Community Action Partnership of San Bernardino County
Food Bank Program
CONGREGATE FEEDING AGENCY (CFA)
QUARTERLY REPORT

For Period Ending:_____20___

CFA AGENCY NAME:_____

ADDRESS:_____

CITY, ZIP CODE:_____

PHONE NUMBER:_____

Please complete this report and return to the Food Bank at the end of the quarter so we can submit our required reports to the State.

MONTH:_____ MONTH:_____ MONTH:_____

MEALS SERVED:		**MEALS SERVED:**		**MEALS SERVED:**	
MALE:		**MALE:**		**MALE:**	
FEMALE:		**FEMALE:**		**FEMALE:**	

COMMENTS:_____

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_____

Please contact our office right away if you have any questions at (909) 723-1580.

_____ _____
SIGNATURE DATE

Mailing Address: CAPSBC Food Bank Program
Attn: Florence Frias
696 S. Tippecanoe Ave.
San Bernardino, CA 92415