

**North Carolina Department of Health and Human Services
Child and Adult Care Food Program
Sponsoring Organization Center Review Form**

Arrival Time: _____

Departure Time: _____

Date: _____

Review: Announced Unannounced

1. Sponsoring Organization Name: _____

Agreement #: _____

Center Name: _____

Center Address: _____

2. Type of Visit (Check all that apply):

Monitoring Follow-up Training/Technical Assistance

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

3. Type of facility:

Child Care Center (non-profit)

Adult Day Care Center (non-profit)

Outside-School-Hours Care Center

Proprietary Title XIX Adult Center (for-profit)

After School "At Risk Program"

Proprietary Title XX Center-Child (for-profit)

Homeless Program

Head Start

4. DHHS Licensing Information

Effective Date: From: _____ To: _____

Capacity: _____ Licensing #: _____ Alternate Approval: _____

Is Licensing Capacity exceeded on day of review? Yes No

5. Eligibility applications are on file at: Central Office Facility

6. Current sponsor/center agreement (CAC 8C) on file? Yes No N/A

7. Are complete and current annual enrollment forms on file for all participants? Yes No

8. Is the facility open to everyone regardless of race, sex, color, age, national origin, or disability? Yes No

9. Has the facility made information about WIC available to parents or guardians of children enrolled in CACFP?.. Yes No

10. Training

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

Date	Topic of Training	Name of Staff in Attendance

Findings _____

Suggestions _____

11. Meal Pattern Analysis on Day of Review:

A.

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

Type of Meal Observed _____

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

Number Served: _____ Birth – 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				

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

If not, list participants without the signed formula provision form

C. (Circle type) Child/ Adult Meals

Number Served: _____ 1-2years _____ 3-5years _____ 6-12years _____ Program Adults _____ Non program Adults

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				

Sponsoring Organization Name: _____

Date: _____

Center Name: _____

Agreement# _____

13. Summary of Findings (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

I, the Facility 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. 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 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.

_____/_____
Facility Authorized Representative Title

Date

I, the Sponsoring Organization Representative, verify that I reviewed this facility on this date and discussed the findings in this report with the Facility Authorized Representative; determined that the facility was not in compliance with certain CACFP requirements; as specified in this report; and explained to the Facility Authorized Representative 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