Test Month/Year:

SPONSORING ORGANIZATION DAY CARE HOME MONITORING TOOL
Department of Health and Human Services
Division of Public Health
Child and Adult Care Food Program

Sponsored Provider Name:

Agreement #:

GENERAL							
The test month must be a complete month in which the Provider has submitted documentation to file a claim.							
Date of Review			Arrival Time				
Type of Visit	☐	Monitoring	☐	Unannounced	☐	Follow Up	
	☐	Announced	☐	Training / Technical Assistance	☐	First 4-week review	
Last Monitoring Visit			Name of Monitor				
Name of Sponsor							
Provider's Address							
Provider's Telephone #							
Person(s) Interviewed							
Approved Days of Care	☐	Sunday	☐	Wednesday	☐	Saturday	
	☐	Monday	☐	Thursday			
	☐	Tuesday	☐	Friday			
Tier Information							
☐	Tier I						
☐	Tier II						
☐	Tier II with Income Eligibility Applications						

LICENSING AND ELIGIBILITY								
License Number			Effective Date					
License Capacity	1st		2nd		3rd			
						Yes	No	N/A
1	The Provider has a current DHHS/State License/Military.					☐	☐	☐
2	The Provider is at/within license capacity at the time of review.					☐	☐	☐
3	The Provider is at/within age limits at the time of review.					☐	☐	☐
REVIEW OF RECORDS AND DOCUMENTATION								
RECORDKEEPING								
1	The following records must be maintained and available at all times:					Yes	No	N/A
a	Sponsor/Provider Agreement					☐	☐	
b	Attachment F – Contractor's Certification					☐	☐	
c	Certification of Single Exclusive CACFP Agreement - Facility					☐	☐	
d	Information on Owners/Principals - Facility					☐	☐	
e	Annual Information Certification for Facilities					☐	☐	☐

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		Yes	No	N/A
2	The Provider has documentation from the Sponsor of their reimbursement options, Tier 1 or Tier II.	☐	☐	
3	Has the Provider made information about WIC available to parents/guardians of children enrolled in CACFP?	☐	☐	
MONITORING				
1	Is the Provider new to CACFP?	☐	☐	
a	If "Yes" to #1, provide the date that the Provider was approved to participate with the CACFP.			
b	If "Yes" to #1, was the first monitoring conducted within the first 4 weeks of program participation?	☐	☐	☐
c	If "Yes" to #1, provide the date that the first monitoring visit was conducted.			
2	Does the Provider have documentation of the Sponsor monitoring visits conducted in the past 12 months on file?	☐	☐	☐
3	List the dates of the Sponsor monitoring conducted in the past 12 months			
4	Were any program violations identified during the last Sponsor conducted monitoring visit?	☐	☐	☐
5	If "Yes," have all corrective actions been implemented?	☐	☐	☐
CIVIL RIGHTS				
		Yes	No	N/A
1	Has the Provider made the "Building for the Future" flier available to parents or guardians of children enrolled in the CACFP?	☐	☐	
2	Are all services, facilities, and program benefits 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, playgrounds, etc.)	☐	☐	
3	Is there a need for bilingual materials? If "Yes," how is this addressed?	☐	☐	
a				
4	Are there any requirements or procedures which restrict or deny enrollment on the basis of race, color, national origin, age, sex, or disability?	☐	☐	
5	Are the non-discrimination statement and complaint procedures included in Provider advertisements when referencing admissions and/or the CACFP?	☐	☐	
ANNUAL REQUIREMENTS				
Current Review Date		Previous Review Date		
***If completed during a previous review, SKIP ANNUAL REQUIREMENTS SECTION**				
CIVIL RIGHTS				
		Yes	No	N/A
1	Has the Provider maintained the ethnic and racial data form for the current year?	☐	☐	
2	Ethnic Categories:			

a	Hispanic or Latino			
b	Not Hispanic or Latino			
c	Total Ethnicity	0		
3	Race Categories:			
a	American Indian or Alaskan Native			
b	Asian			
c	Black or African American			
d	Native Hawaiian or Other Pacific Islander			
e	White			
f	Total Race	0		
		Yes	No	N/A
4	Is the Provider's current participation representative of more than one racial group?	☐	☐	☐
a	If "No," provide a statement indicating the general racial composition of the area the Provider serves.			
5	If ethnic and racial data was obtained by observation, is there documentation on file informing participants and parents/guardians that ethnicity and race will be determined by Provider if not declared by self or parent/guardian?	☐	☐	☐
6	Is the ethnic and racial data collected and maintained for the three preceding fiscal years?	☐	☐	☐
7	Does the Provider have procedures on file for maintaining the confidentiality of beneficiary data collected on individuals and households?	☐	☐	

