



The Child and Adult Care Food Program

At-Risk Facility Monitoring Form

This form should be used for facilities that participate in the at-risk program only.

Name of Sponsoring Organization: _____

Name of Reviewer: _____

Date of Visit: _____ Time of Arrival: _____ Departure Time: _____

1. Name of Facility: _____

2. Name and Title of Responsible Official(s) Interviewed on Day of Visit: _____

3. What agreement type does this facility have with the Sponsoring Organization? Non-Cash: Cash:

4. Type of Visit: Training/Technical Assistance: Monitoring: Follow-up:

a. If training/assistance, what topics are covered? _____

b. If monitoring, what type was it? Announced Unannounced

c. If follow-up, what is it related to? Previous Monitoring Visit Date of Visit: _____

Previous Follow-Up: Date of Visit: _____

5. Number of participants at facility at time of review: _____ Age range of participants: _____

6. Does the facility enroll or serve infants under one (1) year of age? Yes: No:

7. License or Alternate Approval:

a. For Licensed Facilities:

i. Is the license posted? Yes: No:

ii. Is the license current? Yes: No:

Date of license expiration: _____

If no, is the facility complying with renewal procedures? Yes: No:

iii. Does the number in attendance during the visit exceed the licensed capacity? Yes: No:

iv. Does the age range of the participants present comply with the license? Yes: No:

b. For Facilities with Alternate Approval:

i. Is there at least one staff member plus a back-up with a current D.C. Department of Health-issued Certified Food Protection Manager identification card? Yes: No:

ii. Is the facility a licensed school cafeteria? Yes: No:

NOTE: Check "No" if the facility operates within a school but is a separate entity from the school. If no, continue to 7(c). If yes, skip to question 7.

iii. Has the facility received a fire inspection within the past year? Yes: No:

iv. Is the Hazard Analysis Critical Control Point Self-Inspection checklist completed weekly and kept on file? Yes: No:

8. Meal observation

a. Type of food service operation:

FSMC: Self-Prep:

b. Meal type observed:

Breakfast: Lunch/Supper: Snack:

c. Time of meal service: _____

Is this the approved meal time? Yes: No:

d. Meal count (per reviewer): _____

Meal count (per site): _____

e. Does the meal observed meet the meal pattern requirements? Yes: No:

f. Does the meal observed match the menu posted? Yes: No:

g. If no, are the changes recorded on the menu kept on file? Yes: No:

h. **Child Meal** – List **ALL** foods served and note different items for child care versus at-risk meals.

Component	Item(s) Served	Age-appropriate portion?	
Milk	_____	Yes: _____	No: _____
Bread/Bread Alternate	_____	Yes: _____	No: _____
Fruit/Vegetable	_____	Yes: _____	No: _____
Fruit/Vegetable	_____	Yes: _____	No: _____
Meat/Meat Alternate	_____	Yes: _____	No: _____
Other (Optional)	_____	Yes: _____	No: _____

i. *For facilities with family-style meal service:* Does the staff set out enough food for all participants and instruct participants on the appropriate portion? Yes: No:

j. **Infant Meal** (if applicable)

Component	Item(s) Served	Age-appropriate portion?	
Formula/Breast Milk	_____	Yes: _____	No: _____
Infant Cereal	_____	Yes: _____	No: _____
Fruit/Vegetable	_____	Yes: _____	No: _____
Meat/Meat Alternate	_____	Yes: _____	No: _____
Bread/Cracker	_____	Yes: _____	No: _____

k. Which formula(s) does the facility offer to infants? _____

9. Five Day Meal Count Reconciliation

For each of the five days preceding the day of the monitoring visit, compare attendance, enrollment, and meal counts.

*If the center/facility has 50 or less children enrolled, **complete the first chart** and review at least 5 children's records. Must review at least 10% of the center/s/facility's enrolled children.

*If there are no enrollment forms, the monitor would reconcile aggregate meal counts to attendance records and **complete the second chart**.

Child's Name	Enrollment		Attendance Date (m/d/yr)				
	Day(s)	Time	Day 1 _____	Day 2 _____	Day 3 _____	Day 4 _____	Day 5 _____
Enrollment Totals							

Date (m/d/yr)	Attendance	Meal Count					
		Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Day 1							
Day 2							
Day 3							
Day 4							
Day 5							

