



# 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:

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**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: \_\_\_\_\_

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**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: \_\_\_\_\_

