



CACFP-Family Day Care Home Sponsor Provider File Review Self-Assessment Tool

Fiscal Year _____ Review Month _____
 Provider Name _____
 Provider ID # _____ Date _____

Instructions: Select a random sample of providers. An appropriate sample size would be at least half the number of providers that would be reviewed in the event of a State Agency review. See the Federal regulations for specific percentages.
 Use the checklist below to assess provider file completeness, edit checks, claim accuracy and current practices.

INITIAL SIGN UP AND HOME VISITS

STANDARD	YES	NO*	COMMENTS: <i>*Expand on any "NO" answers</i>
Provider Date of Birth _____			
Permanent Agreement on file.			
Current license, license exempt paperwork on file: Effective date _____ Expiration date _____ License capacity _____ <u>Days of care</u> <u>Hours</u> <input type="checkbox"/> Sunday _____ <input type="checkbox"/> Monday _____ <input type="checkbox"/> Tuesday _____ <input type="checkbox"/> Wednesday _____ <input type="checkbox"/> Thursday _____ <input type="checkbox"/> Friday _____ <input type="checkbox"/> Saturday _____			
Pre-approval, Initial Training document on file. Date of Pre-approval: _____.			
4 week follow up visit documentation on file. Visit was within 4 weeks of first day of participation (claiming): Start Date _____ Date of 4 Week Visit: _____			
Home Visit documentation Visit 1 _____ <input type="checkbox"/> announced <input type="checkbox"/> unannounced <input type="checkbox"/> meal Visit 2 _____ <input type="checkbox"/> announced <input type="checkbox"/> unannounced <input type="checkbox"/> meal Visit 3 _____ <input type="checkbox"/> announced <input type="checkbox"/> unannounced <input type="checkbox"/> meal Date of other misc. or follow up visit _____ Date of other misc. or follow up visit _____ Date of other misc. or follow up visit _____			
If less than 3 visits were conducted, expand on reason: <input type="checkbox"/> Averaging, provider did not block claim <input type="checkbox"/> Provider is new, began participation mid year <input type="checkbox"/> Provider quit the program, did not participate the full year. <input type="checkbox"/> Other _____			
2 home visits in the fiscal year were unannounced.			
1 unannounced visit included the observation of a meal.			

REVIEW OF PROVIDER REIMBURSEMENT CHECKS: Test Month of _____

Meal totals from claim:

TIER I

Breakfast _____ x rate \$ _____ = \$ _____
AM Snack _____ x rate \$ _____ = \$ _____
Lunch _____ x rate \$ _____ = \$ _____
PM Snack _____ x rate \$ _____ = \$ _____
Supper _____ x rate \$ _____ = \$ _____
EV Snack _____ x rate \$ _____ = \$ _____

TOTAL = \$ _____

TIER II

Breakfast _____ x rate \$ _____ = \$ _____
AM Snack _____ x rate \$ _____ = \$ _____
Lunch _____ x rate \$ _____ = \$ _____
PM Snack _____ x rate \$ _____ = \$ _____
Supper _____ x rate \$ _____ = \$ _____
EV Snack _____ x rate \$ _____ = \$ _____

TOTAL = \$ _____

TIER I + TIER II TOTAL = \$ _____

Check number _____

Check Amount \$ _____

Meal totals and reimbursement from claim match check calculations and check amount? Yes No

Check has cleared the bank? Yes No

Date that check was cancelled and cleared the bank _____

PROVIDER TRAINING

Date of last training provider completed _____

Training Method:

- In home
- Workshop
- Home study lesson
- Other _____

Title of Training(s) _____

Training Topics covered:

- Menu Planning
- Nutrition Education
- Health/Safety/Sanitation
- New CACFP Information
- Other: _____
- Claiming Meals
- Attendance/Meal Counts
- Recordkeeping
- Reimbursement

Comments: _____

RECORDKEEPING AND REIMBURSEMENT EDIT CHECKS

During any of the Home Visits were records unavailable or incomplete? Yes No

If Yes:

Date of Home Visit	Dates and Meals to be Disallowed	Review Corresponding Claim
		<input type="checkbox"/> Meals were disallowed or not claimed <input type="checkbox"/> Meals were paid
		<input type="checkbox"/> Meals were disallowed or not claimed <input type="checkbox"/> Meals were paid
		<input type="checkbox"/> Meals were disallowed or not claimed <input type="checkbox"/> Meals were paid

BLOCK CLAIMING REVIEW

- Provider did not block claim during review period—no further action needed
- Block claim identified on _____
- Unannounced home visit conducted on _____.

Describe Observation/outcome:

SERIOUS DEFICIENCY/CORRECTIVE ACTION

- Provider has not been declared seriously deficient
- Provider was declared seriously deficient on: _____
- Correspondence mailed via certified mail or other approved delivery method Yes No
- Corrective action outcome: _____

ASSESSMENT SUMMARY AND ACTION PLANS

List missing items, errors, discrepancies or concerns identified in the file review. Outline a plan of action to correct items. As you self assess, try to determine if the concern was a clerical error or an issue that needs to be addressed via training, a change in policy or procedure, or some other plan of action.

1. Problem or Concern: _____

Action Plan: _____

Due Date: _____ Responsible Staff Person: _____

2. Problem or Concern: _____

Action Plan: _____

Due Date: _____ Responsible Staff Person: _____

3. Problem or Concern: _____

Action Plan: _____

Due Date: _____ Responsible Staff Person: _____