10. Facility Management:

- a. Are Infant Food and Formula Notification Forms on file at the facility? Yes: No: N/A:
- b. If yes, is there an Infant Formula Notification Form on file for each infant? Yes: No: N/A:
- c. Are Medical Substitution Forms on file at the facility? Yes: No:
- d. Are the Medical Substitution Forms being followed correctly? Yes: No: N/A:
- e. Are dated daily menus on file (at least for the current month)? Yes: No:
- f. Do the menus reflect all foods actually served? Yes: No:
- g. If the facility uses a FSMC, are daily delivery tickets on file (at least for the current month)? Yes: No: N/A:
- h. If the facility prepares meals on site, is record kept of the number of meals prepared? Yes: No: N/A:
- i. Are meal count records accurate and up-to-date? Yes: No:
- j. Are dated, daily attendance records accurate and up-to-date? Yes: No:
- k. If for-profit, does the facility maintain or submit adequate documentation to support its eligibility? Yes: No: N/A:
- l. Have key staff members attended CACFP training within the past 12 months? Yes: No:
- n. Is the non-discrimination "And Justice For All" poster displayed? Yes: No:
- o. Is the "Building for the Future" flyer displayed? Yes: No:
- p. Is the facility open to all regardless of race, sex, color, age, national origin, or disability? Yes: No:
- q. Is the facility open to all regardless of marital status, personal appearance, sexual orientation, gender identity or expression, family responsibilities, familial status, source of income, place of residence or business, genetic information, matriculation, or political affiliation? Yes: No:

For Unaffiliated Facilities with a Cash Agreement with the Sponsor:

- r. Are invoices/receipts available? Yes: No:
- s. Total documented CACFP-related costs: _____
- t. Amount of reimbursement, less administrative fees, for the previous month: _____
- u. If reimbursement exceeds costs, explain how the facility is maintaining a non-profit food service operation:

11. Food Service Related Licenses, Facilities and Sanitation Procedures

Note: "Adequate" means capable of handling the proposed type and scale of the facility's food service operations.

- a. Are there any obvious fire, health or safety hazards in the facility? Yes: No:
- b. If meals are prepared at a central kitchen, is it operated by the center (not a licensed Food Service Management Company) and distributed to the facility? Yes: No:
- c. If yes, are there adequate systems and equipment to properly transport food? Yes: No:
- d. Are the kitchen and food preparation areas clean? Yes: No:
- e. Does the facility have adequate access running water (including drinking water)? Yes: No:
- f. Does the facility have adequate space and equipment for washing dishes? Yes: No:
- g. Does the facility have adequate working refrigerated storage space? Yes: No:
- h. Are all of the refrigeration units clean? Yes: No:
- i. Are all of the refrigeration units maintained at the proper temperature? Yes: No:
- j. Is the food properly stored in the refrigeration units? Yes: No:
- k. Does the facility have adequate working freezer storage space? Yes: No:
- l. Are all of the freezer units clean? Yes: No:
- m. Are all of the freezer units maintained at the proper temperature? Yes: No:
- n. Is the food properly stored in the freezer units? Yes: No:
- o. Does the facility have adequate dry storage space? Yes: No:
- p. Is food properly stored in the dry storage areas? Yes: No:
- q. Are cleaning supplies and other toxic materials stored separately from food and out of reach of children? Yes: No:
- r. Is there evidence of rodent or insect infestation? Yes: No:
- s. Is there documentation of an exterminating schedule? Yes: No:
- t. Is there a Certified Food Handler on site during the visit? Yes: No:
 Name: _____ Certification expiration: _____
- u. Is the Certified Food Handler following proper food safety/sanitation procedures? Yes: No:
- v. Was food service conducted in compliance with generally accepted health and sanitation practices? Yes: No:
- t. Did the provider and the children wash hands prior to food handling? Yes: No:
- w. Did the provider and the children wash hands prior to eating? Yes: No:
- x. Is the serving area equipped for the program? Yes: No:
- y. Is the serving area seating capacity adequate? Yes: No:

z. Is the serving area clean and well ventilated?

Yes: No:

12. Notes

Describe any items that require further explanation.

13. Summary of Technical Assistance Given On-Site (list the scenario that occurred during the visit and related technical assistance given)

Review Item	Brief Description	Technical Assistance Given	Individual Receiving Technical Assistance

14. Summary of Findings

List any problems that were noted during the visit and any related corrective actions that were initiated to correct the problems.

Review Item	Brief Description	Corrective Action	Corrective Action Due Date

[] The undersigned certifies that on this day, the facility was reviewed and the findings in this report were discussed. The Reviewer has determined that the facility **was in compliance** with the above CACFP requirements.

[] The undersigned certifies that on this day, the facility was reviewed, the areas in this report were discussed and the Reviewer determined the facility **to not be in compliance** with the above CACFP requirements. The facility's Authorized Representative understands that failure to implement the corrective actions within the specified time frame(s) as indicated above could result in termination of the facility's agreement with the sponsoring organization.

Signature of Facility's Authorized Representative

Title

Date

Signature of Reviewer

Title

Date