TRAINING

		Yes	No	N/A
1	Date of the last CACFP programmatic training session the Provider attended:			
2	Does the Provider have documentation of the CACFP programmatic training on file?	☐	☐	
3	List the date of the last CACFP civil rights training session the Provider attended:			
4	Does the Provider have documentation of the CACFP civil rights training on file?	☐	☐	

ATTENDANCE AND ENROLLMENT DATA FOR THE DAY OF THE REVIEW

	Full Name of All Children Enrolled	In Attendance	Age	Enrollment Form	Provider's Own Child	Meal Participant	Claiming Meal
	Example: Brooks Lee	*1*	*3*	*1*		*1*	*1*
1							
2							
3							
4							
5							

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Full Name of All Children Enrolled		In Attendance	Age	Enrollment Form	Provider's Own Child	Meal Participant	Claiming Meal
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34							
35							
36							
Total (1's will auto-tally)		0	N/A	0	N/A	0	0

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DOCUMENTS TO ASSESS ON THE DAY OF THE REVIEW					
MEAL SERVICE TIMES					
	Yes	No		Start Time	End Time
Breakfast	☐	☐	Approved Serving Times		
AM Snack	☐	☐			
Lunch	☐	☐			
PM Snack	☐	☐			
Supper	☐	☐			
Night Snack	☐	☐			

		Yes	No
1	Are serving schedules in accordance with those on the Provider application in NC CARES?	☐	☐
2	Is the Provider only claiming meal service(s) which were approved on their application?	☐	☐
3	Are the meals claimed served to participants who are within regulatory age limits?	☐	☐

MEAL QUESTIONS

		Yes	No
4	Does the Provider charge separately for meals?	☐	☐
5	Does the Provider have menus for the current month?	☐	☐
6	Were daily meal counts documented by the end of the day for the previous day?	☐	☐
a	If "No" to question 6, document the last day recorded:		
7	Does the Provider have attendance documented for the current month?	☐	☐
a	Was daily attendance documented by the end of the day for the previous day?	☐	☐
b	If "No" to question 7a, document the last day recorded:		
8	Document attendance and meal records for past consecutive five days:		

Date	Enrollment	Attendance	Recorded Meal Counts

		Yes	No
a	Do the attendance and meal counts appear reasonable when compared to today's count?	☐	☐

A. INFANT QUESTIONS

		Yes	No
1	Does the Provider enroll infants in its childcare? [If "No," skip to section Meal Observation on the Day of Review (As Applicable)]	☐	☐

		Yes	No
2	Are infants currently enrolled with the Provider? [If "No," skip to section Meal Observation on the Day of Review (As Applicable)]	☐	☐
3	Does the Provider offer the infant meal pattern to currently enrolled infants?	☐	☐
	If "No," list participants for whom the Provider lacks the documentation that the infant meal pattern is offered, including Infant Feeding Consent Form:		
4	List the type of infant formula the Provider provides:		
5	Is the formula offered by the Provider in stock?	☐	☐
6	Provide the expiration date of the formula in stock		
7	Are solid foods provided?	☐	☐
8	Does the Provider provide all or all except one of the required components of the infant meal pattern?	☐	☐
a	If "No," does the parent provide no more than one component of the infant meal for meals claimed?	☐	☐

MEAL OBSERVATION ON THE DAY OF THE REVIEW (AS APPLICABLE)

☐	**No Meal Observed Check Box (SKIP to Meal Count Section)**					
	Type of Meal Observed	Breakfast				
	Time Served FROM		AM		PM	
	Time Served TO		AM		PM	

A. INFANT MEAL OBSERVATION

Check the appropriate box below:

