CHILD AND ADULT CARE FOOD PROGRAM
FAMILY CHILD CARE LEARNING HOME (FCCLH) MONITORING FORM

Date of Review: _____ **Arrival Time:** _____ AM/PM **Departure Time:** _____ AM/PM ☐ **Review Unannounced**

Name of Sponsor:	**Sponsor Agreement Number:**
Name of Provider:	**Address:**
Provider Telephone Number:	
Reviewer(s):	**Tier I** ☐ **Tier II** ☐ **Tier II with Income Eligibility Applications** ☐

Family Child Care Learning Home (DCH)	**Approved License Capacity:** _____ **License #** _____ **Date of Last Inspection:** _____ **Expiration Date:** _____ **Informal Provider:** ☐ **# of Children in Care:** _____ **Subsidy Verification from CAPS:** ☐ **Form 58** ☐ **Form 59** ☐ **Form 62**	
Home Operation and Attendance **Normal Hours of Operation:** _____ **AM to** _____ **PM**	**Check Normal Days of Care:** ☐ **Monday – Friday** ☐ **Sun.** ☐ **Mon.** ☐ **Tues.** ☐ **Wed.** ☐ **Thurs.** ☐ **Fri.** ☐ **Sat.**	**Holiday Care:** ☐ **Yes** ☐ **No** **Multiple Shifts** ☐ **Yes** ☐ **No**

Approved Meal Types:	**Breakfast**	**AM Snack**	**Lunch**	**PM Snack**	**Supper**	**Evening Snack**
	☐	☐	☐	☐	☐	☐

	ATTENDANCE AND ELIGIBILITY DATA							
Full Name of all Children listed on the Roster from all shifts	**Child in Attendance?**	**Age**	**Enrollment Form on file?**	**Indicate Relationship to Provider**	**For Pay**	**Not for Pay**	**Meal Participant**	**Meal Claimed**
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								

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LICENSING REQUIREMENTS	YES	NO	NA	COMMENTS
1) Is the Provider's license current/valid at the time of the visit?				
2) Does the Provider meet license capacity at the time of the visit?				
a) Does the Provider have more than twelve (12) related children or children that reside in the home, under the age of 13, present at one time?				
3) Does the Provider have more than six (6) unrelated children, under the age of 13, for pay or not for pay in care at one time?				
4) Does the Provider have written approval from DECAL's CCS Unit to care for an additional two (2) unrelated children, for pay or not for pay, for up to two (2) hours per day?				
5) If an Informal Provider, are there no more than six (6) related children in care for pay? If there is a combination of unrelated and related children in care, does the Informal Provider meet the capacity requirements? Reference CAPS Policy – Participating Providers https://caps.decal.ga.gov/en/Policy/				
6) If an Informal Provider, are there no more than two (2) unrelated children for pay in care at one time?				
a) If an Informal Provider, are the following requirements met: At least 21 years of age?				
b) Have a successful CRC on file?				
c) Eight (8) hours of approved training on Health and Safety?				
d) Have CPR certification on file or within six months of approval?				
e) Have a recent successful home inspection by CCS?				
f) Have a working fire extinguisher and smoke detector where children are located?				
PARTICIPANT ELIGIBILITY/MEAL COUNTS	**YES**	**NO**	**NA**	**COMMENTS**
7) Are the meals only served to children who meet age requirements claimed for reimbursement?				
8) Are meals served to the Provider's own children or foster children in the Provider's care? If so, are the meals/snacks claimed for reimbursement when the following requirements met:				
a) When the Provider's own or foster child(ren) are enrolled for care?				
b) When the Provider's own or foster child(ren) meet eligibility requirements?				
c) When other enrolled child(ren) are present and participating in the meal service?				
9) Are the meals counts recorded on the DCH Weekly Meal Count Record, or an approved alternate form?				
10) Are meal counts consistent with enrollment and attendance for children in care? Use the Meal Reconciliation page to document the number of participants in care according to attendance records.				
CIVIL RIGHTS	**YES**	**NO**	**NA**	**COMMENTS**
11) Based on observation, does the Provider allow all children equal access to childcare services and facilities regardless of race, color, sex, age, disability or national origin?				
12) Does the Provider serve meals to all enrolled children equally regardless of the child's race, color, sex, age, disability or national origin?				
13) Is current racial/ethnic data collected annually and maintained on file by the Provider?				
HEALTH/SAFETY/SANITATION	**YES**	**NO**	**NA**	**COMMENTS**
14) Are the refrigeration and freezer units clean and maintained at required temperatures? (41 and 0 degrees respectively)				

