home Sponsor Claim, Form NDE 28-037.

- **Summer Food Service Program:** Sponsor Application, Form NDE 01-023; Site Application, Form NDE 01-022; Sponsor Budget, Form NDE 01-023; Claim, Form NDE 28-034.

The Authorized Representative/Responsible Individual will be responsible for the security and the integrity of the electronic signature (User ID and Password) as issued by Nutrition Services. The Authorized Representative/Responsible Individual has a duty to exercise reasonable care to retain control of the electronic signature (User ID and Password) and prevent its disclosure to other persons.

Extending Rights to Other Staff

If more than one individual is responsible for entering data, the Authorized Representative/Responsible Individual should assign employees rights to a User ID and Password. Instructions to create a new user are at https://nutrition.education.ne.gov under the Login/Password/System Navigation heading, Security Administrative Manual. The Authorized Representative/Responsible Individual and any sub users who you assign will be liable for any misuse of the electronic signature (User ID and Password).

The Authorized Representative/Responsible Individual and any sub users understand and agree that by using the electronic signature (User ID and Password) he/she is signing and legally validating the electronic document.

NDE requires assurance that the Authorized Representative/Responsible Individual has permission of the System/Sponsor to enter into this agreement. The person who signs as the Board President/Owner/CEO provides this assurance. One of the following persons must complete items 9-14 on page 2 of this application and agreement:

- For Local Education Agencies : Board of Education President or Superintendent
- For Non Profit Agencies: Board President or Chief Executive Officer (CEO)
- For Privately-Owned Center: Owner

Nebraska Department of Education
Nutrition Services
301 Centennial Mall South
P.O. Box 94987
Lincoln, NE 68509-4987

Authorized Representative/Responsible Individual Profile
(Information must match online program application and signatures must be kept current)

1. Print Name of Authorized Representative/Responsible Individual	2. Signature of Authorized Representative/Responsible Individual
3. Title of Authorized Representative/Responsible Individual	4. Date of Birth of Authorized Representative/Responsible Individual
5. Sponsor/System Name	6. Agreement Number (assigned by NDE)
7. Email address	8. Telephone Number ( )

Sponsor/System Approval for CNP System Access	
9. Printed Name of Board President/Owner/CEO	10. Signature of Board President/Owner/CEO
11. Title of Board President/Owner/CEO	12. Date of Birth of Board President/Owner/CEO
13. Telephone Number ( )	14. Date Signed

15. Check all Program agreements that apply

- ❑ National School Lunch Program, School Breakfast Program and Special Milk Program
- ❑ Child and Adult Care Food Program
  Check one: ____ Child Care Center ___ Adult Care Center ____ Family Day Care Home Sponsor
- ❑ Summer Food Service Program

Please submit the completed form to Nutrition Services at nde.nsweb@nebraska.gov.

NDE USE ONLY

☐ Request Granted ☐ Request Denied

Effective Date_____ _____
Director, Nutrition Services

URL: **https://nutrition.education.ne.gov**

User ID _____ Revocation Date_____

An email with the subject line "Confirmation Email for UserID" will be sent to the email address listed in #7. Please refer to the email for your first time log on to the CNP system. If this individual leaves the organization, a new form must be sent to NDE.

Additional programs requested after initial Computer Access in #15:

Program	Effective Date	Revocation Date
☐ National School Lunch Program, School Breakfast Program and Special Milk Program	_____	
☐ Child and Adult Care Food Program (Check One) ____ Child Care Center ___ Adult Care Center	_____	_____
☐ Summer Food Service Program	_____	_____