TIME DISTRIBUTION REPORT

CHILD & ADULT CARE FOOD PROGRAM

Employee Name: ____

Payroll Period: ____

Instructions: The employee must complete this form according to his/her pay schedule whether weekly, bi-weekly, twice a month, or monthly. In column A and F indicate the correct month that corresponds to the date in the pay period being documented. For example, if the pay period is 3/31-4/14, March would be noted in column F beside the 31st date, where April would be noted beside the remaining days. In columns C and/or H, indicate the number of hours per day spent on administrative and operational activities related to the CACFP, and in column D and/or I those hours worked on non-CACFP related activities for each day worked in the pay period. Employees who work for an Administrative and Day Care Home Sponsor would split the number of hours in columns C and/or H between each sponsorship instead of between administrative/operating duties. Proper notation should be made on this form to distinguish the sponsorship type. Columns E and/or I must equal the total number of hours the employee worked for the organization completing both CACFP and Non-CACFP duties for each day. Use the formula at the bottom to prorate the labor cost and charge only the applicable portion to the CACFP. (For Administrative and/or DCH sponsorships, the applicable portion to each sponsorship.)

A	B	C		D	E	F	G	H		I	J
Month	Date of Month	Hours Worked on CACFP		Non-CACFP Hours Worked	Total Hours Worked for Organization	Month	Date of Month	Hours Worked on CACFP		Non-CACFP Hours Worked	Total Hours Worked for Organization
		Admin.	Oper.					Admin.	Oper.		
	1st						17th				
	2nd						18th				
	3rd						19th				
	4th						20th				
	5th						21st				
	6th						22nd				
	7th						23rd				
	8th						24th				
	9th						25th				
	10th						26th				
	11th						27th				
	12th						28th				
	13th						29th				
	14th						30th				
	15th						31st				
	16th						**TOTAL**				

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

____ ____________________

Employee's Signature Date

TO BE COMPLETED BY SUPERVISOR/AUTHORIZED REPRESENTATIVE

A. (HOURLY PAID STAFF) Complete only for staff paid on an hourly basis.

Total administrative hours worked on CACFP ________ x $________(hourly wage) = $_________(Total admin. CACFP salary)

Total operational hours worked on CACFP ________ x $ ________(hourly wage) = $ _________(Total oper. CACFP salary)

B. (SALARIED STAFF) Complete only for staff not paid on an hourly basis.

Total administrative hours worked on CACFP ________ ÷ Total hours worked ________ = _________%

Total Salary for pay period $ ________ x ________% = $ _________(Total admin. CACFP salary)

Total operational hours worked on CACFP ______ ÷ Total hours worked ______ = _________%

Total Salary for pay period $ ________ x ________% = $ _________(Total oper. CACFP salary)

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

Signature of Supervisor/Authorized Representative ____ Date ________________