Facility Monitoring Form (for non At-Risk sites)

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. a. Is the facility *unaffiliated* from the Sponsor (i.e. a distinct legal entity)?   Yes: ☐   No: ☐

   b. If *yes*, which type of agreement does this facility have with the Sponsor?   Non-Cash: ☐   Cash: ☐

4. Which program(s) does this facility operate? *Check all that apply.*   Child Care: ☐   At-Risk: ☐

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

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

   _____

   b. If monitoring, is it announced or unannounced?   Announced: ☐   Unannounced: ☐

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

   Previous Follow-Up: ☐   Date of Visit: _____

6. Number of participants at facility at time of review: _____

7. Age range of child care participants served: _____

   If applicable: Age range of at-risk participants served: _____

8. Licensing:

   a. Is the facility licensed?   Yes: ☐   No: ☐

   b. Is the license posted?   Yes: ☐   No: ☐

   c. Is the license current?   Yes: ☐   No: ☐

   Date of license expiration: _____

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

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

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

   f. *If applicable:* Does the age range of the **at-risk** participants comply with the license?   Yes: ☐   No: ☐

   g. Does the facility currently enroll infants under one (1) year of age?   Yes: ☐   No: ☐

9. Meal observation

    a. Type of food service operation: From a central kitchen: ☐   Self-Prep: ☐   FSMC: ☐

    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 using family-style meal service*, does the staff set out enough food for all children and instruct children 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? _____

10. Five Day Meal Count Reconciliation

Compare meal counts with one of the following: attendance/sign-in sheets/enrollment forms. Choose one of the two options below for reconcilation.

Aggregate reconciliation of attendance/sign-in/enrollment with meal counts

To determine enrollment use the top portion of the IES. Collect the total number of children enrolled based on the weekday information found on enrollment forms.

*Note: if using enrollment forms, ensure you're determining which children are enrolled for each weekday. If weekday information is not electronically stored, the State Agency advises doing the by-name reconciliation to reduce time spent on compiling information.

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

By-name reconciliation

*Review at least 10% of the center's enrolled children. If the center has 50 or less children enrolled, review 5 children's records.

Use either center enrollment column or attendance column for each child to compare meal counts.

Child's Name	Center Enrollment		Attendance Date (m/d/yr)				
	If yes, report weekdays child is enrolled	Time	Day 1 _____	Day 2 _____	Day 3 _____	Day 4 _____	Day 5 _____
Enrollment/Attendance Totals							

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

11. Facility Management:

    a. Are the Enrollment Form/Income Eligibility Statements on file at the facility?   Yes: ☐   No: ☐   N/A: ☐

    b. If yes, are all EF/IES on file and correctly classified?   Yes: ☐   No: ☐

    c. Are Infant Formula Notification Forms on file at the facility?   Yes: ☐   No: ☐   N/A: ☐

    d. If yes, is there an Infant Formula Notification Form on file for each infant?   Yes: ☐   No: ☐   N/A: ☐

    e. Are Medical Substitution Forms on file at the facility?   Yes: ☐   No: ☐   N/A: ☐

    f. Are the Medical Substitution Forms being followed correctly?   Yes: ☐   No: ☐

    g. Are dated daily menus on file (at least for the current month)?   Yes: ☐   No: ☐

    h. Do the menus reflect all foods actually served?   Yes: ☐   No: ☐

    i. If the facility uses a FSMC, are daily delivery tickets on file (at least for the current month)?   Yes: ☐   No: ☐   N/A: ☐

    j. Are meal count records accurate and up-to-date?   Yes: ☐   No: ☐

    k. Are dated, daily attendance records accurate and up-to-date?   Yes: ☐   No: ☐

    l. If for-profit, does the facility maintain or submit adequate documentation to support its eligibility?   Yes: ☐   No: ☐   N/A: ☐

12. Have key staff members attended CACFP training within the past 12 months?   Yes: ☐   No: ☐

13. Has the facility made information about WIC available to parents/guardians of enrolled children?   Yes: ☐   No: ☐   N/A: ☐

14. Is the non-discrimination "And Justice For All" poster displayed?   Yes: ☐   No: ☐

15. Is the "Building for the Future" flyer displayed?   Yes: ☐   No: ☐

16. Is the facility open to all regardless of race, sex, color, age, national origin, or disability?   Yes: ☐   No: ☐

17. 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:

    s. Are invoices/receipts available?   Yes: ☐   No: ☐

    t. Total documented CACFP-related costs: _____

    u. Amount of reimbursement, less administrative fees, for the previous month: _____

    v. If reimbursement exceeds costs, explain how the facility is maintaining a non-profit food service operation:

_____

_____

_____

12. 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. Are meals prepared at a central kitchen 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: ☐

    w. Did the provider and the children wash hands prior to food handling?   Yes: ☐   No: ☐

    x. Did the provider and the children wash hands prior to eating?   Yes: ☐   No: ☐

    y. Is the serving area equipped for the program?   Yes: ☐   No: ☐

    z. Is the serving area seating capacity adequate?   Yes: ☐   No: ☐

    aa. Is the serving area clean and well ventilated?   Yes: ☐   No: ☐

13. Summary of Technical Assistance Given On-Site (list the scenario that occurred during the visit, technical assistance given, and have the individual receiving technical assistance sign and report their job title)

Review Item	Brief Description	Technical Assistance Given	Individual Receiving Technical Assistance	
			Signature	Job Title

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 Non-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.

[　] 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 be in Compliance** with the above CACFP requirements.

_____   _____   _____

Signature of Facility's Authorized Representative   **Title**   **Date**

_____   _____   _____

 Signature of Reviewer   **Title**   **Date**