

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	Sp Needs	Sp Diet	Sex	School Level	District
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 : ____/____/____

Signature: _____ Date: ____/____/____

Relation	Legend 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	

