South Carolina Department of Social Services
Emergency Shelters Program

CLAIM FOR REIMBURSEMENT

Read instructions carefully before completing this claim.
If the claim is incomplete, your reimbursement will be delayed.

Check One: Original Claim ❑ Revision ❑1 ❑2 ❑3	1. Agreement Number: ______________ FEIN: ______________
2. Name and Address of Institution:	**For SCDSS Use Only:** Y M M D D
3. Month and Year Claimed:	4. Total Number of Meal Service Days for Month Claimed:
5. Average Daily Attendance:	6. Number of Sites Operating for Month Claimed:

7. Total Number of Meals Served to Children for Month Claimed:

Breakfasts	**Lunches**	**Suppers**	**Snacks**

8. Please indicate if you have had a change in staff involved with meal service and/or recordkeeping for this program that would require training. A technical assistance visit will be scheduled.

9. Remarks:

I certify to the best of my knowledge and belief, this claim is true and correct in all respects, that records are available to support this claim, and that it is in accordance with the terms of the existing agreement. I recognize that I will be fully responsible for any excess amounts which may result from erroneous or neglectful reporting herein. I further certify that all claims for reimbursement shall be submitted to the South Carolina Department of Social Services within the time frame prescribed by the department. I understand that failure to submit claims within the prescribed time frame may result in such claims not being paid.

10. Signature of Authorized Representative:	11. Title:	12. Preparation Date:

All receipts, invoices and other evidence of purchases must be retained and available for future audit for a period of three (3) years after the end of the fiscal year to which they pertain. No further monies or other benefits may be paid out under this program unless this report is completed and filed as required by existing regulations (7CFR 226).

INSTRUCTIONS FOR DSS FORM 3401

Report data for one calendar month only.

If you have any questions about how to complete this form, please contact the
South Carolina Department of Social Services, Emergency Shelters Program for assistance at (803) 734-9527.

Sign and date this claim before mailing it to:
South Carolina Department of Social Services,
Emergency Shelters Program – Family Nutrition Programs,
P.O. Box 1520, Columbia, SC 29202-1520.

Check the appropriate box to indicate "Original Claim," Revision 1, Revision 2 or Revision 3. A revised claim completely voids all previous claims for the same month. Therefore, when you submit a revised claim, include all reporting data for documentation to support the claim for reimbursement.

Any revised claim submitted after the legislatively mandated deadline of **60 days** after the end of the claim month will not be paid. **In some cases, 60 days will be prior to the end of the third month.**

1. Enter your seven digit agreement number, located in your approval letter, that begins with ES and your Federal Identification Number (FEIN).
2. Enter the institution's name and address.
3. Enter the month and year for this claim. Example: 01 2000 for January 2000.
4. Enter the total number of days that meals were served during the claim month.
5. Count the number of children attending each day at each participating Emergency Shelters Program site to arrive at the total monthly attendance. Divide total monthly attendance for all sites by the number of days meals were served. **If your result includes a fraction, round up to the next whole number. ALWAYS ROUND UP.**
6. Enter the total number of emergency shelter sites reporting this month.
7. Enter the total number of eligible meals by type served to children at all of the Emergency Shelters Program sites reporting for the claim month.
8. Indicate any change in staff (new hires, changes in responsibility of current staff, etc.) involved with operating the Emergency Shelters Food Program. This will alert our staff to the need for a technical assistance visit to your organization.
9. Enter any comments concerning the claim information or requests for forms or supplies, if needed.
10. This **must** be the signature of the individual designated on the "Statement of Authority" to sign the claim for reimbursement. **If this person has changed since the initial application, a new "Statement of Authority" must be submitted prior to SCDSS processing the claim.**
11. Enter the title of the individual designated on the "Statement of Authority" to sign the claim for reimbursement.
12. Enter the date the claim for reimbursement was prepared. This date must be **after** the last calendar day of the food service claim month.