a) Indicate the refrigerator temperature b) Indicate the freezer temperature	Refrigerator Temp: _____ Freezer Temp: _____			
15) Is food properly thawed? Method Used?				
16) Is food properly stored in refrigeration/freezer units and in dry areas?				
a) Are storage areas adequate?				
b) Is all food off the floor?				
c) Is food stored separately from cleaning items and other toxic materials?				
17) Are trash containers covered?				
18) Are wiping cloths clean and replaced often?				
19) Is the home free of rodent or insect infestation?				
20) Is the home free from any obvious fire, health and/or safety hazards?				
21) Is food service conducted in compliance with generally accepted health and sanitation practices?				
22) Does the Provider and children wash hands prior to food handling and eating?				
TRAINING	**YES**	**NO**	**NA**	**COMMENTS**
23) Has the Provider attended the sponsor's training within the last twelve months?				
24) Has the Provider implemented the information provided at training?				
25) If an Informal Provider, is there written record of completing the required Child Care and Parent Services (CAPS) 8-hour Health/Safety Training?				
RECORDKEEPING	**YES**	**NO**	**NA**	**COMMENTS**
26) Is the monthly menu posted in accordance with DECAL's Child Care Services requirements?				
27) Are all meals and snacks on the monthly menu creditable?				
28) Are annually updated enrollment forms, with parent signature and date, on file for all participants?				
29) Does the Provider have copies of previous monitoring reports?				
30) Does the Provider have notification of reimbursement options Tier I or Tier II, on file?				
31) Does the Provider have a copy of the current sponsor/provider agreement on file?				
32) Does the Provider maintain documentation of the non-pay status of related and unrelated children in care?				
PARTICIPANT INFORMATION	**YES**	**NO**	**NA**	**COMMENTS**
33) Is current WIC information distributed to participants per 7 CFR 226.15(n)?				
34) Is the Building for the Future Flyer or applicable sponsor notice that contains the required information distributed to participant households to inform them of the homes' participation in the CACFP per 7 CFR 226.16(b)(5)?				
OTHER REQUIREMENTS	**YES**	**NO**	**NA**	**COMMENTS**
35) Has effective corrective action been implemented for all findings identified in the previous review?				

OBSERVATION OF MEAL SERVICE

36) Record the meal/snack observed, the total number of participants in attendance at the meal service, food items served, and the total number of meals/snacks served to children in care and infant meals, if applicable.

Meal/Snack Type Observed:		**Total Number of Participants Enrolled on Date of Visit:**	**1-13 yrs.**	**Infants**
Meal/Snack Time:				

1-13 yrs.

Meal Components	**Food Item(s)**	**Number of Meals/Snacks Served**				
		1 yr.	2 yr.	3-5 yrs.	6-12 yrs.	13 yrs.
Milk						
Meat/Meat Alternate						
Fruits						
Vegetables						
Grains **At least one serving a day must be WGR**	☐WG					

Infants

Meal Components	**Food Item(s)**	**Number Meals/Snacks Served**	
		Birth through 5 Months	**6 through 11 Months**
Iron-fortified Formula/Breast Milk			
Infant Cereal, Bread, Crackers			
Fruit/Vegetable			
Meat/Meat Alternate			
Sliced Bread or Crackers			

