

**North Carolina Department Of Health And Human Services
Child and Adult Care Food Program
Sponsoring Organization Day Care Home Review Form**

Date of Review: _____

Arrival Time: _____ Departure Time: _____

Tier I Tier II Tier II with Income Eligibility Applications

Type of Visit: Announced Unannounced
 Monitoring Follow-up Training/Technical Assistance

If Follow-up, to which contact? Monitoring Date _____ Previous Follow-up Date _____

I. GENERAL DATA

1. Name of Sponsoring Organization _____ 2. Agreement Number: _____

3. Name of Provider _____ 4. Provider's Telephone Number: (____) _____

5. Provider's Address _____

6. Name of Monitor (s) _____

7. A copy of the current sponsor/provider agreement is on file at the provider's home Yes No

8. DHHS Licensing Information

Effective Date: From: _____ To: _____

Capacity: _____ Licensing #: _____ Alternate Approval: _____

Is Licensing Capacity exceeded on day of review? Yes No

9. Days of Organized Care: Sun. Mon. Tue. Wed. Thurs. Fri. Sat.

Holiday Care: Yes No

10. Meal Services:

| | Authorized Meal Services | | Serving Times |
|-----------|--------------------------|----|---------------|
| | Yes | No | Approved |
| Breakfast | | | |
| AM Snack | | | |
| Lunch | | | |
| PM Snack | | | |
| Supper | | | |
| LPM Snack | | | |

Findings _____

Suggestions _____

II. ATTENDANCE AND ELIGIBILITY DATA

1.

| Full Name of All Children in Attendance | Age | Enrollment Form | Provider's Own Child | Meal Participant | Meal Claimed |
|---|-----|-----------------|----------------------|------------------|--------------|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |
| 9. | | | | | |
| 10. | | | | | |
| 11. | | | | | |
| 12. | | | | | |
| TOTALS | | | | | |

- | | YES | NO | N/A |
|---|--------------------------|--------------------------|--------------------------|
| 2. The observed meal was served at the approved, scheduled time. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. If "NO" to question 2, did the provider notify the sponsor of the change. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. The provider is at provider/child ratio. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. The children in attendance and participating in the meal service have complete and current enrollment forms. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. The meals claimed are served to children who are within regulatory age limits. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Meals served to the provider's own children are claimed only if the child is enrolled, eligible, and other eligible enrolled children are participating in the meal service. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. The provider charges separately for meals. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Findings _____

Suggestions _____

III. CIVIL RIGHTS

- | | YES | NO | N/A |
|--|--------------------------|--------------------------|--------------------------|
| 1. The provider allows all children equal access to its child care services and facilities regardless of race, color, sex, age, disability or national origin. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. The provider serves meals to all enrolled children equally regardless of the children's race, color, sex, age, disability, or national origin. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. The nondiscrimination statement and complaint procedures are included in provider advertisements when referencing admissions and/or the CACFP. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Findings _____

Suggestions _____

IV. PARENTAL NOTIFICATION

| | | YES | NO | N/A |
|----|--|--------------------------|--------------------------|--------------------------|
| 1. | The provider has informed the parents or guardians of children enrolled in CACFP about the program and its benefits. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | The provider has "Building for the Future" flyer. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | The provider has made the Building for the Future flyer available to parents or guardians of children enrolled in CACFP. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | The provider has made information about WIC available to parents or guardians of children enrolled in CACFP. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Findings _____

Suggestions _____

V. DAY OF REVIEW – OBSERVATION OF MEAL SERVICE

Type of Meal Observed _____ Time Served from _____ am/pm to _____ am/pm

A. **Infants** Does the provider enroll infants in its child care? Yes No (If no, skip to Section B on page 4.)

Number Served: _____ Birth – 3 months, _____ 4-7 months, _____ 8-11 months

| Food Components | Birth—3 Months Amounts Available to be Served | 4-7 Months Amounts Available to be Served | 8-11 Months Amounts Available to be Served |
|--|---|---|--|
| Meat/Meat Alternate | | | |
| Fruit/Vegetable | | | |
| Infant Cereal/ Bread/Bread Alternate | | | |
| Iron Fortified Formula or Breast Milk | | | |

Does the provider offer the infant meal pattern to currently enrolled infants? Yes No

If not, list participants without the signed formula provision form

VI. 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. Are cleaning supplies and other toxic materials safely stored out of reach of children and away from food? | | |
| 4. Is there evidence of rodent or insect infestation? | | |
| 5. Are there obvious fire, health and/or safety hazards observed in the center? | | |
| 6. Was food service conducted in compliance with generally accepted health and sanitation practices? | | |
| 7. Did the provider and children wash hands prior to food handling and eating? | | |

Findings _____

Suggestions _____

VII. SPONSOR TRAINING/MONITORING

- List the date of the last sponsor conducted training session the provider attended:

- Provider recommendations for future training topics/needs or training improvement ideas are: _____

- List date of last monitoring: _____
List problem(s) identified during the last monitoring visit : _____

- Have all corrective actions been implemented? Yes No N/A

Findings _____

Suggestions _____

VIII. SUMMARY OF FINDINGS (If problems/errors are found, skip this section and go to page 7.)

A. Complete section (ONLY IF NO PROBLEM/ERRORS ARE FOUND)

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

_____/_____
 Provider Title Date

_____/_____
 Sponsoring Organization Representative Title Date

Sponsoring Organization: _____

Date: _____

Provider Name: _____

Agreement#: _____

B. Complete section (ONLY IF PROBLEMS/ERRORS ARE FOUND)

| Review Page/Item # | Brief Description of Finding(s) | Corrective Action (C.A.) Needed | Corrective Action Due Date | On Site Follow-up Yes or No |
|--------------------|---------------------------------|---------------------------------|----------------------------|-----------------------------|
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I, the Provider, verify that this facility was reviewed on this date and that the reviewer discussed the findings in this report with me prior to my signing. I understand that the reviewer determined that this facility is not in compliance with certain CACFP requirements; that this report serves as a warning regarding compliance with those requirements; that I am required to implement the corrective action stated above within the time frame(s) indicated to bring the facility into compliance with CACFP requirements; and that failure to implement the corrective action within the time frame(s) indicated could result in termination by the sponsoring organization.

_____/_____
Provider Title

Date

I, the Sponsoring Organizations Representative, verify that I reviewed this facility on this date and discussed the findings in this report with the Provider; determined that the facility was not in compliance with certain CACFP requirements; as specified in this report; and explained to the Provider that failure to implement the corrective action stated above within the time frame(s) indicated could result in termination of the facility's agreement with the sponsoring organization.

_____/_____
Sponsoring Organization Representative Title

Date