



The Child and Adult Care Food Program

Facility Pre-Approval Review Form

Name of Sponsoring Organization: _____

Name of Reviewer: _____

Date of Visit: _____ Arrival Time: _____ Departure Time: _____

1. Name of Facility: _____

2. Address and Phone Number of Facility: _____

3. Name and Title of Responsible Official(s) Interviewed on Day of Visit: _____

4. What agreement type will this facility have with the Sponsoring Organization? Non-Cash: Cash:

5. Which program(s) will this facility operate? *Check all that apply.* Child Care: At-Risk:

6. Has the staff attended training from the Sponsoring Organization? Yes: No:

Provide the date(s) of the training: _____

If no, when will staff be trained? _____

7. Number of participants at facility at time of review: _____

8. Age range of child care participants served: _____

If applicable: Age range of at-risk participants served: _____

9. Licensing:

a. Is the facility licensed? Yes: No:

b. Is the license posted? Yes: No:

c. Is the license current? Yes: No:

Date of license expiration: _____

If no, is the facility complying with renewal procedures? Yes: No:

d. Does the number in attendance during the visit exceed the licensed capacity? Yes: No:

e. Does the age range of the **child care** participants comply with the license? Yes: No:

f. *If applicable:* Does the age range of the **at-risk** participants comply with the license? Yes: No:

g. Does the facility currently enroll infants under one (1) year of age? Yes: No:

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

11. Is the facility open to all regardless of marital status, personal appearance, sexual orientation, gender identity or expression, family responsibilities, familial status, source of income, place of residence or business, genetic information, matriculation, or political affiliation? Yes: No:

12. Facility Management:

Does the facility currently have adequate staff to complete the following required CACFP duties?

- a. Take daily attendance Yes: No:
- b. Prepare or check dated daily menus for compliance with meal patterns Yes: No:
- c. Prepare meals (shopping, cooking, unloading deliveries, assembling, etc.) Yes: No:
- d. *For facilities receiving meals from the Sponsoring Organization or Food Service Management Company:* Maintain daily delivery tickets Yes: No:
- e. Serve meals Yes: No:
- f. Take meal counts at the point-of-service for each meal claimed Yes: No:
- g. *For facilities with a cash agreement:* Maintain itemized bills and receipts for all CACFP-related expenses Yes: No:
- h. Collect an Income Eligibility Statement for each enrolled participant Yes: No:

Comments: _____

13. Meal observation

- a. Type of food service operation: Food From Home: FSMC: Self-Prep:

Note: If the facility currently relies on food brought from home, the facility will need to begin procuring meals from Food Service Management Company (FSMC), or purchasing food to prepare in an on-site or off-site kitchen prior to claiming meals for reimbursement. Please indicate the proposed type of food service operation on the Facility Information Form (FIF).

- b. Meal type observed: Breakfast: Lunch/Supper: Snack:

- c. Time of meal service: _____ d. Number of meals served: _____

- e. Does the meal observed meet the meal pattern requirements? Yes: No:
- f. Does the meal observed match the menu posted? Yes: No:

g. **Child Meal** – List **ALL** foods served and note different items for child care versus at-risk meals.

Component	Item(s) Served	Age-appropriate portion?	
Milk	_____	Yes: _____	No: _____
Bread/Bread Alternate	_____	Yes: _____	No: _____
Fruit/Vegetable	_____	Yes: _____	No: _____
Fruit/Vegetable	_____	Yes: _____	No: _____
Meat/Meat Alternate	_____	Yes: _____	No: _____
Other (Optional)	_____	Yes: _____	No: _____

- h. *For facilities with family-style meal service:* Does the staff set out enough food for all participants and instruct participants on the appropriate portion? Yes: No:

i. **Infant Meal** (if applicable)

Component	Item(s) Served	Age-appropriate portion?	
Formula/Breast Milk	_____	Yes: _____	No: _____
Infant Cereal	_____	Yes: _____	No: _____
Fruit/Vegetable	_____	Yes: _____	No: _____
Meat/Meat Alternate	_____	Yes: _____	No: _____
Bread/Cracker	_____	Yes: _____	No: _____

- j. Which formula(s) does the facility offer to infants? _____

14. Food Service Related Licenses, Facilities and Sanitation Procedures

Note: "Adequate" means capable of handling the proposed type and scale of the facility's food service operations.

- a. Are there any obvious fire, health or safety hazards in the facility? Yes: No:
- b. Are meals prepared at a central kitchen operated by the center (not a licensed Food Service Management Company) and distributed to the facility? Yes: No:
- c. If yes, are there adequate systems and equipment to properly transport food? Yes: No:
- d. Are the kitchen and food preparation areas clean? Yes: No:
- e. Does the facility have adequate access running water (including drinking water)? Yes: No:
- f. Does the facility have adequate space and equipment for washing dishes? Yes: No:
- g. Does the facility have adequate working refrigerated storage space? Yes: No:
- h. Are all of the refrigeration units clean? Yes: No:
- i. Are all of the refrigeration units maintained at the proper temperature? Yes: No:
- j. Is the food properly stored in the refrigeration units? Yes: No:
- k. Does the facility have adequate working freezer storage space? Yes: No:
- l. Are all of the freezer units clean? Yes: No:
- m. Are all of the freezer units maintained at the proper temperature? Yes: No:
- n. Is the food properly stored in the freezer units? Yes: No:
- o. Does the facility have adequate dry storage space? Yes: No:
- p. Is food properly stored in the dry storage areas? Yes: No:
- q. Are cleaning supplies and other toxic materials stored separately from food and out of reach of children? Yes: No:
- r. Is there evidence of rodent or insect infestation? Yes: No:
- s. Is there documentation of an exterminating schedule? Yes: No:
- t. Is there a Certified Food Handler on site during the visit? Yes: No:

Name: _____ Certification expiration: _____

- u. Is the Certified Food Handler following proper food safety/sanitation procedures? Yes: No:
- v. Was food service conducted in compliance with generally accepted health and sanitation practices? Yes: No:
- w. Did the provider and the children wash hands prior to food handling? Yes: No:
- x. Did the provider and the children wash hands prior to eating? Yes: No:
- y. Is the serving area equipped for the program? Yes: No:
- z. Is the serving area seating capacity adequate? Yes: No:
- aa. Is the serving area clean and well ventilated? Yes: No:

15. During your visit, please do the following:

✓ when completed

- a. Review menus posted at facility *(if facility currently provides meals)*. _____
- b. Discuss meal pattern requirements, menu planning, and maintaining accurate menus. _____
- c. Discuss procedures for taking and maintaining daily attendance records. _____
- d. Discuss procedures for taking and maintaining point-of-service meal count records. _____
- e. Discuss procedures for distributing and collecting Enrollment/Income Eligibility Statements. _____
- f. *For facilities with a cash agreement:* Discuss procedures for maintaining itemized receipts and invoices and tracking CACFP-related expenses. _____
- g. *For facilities that serve infants:* Discuss procedures for distributing and maintaining Infant Formula Notification forms. _____
- h. Discuss procedures for distributing and maintaining Medical Substitution forms. _____
- i. Discuss other records required by the Sponsoring Organization, if applicable. _____
(Specify records): _____
- j. Discuss procedures for submitting records to the Sponsoring Organization. _____
- k. Discuss Sponsoring Organization monitoring procedures. _____
- l. Observe a meal service. _____

16. List any problems noted during the visit and any related corrective actions that were initiated to correct the problems.

<u>Problem</u>	<u>Corrective Actions</u>	<u>Due Date</u>

Signature of Facility CACFP Representative: _____ Date: _____

Signature of Reviewer: _____ Date: _____