Observed Meal Service on Date of Review	**YES**	**NO**	**N/A**	**COMMENTS**
37) Was the meal/snack served at the approved, scheduled time?				
a) If "NO," does the Provider have documentation that the sponsor notified of the change?				
38) Are items served consistent with the posted menu?				
39) Does the meal/snack observed contain all required components?				
40) Was unflavored whole milk served to children ages 1 yr. and up to 2 years old?				
41) Was unflavored low-fat or fat-free milk served to children ages 2-5?				
42) Was unflavored low-fat, unflavored fat-free milk, flavored low-fat or flavored fat-free milk served to children ages 6 or older?				
43) Were the required serving sizes for each component/food items available and served?				
44) Does the observed meal/snack provide a variety of colors, temperatures, textures, shapes, sizes and favor?				
45) Does the meal service occur in a positive/pleasant environment?				
46) Are medical statements on file for all substitutions related to disabilities or medical needs?				
47) Is the Provider suppling all but one (1) meal component of the CACFP meal pattern?				
48) Is the number of participants in care at the time of the meal service consistent with the number of participants being claimed for the previous days?				

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MEAL COUNT RECONCILIATION

For the current or prior claiming period, for any five consecutive days, determine the number of participants in care according to attendance and enrollment records. Using the Weekly Meal Count Record, document the home's meal counts numbers and attach the Weekly Meal Count Records and the attendance records for the five days reviewed to this form.

☐ **Check box if an automated system was used to satisfy the 5-day meal count reconciliation requirement.**

Breakfast Meal Service			
Date	Number According to Attendance	Number According to Enrollment	Meal Counts Documented by Provider
AM Snack Service			
Date	Number According to Attendance	Number According to Enrollment	Meal Counts Documented by Provider
Lunch Meal Service			
Date	Number According to Attendance	Number According to Enrollment	Meal Counts Documented by Provider
PM Snack Service			
Date	Number According to Attendance	Number According to Enrollment	Meal Counts Documented by Provider
Supper Meal Service			
Date	Number According to Attendance	Number According to Enrollment	Meal Counts Documented by Provider
Evening Meal Service			
Date	Number According to Attendance	Number According to Enrollment	Meal Counts Documented by Provider

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	Meal Service Time Ranges		Day of the Week	Date
Licensed Capacity:	Breakfast		Day 1	
	AM Snack		Day 2	
	Lunch		Day 3	
	PM Snack		Day4	
	Supper		Day 5	
	Evening Snack			

1. Insert the mealtime ranges for the home and dates chosen for the five-day meal reconciliation.
2. Insert each child's name.
3. Record the meal types claimed for each child from the weekly meal count records for the five-day period.
4. Reconcile claimed meals for each child with attendance records for the five-day period.
5. Using each child's enrollment form, check if enrollment information is complete and current and compare the days, meals, and times the parent indicated the child would be in attendance to their meal service records to see if they reconcile for the five-day period.

Child's Name	Day	Meal Participation						Present		Attendance				Enrollment									
										Times				Is Enrollment Form Current & Complete?				Does Enrollment Form Reconcile to Meal Service Records?					
		Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack	Yes	No	AM Time		PM Time		Days		Times		Dey		Meal		Time	
										In	Out	In	Out	Y	N	Y	N	Y	N	Y	N	Y	N
	Day 1																						
	Day 2																						
	Day 3																						
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Child's Name	Day	Meal Participation						Present		Attendance				Enrollment									
										Times				Is Enrollment Form Current & Complete?				Does Enrollment Form Reconcile to Meal Service Records?					
		Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack	Yes	No	AM Time		PM Time		Days		Times		Day		Meal		Time	
										In	Out	In	Out	Y	N	Y	N	Y	N	Y	N	Y	N
	Day 1																						
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Summary of Findings

Provider's Name: _____

Review Item #	Brief Description of Finding(s)	Corrective Action Plan (CAP) Needed	Corrected Onsite?	CAP. Due Date	Follow-up Visit Date	Date Corrected

Provider Signature: _____ Date: _____

Reviewer Signature: _____ Date: _____