☐	No infants were in attendance during meal observation (skip to section B)		
☐	No infants were being fed during meal observation – fed on demand (skip to section B)		
	Number of infants in attendance but not served during meal observation:		
	Number served for each age group:		Birth – 5 months
			6-11 months

Food Component (Infants)	Amount prepared for meal service	Amount to be adequate	Adequate Yes	Adequate No
Meat / Meat Alternate Component			☐	☐
Vegetable / Fruit Component			☐	☐
Iron-Fortified Infant Cereal / Grain Component			☐	☐
Breastmilk / Iron Fortified Formula Component			☐	☐

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B. CHILD MEAL OBSERVATION

	# Served	# Non-Dairy
1 year		
2 years		
3-5 years		
6-12 years		
13-18 years		
Program Adults		
Non-program Adults		

Food Component (Children)	Amount prepared for meal service	Amount to be adequate	Adequate	
			Yes	No
Meat / Meat Alternate Component			☐	☐
Fruit Component			☐	☐
Vegetable / Vegetable Component			☐	☐
Grain Component			☐	☐
Whole Milk Component			☐	☐
Low-Fat / Skim Milk Component			☐	☐
Non-Dairy Beverage Component			☐	☐

		Yes	No	N/A
1	Did the observed meal meet the meal pattern requirements?	☐	☐	☐
2	Were all meal components served at the same time?	☐	☐	☐
3	Does the Provider provide all or all except one of the required components for the child meal pattern?	☐	☐	☐
4	Are all participants over 2 years of age served fat-free / low-fat milk during the meal service?	☐	☐	☐
5	Does the Provider make meal modifications for enrolled participants with medical conditions (i.e. physical or mental impairments)?	☐	☐	☐
a	If “Yes,” is a signed medical statement or comparable documentation describing the medical condition available for review?	☐	☐	☐

b	Are meal modifications documented on the menu?	☐	☐	☐
6	Were non-dairy beverages served in lieu of fluid milk?	☐	☐	☐
a	If "Yes," are the non-dairy beverages nutritionally equivalent to fluid milk and meet the nutritional standards for fortification of calcium, protein, vitamin A, vitamin D, and other nutrients to levels found in cow's milk, as outlined in the National School Lunch Program (NSLP) regulations at 7 CFR section 210.10 (m)(3)?	☐	☐	☐
7	Is water made available to drink during meal service and throughout the day?	☐	☐	☐
8	If family style dining is used, answer the following questions:			
a	Is each participant offered all components?	☐	☐	☐
b	Is enough food available to provide the minimum servings of all required components for all participants?	☐	☐	☐

ASSESSMENT OF DOCUMENTATION FOR THE TEST MONTH

MEAL COUNTS

Total # days food service was provided		Average Daily Attendance	

Meals Served	Provider Reported	Reviewer Verified	Outcome Review of Records
Breakfast			O
AM Snack			O
Lunch			O
PM Snack			O
Supper			O
Night Snack			O
Totals	0	0	

Outcome reasons: C = correctly stated, O = overstated, U = understated

		Yes	No	N/A
1	Are there daily records of meal counts by type (breakfast, lunch, supper, and snacks) served to enrolled participants?	☐	☐	☐
2	Did the Provider report more meals than participants in attendance?	☐	☐	☐
3	Did the Provider report meals on days when they were closed (i.e. holidays, vacations)?	☐	☐	☐
4	Did the Provider report more than one meal and two snacks or two meals and one snack per participant?	☐	☐	☐

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MENU REVIEW					
	Number of Meals Disallowed	Reason Codes			
Breakfast		A	Missing infant formula/breastmilk	I	Missing grain component
AM Snack		B	Juice served to infants	J	Missing vegetable or fruit component
Lunch		C	Missing creditable grain for infants at snack	K	Juice served more than once per day
PM Snack		D	Missing meat/meat alternate/iron-fortified infant cereal	L	Missing meat/meat alternate component
Supper		E	Missing milk component	M	Yogurt exceeds sugar limit
Night Snack		F	Missing whole grain rich once per day (child and adult menus only)	N	Missing 2nd creditable component at snack (child and adult menus only)
		G	Grain-based dessert served	O	Deep-fat frying on site/in satellite kitchen
		H	Cereal exceeds sugar limit	P	Missing menu
		* Missing supporting documentation			

