HOME VISIT REVIEW REPORT

Provider Name: _____ **Date:** _____ **Phone Number:** _____

Address: _____ **Arrival Time:** _____ **Departure Time:** _____

License Information: _____ _____ _____ Capacity: _____ Posted: ☐ Yes ☐ No **KDHE Exception:** ☐ Yes ☐ No
Number *Effective* *Expiration*

Type of Visit: ***(Check all that apply)*** ☐ Announced ☐ Unannounced ☐ Meal/Snack ☐ Admin ☐ Follow-up **5-Day Reconciliation:** ☐ Onsite ☐ Office

Meal Times: Breakfast _____ Lunch _____ Dinner _____

(Circle meal observed) AM Snack_____ PM Snack _____ Eve Snack _____

Days of Operation: ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun **Care provided on major holidays?** ☐ Yes ☐ No

Full Name of Children in Attendance	***Age***	***Meal Participant?***	***Provider's Child?***	***Menu Items Served:***	***Infant Menu Items Served:***
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

Meal Service	***Yes***	***No***	***N/A***	***Comments:***
Did all meals and snacks served meet meal pattern requirements?				
Did the quantity meet requirements?				
Did each child receive each component?				
Was the meal served as a unit?				
Was the meal served during the scheduled time?				
Is the eating environment pleasant, clean and relaxing?				
Is water being served throughout the day?				
Are additional children expected later for this meal? *If yes, note names.*				
Food Safety and Sanitation	***Yes***	***No***	***N/A***	
Is food kept at the proper temperature? (hot foods hot; cold foods cold)				
Is food properly stored in the refrigerator and cabinets?				
Is the provider and the children properly washing hands?				
Is the trash covered?				
Are pets out of the preparation/serving area?				
Menu Evaluation	***Yes***	***No***	***N/A***	
Was at least one serving of grain per day a whole grain?				
Was juice limited to once per day?				
Grain-based desserts are **not** being claimed as meal components?				
Was cereal limited to 6 grams of sugar per dry ounce?				
Was yogurt limited to 23 grams of sugar per 6 ounces?				
What type of milk is served? List type(s)				
Record Keeping and Capacities	***Yes***	***No***	***N/A***	
Are menus up-to-date and complete? *If no, specify days/meals.*				
Are meal counts up-to-date? *If no, specify days/meals.*				
Is daily attendance up-to-date? *If no, specify days.*				
Is there documentation of whole grain and cereal/yogurt served?				
Is infant formula offered by provider? *(List formula name in Comments)*				
Do children have a current enrollment form?				
Is the home within license capacity?				
Are meal modifications outside the meal pattern supported by a medical statement?				
Are CACFP records available for current year and 3 prior years?				
Is the CACFP training requirement completed for this program year?				
Were findings documented and discussed with provider during visit?				
Are previous CAP findings corrected?				
Are WIC and Building for the Future info distributed/displayed?				
Have findings from KDHE licensing surveys been corrected?				

_____ _____ _____ _____
Reviewer's Signature Date Provider's Signature Date

This institution is an equal opportunity provider.