

**North Carolina Department Of Health And Human Services
Child and Adult Care Food Program
Sponsoring Organization 3-Year Center Review**

Name of Sponsoring Organization _____ Agreement #: _____

Review: Announced Visit Unannounced Visit

I. GENERAL INFORMATION Arrival Time: _____ Departure Time: _____

Center Name: _____ Date: _____

Street Address: _____

Telephone: _____

Type of center:

- | | | |
|---|--|---|
| <input type="checkbox"/> Child Care Center | <input type="checkbox"/> Title XX Center – Child | <input type="checkbox"/> Title XIX Center-Adult |
| <input type="checkbox"/> Outside-School-Hours Care Center | <input type="checkbox"/> Head Start | <input type="checkbox"/> Title XX Center-Adult |
| <input type="checkbox"/> “At Risk” School Children | <input type="checkbox"/> Adult Day Care Center | <input type="checkbox"/> Emergency Shelter |

Person(s) Interviewed:

_____/Title
_____/Title

License # _____ License Capacity _____ Effective Date(s) _____ Alternate approval _____

Number of participants observed in attendance on day of review _____

The center is at/within license capacity at the time of review. Yes No

The center is at/within provider/child ratio at the time of review. Yes No

Are income eligibility applications on file at: Central Office Facility

Documentation – Are the following documents on file and available for inspection for the current year (October 1 – September 30)? If no, explain.

	YES	NO	N/A
1. Invoices/record of food service expenditures.....	<input type="checkbox"/>	<input type="checkbox"/>	
2. Copies of foodservice contracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Delivery tickets for catered meals.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. CAC 7Facility application.....	<input type="checkbox"/>	<input type="checkbox"/>	
5. Sponsor/Center Agreement	<input type="checkbox"/>	<input type="checkbox"/>	
6. Are enrollment forms updated annually for all participants.....	<input type="checkbox"/>	<input type="checkbox"/>	
7. Are enrollment forms signed by a parent or legal guardian.....	<input type="checkbox"/>	<input type="checkbox"/>	
8. Does the enrollment forms contain the normal days and hours of care and the meals normally received while in care?.....	<input type="checkbox"/>	<input type="checkbox"/>	
9. Does the facility make information regarding WIC available to participants?.....	<input type="checkbox"/>	<input type="checkbox"/>	
10. Documentation of “area eligibility” for At Risk school children.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Documentation of eligibility for Emergency Homeless Shelter.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FINDINGS: _____

SUGGESTIONS: _____

- Required corrective actions listed on supplemental summary of finding for the review section.
- No corrective action required for this section.

II. CIVIL RIGHTS

YES NO

- A. Is an approved and up-to-date civil rights "And Justice for All" poster displayed?
- B. Are all services and the facility used routinely by all persons without regard to race, color, national origin, age, sex, or disability? (e.g., social and recreational areas, study areas, lavatories, waiting rooms, chapels, playgrounds, etc.)
- C. Are program benefits made available to all eligible individuals without regard to race, color, national origin, sex, age, or disability?
- D. Is there a need for bilingual materials?
If yes, how is it addressed? _____
- E. Does the facility make information regarding CACFP available to the public upon request? . .
- F. Does the facility make available to the public the CACFP nondiscrimination statement and the CACFP procedure for filing a complaint?
- G. Are there any requirements or procedures which restrict or deny enrollment on the basis of race, color, sex, age, disability, or national origin?
- H. Estimated Current Participation by Ethnic Group

Indicate method institution obtained information: observation parents/guardian participant

Hispanic or Latino	Not Hispanic or Latino

I. Estimated Current Participation by Racial Group (leave boxes blank for those not included)

Indicate method institution obtained information: observation parents/guardian participant

NOTE: Any review of institution having only one race should include a statement indicating the general racial composition of the area the institution serves.

All items must be answered numerically (no percentages). Do not use words "all" or "none".

# American Indian or Alaskan Native	# Asian	# Black or African American	# Native Hawaiian or Other Pacific Islander	# White	Total Numbers

FINDINGS: _____

SUGGESTIONS: _____

Required corrective actions listed on supplemental summary of finding for the review section.
 No corrective action required for this section.

Center Name: _____

C. Meal Pattern Analysis (Infant 0 – 11 months)

Does the facility enroll infants in its child care? Yes No (If no, skip to D.)

Circle meal observed (day of review): Breakfast / AMS / Lunch / PMS / Supper /LPMS N/A _____
 If N/A, record an explanation _____

Number served: _____ 0-3 months _____ 4-7 months _____ 8-11 months

Food Components	Amount Available To Be Served	Amounts Needed To Be Adequate	Adequate	
			Yes	No
Meat/Meat Alternate				
Fruit/Vegetable				
Infant Cereal/ Bread/Bread Alternate				
Iron Fortified Formula or Breast Milk				

Meal meets meal pattern requirements by:

Computation by Amount Weight Observation (beginning to end of service)

Does the facility offer the infant meal pattern to currently enrolled infants? Yes No
 If not, list participants without the signed formula provision form

D. Meal Pattern Analysis (Child/Adult Care)

Circle meal observed (day of review): Breakfast / AMS / Lunch / PMS / Supper /LPMS

Number served: _____ 1-2 years _____ 3-5 years _____ 6-12 years & over

_____ Program Adults (adult day care) _____ Non-program adults _____ Catered out

Food Components	Amounts Available To Be Served	Amounts Needed To Be Adequate	Adequate	
			Yes	No
Meat/Meat Alternate				
Fruit/Vegetable				
Fruit/Vegetable				
Bread/Bread Alternate				
Fluid Milk				