		Yes	No	N/A
1	Is the type of milk recorded on the menu, including flavored or unflavored and fat content?	☐	☐	☐
2	Is a fruit and vegetable or two vegetable components provided daily at lunch and/or supper?	☐	☐	☐
3	Is 100% juice offered more than once per day?	☐	☐	☐
4	Is juice offered to infants?	☐	☐	☐
5	Was at least one serving of whole grains identified on the menu each day?	☐	☐	☐
6	Are all grains either whole grain or enriched?	☐	☐	☐
7	Are all breakfast cereals six grams of sugar or less per dry ounce?	☐	☐	☐
8	Is the type of cereal identified on the menu?	☐	☐	☐
9	Are grain-based desserts counted towards the grain component?	☐	☐	☐
10	If served at breakfast, are meat/meat alternates served in place of grains no more than three times per week?	☐	☐	☐
11	Is deep-fat frying used as a cooking method?	☐	☐	☐
12	Is unflavored milk provided to participants from one to five years of age?	☐	☐	☐
13	If served, is flavored milk fat-free/1% for participants ages six and up?	☐	☐	☐
14	For all combination foods does the Provider have on file and utilize CN labels, product formulation statements, or standardized recipes?	☐	☐	☐

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SUMMARY – NO CORRECTIVE ACTION REQUIRED			
☐	NO CORRECTIVE ACTION REQUIRED		
☐	CONSIDER THIS REVIEW CLOSED		
I verify that this Provider 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 Provider's authorized representative.			
Provider's Authorized Representative			
Provider's Authorized Representative Title		Date:	
Sponsoring Organization Representative			
Sponsoring Organization Representative Title			
Departure Time		Date:	

SUMMARY – CORRECTIVE ACTION REQUIRED			
I, the Provider's authorized representative, verified that this Provider 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 Provider is not in compliance with certain CACFP requirements; that this report serves as a warning regarding non-compliance with those requirements; that I am required to implement the corrective action stated in this report within the timeframe(s) stated to bring this Provider into compliance with CACFP requirements; and that failure to implement the corrective action within the timeframe(s) stated could result in termination of this Provider from participation in the CACFP. I understand that all corrective actions must be implemented fully and permanently. I further understand that this Provider owes the estimated amount of monies listed below due to rate changes and/or disallowances.			
Provider's Authorized Representative			
Provider's Authorized Representative Title		Date:	
Circle One: Total Estimated Amount Due / Or Disallowances Previously Deducted:	$		
I, the Sponsoring Organization Representative, verify that I reviewed this Provider's operation and records on this date and determined that the Provider was not in compliance with certain CACFP requirements, as specified in this report; discussed the findings in this report with the Provider's authorized representative and explained that failure to implement the corrective action required within the timeframe(s) stated could result in termination of the Provider from participation in the CACFP program. Timeframe(s) for implementing the corrective action(s) begin(s) on the date signed above by the Provider's authorized representative. Due date(s) for completion of corrective action(s) is/are stated below and on the attached Summary of Findings.			
☐	Technical Assistance Provided		
Follow-Up Required:			
☐	Unannounced on-site visit by Sponsoring Organization Representative		
☐	Written response to Sponsoring Organization reviewer by Provider on/before:		
	Send written response to:		
Sponsoring Organization Representative			
Sponsoring Organization Representative Title			
Departure Time		Date:	

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SUMMARY – CORRECTIVE ACTION DOCUMENT (CAD)						
Page / Item Number	Brief Description of Program Violation(s)	Repeat Finding?	Corrective Action Document (CAD) Needed	CAD Due Date	On-site Follow-up	
					Yes	No
		No			☐	☐
		No			☐	☐
		No			☐	☐
		No			☐	☐
		No			☐	☐
		No			☐	☐

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Page / Item Number	Brief Description of Program Violation(s)	Repeat Finding?	Corrective Action Document (CAD) Needed	CAD Due Date	On-site Follow-up	
					Yes	No
		No			☐	☐
		No			☐	☐
		No			☐	☐
		No			☐	☐
		No			☐	☐
		No			☐	☐