Meal meets meal pattern requirements by:

Computation by Amount Weight Observation (beginning to end of service)

Center Name: _____

- | | | YES | NO | NA |
|----|--|--------------------------|--------------------------|--------------------------|
| E. | 1. Did the meal meet the meal pattern requirements?..... | <input type="checkbox"/> | <input type="checkbox"/> | |
| | 2. Were all meal components served at the same time?..... | <input type="checkbox"/> | <input type="checkbox"/> | |
| | 3. Was the menu adjusted for all special dietary needs?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | 4. Was medical documentation available? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

List participants with no documentation _____

F. List the meal counts for each meal type claimed by the institution for the 5 preceding days of the meal observation.

Dates	Breakfast Meal Counts	AM Snack Meal Counts	Lunch Meal Counts	PM Snack Meal Counts	Supper Meal Counts	Late PM Snack Meal Counts	Number of Participants in Attendance	Number of Participants Enrolled

1. Based on the comparisons, are the meal counts for each meal service accurate? Yes No
 a. If “no” obtain and record an explanation from the center’s representative. _____

2. Did the meal counts exceed the attendance in the prior five days? Yes No

FINDINGS: _____

SUGGESTIONS: _____

- Required corrective actions listed on supplemental summary of finding for the review section.
- No corrective action required for this section.

V. THREE-MONTH REVIEW

A. 1. Reviewed Menu Records

Month/Year	Number of Meals Disallowed and reason*	Month/Year	Number of Meals Disallowed and reason*	Month/Year	Number of Meals Disallowed and reason*
Breakfast		Breakfast		Breakfast	
AM Snack		AM Snack		AM Snack	
Lunch		Lunch		Lunch	
PM Snack		PM Snack		PM Snack	
Supper		Supper		Supper	
Late PM Snack		Late PM Snack		Late PM Snack	
Total		Total		Total	

*Codes: A=Missing/Incomplete Menus B=Missing Invoices/Receipts D=Missing/Incomplete Record(s) of Number of meals by type F=Calculation Error G=Inadequate Quantity of Meal Component(s) H=Missing Meal Component(s) or amounts J=Unapproved facility K=Unapproved month L=Other (please explain)

Total number of meals disallowed for the three months reviewed _____

Estimated amount owed by the facility for the above three months reviewed \$ _____

2. RESULTS FROM MILK AUDIT

Test Month _____

(Record from Milk Reconciliation Worksheet)

Total Ounces of Milk Required (A)	Total Ounces of Milk Purchased (B)	Difference (A - B) = (C)	(C) ÷ (A) = % Short

Estimated amount of adjustment due to milk shortage for this facility \$ _____

FINDINGS: _____

SUGGESTIONS: _____

B. Health/Safety/Sanitation

	Yes	No
1. Are the refrigeration units clean and maintained at required temperatures?		
2. Is food properly stored in the refrigeration units and in dry areas?		
3. Is there evidence of rodent or insect infestation?		
4. Are there obvious fire, health and/or safety hazards observed in the center?		
5. Was food service conducted in compliance with generally accepted health and sanitation practices?		
6. Has the local sanitation agency made a recent inspection? Date:		
7. Has the local fire department made a recent inspection? Date:		

FINDINGS: _____

SUGGESTIONS: _____

- Required corrective actions listed on supplemental summary of finding for the review section.
- No corrective action required for this section

VI. TRAINING

List the training session the center's key staff attended:

Date	Topic of Training	Name of Staff in Attendance

FINDINGS: _____

SUGGESTIONS: _____

- Required corrective actions listed on supplemental summary of finding for the review section.
- No corrective action required for this section

VII. SUMMARY (complete the applicable section)

Center Name: _____

A. NO CORRECTIVE ACTION REQUIRED

I verify that this facility was reviewed on this date and was found to be in compliance with CACFP requirements for the program areas reviewed, as specified in this report. The findings in this report have been discussed with the facility's authorized representative.

Facility's Authorized Representative

Title

Sponsoring Organization Representative

Date

Date

PLEASE CONSIDER THIS REVIEW CLOSED

B. CORRECTIVE ACTION REQUIRED

I, the facility's authorized representative, verify that this facility was reviewed on this date and that the Sponsoring Organization representative discussed the findings in this report with me prior to my signing it. I understand that the Sponsoring Organization representative determined that this facility is not in compliance with certain CACFP requirements; that this report serves as a warning regarding noncompliance with those requirements; that I am required to implement the corrective action stated in this report within the time frame(s) stated to bring this facility into compliance with CACFP requirements; and that failure to implement the corrective action within the time frame(s) stated could result in termination of this facility from participation in the CACFP. I further understand that all corrective actions must be implemented fully and permanently. I further understand that this facility owes the estimated amount of monies listed below due to rate changes and/or disallowances.

Facility's Authorized Representative

Title

Date

Disallowance(s) \$ _____

Milk Audit \$ _____

Total Estimated Amount Due \$ _____

I, the Sponsoring Organization representative, verify that I reviewed this facility's operation and records on this date and determined that the facility was not in compliance with certain CACFP requirements, as specified in this report; discussed the findings in this report with the facility's authorized representative and explained that failure to implement the corrective action required within the time frame(s) stated could result in termination of the facility from participation in the CACFP.

Time frame(s) for implementing the corrective action(s) begin(s) on the date signed above by the facility's authorized representative.

Due date(s) for completion of corrective action(s) is/are stated on the attached Summary of Findings.

Sponsoring Organization Representative

Date

Follow-up required:

Unannounced on site visit by Sponsoring Organization representative

Written response to Sponsoring Organization reviewer by facility on or before **Date** _____