**SFY26 Senior Nutrition Program Monitoring Tool**

This tool covers monitoring for the following nutrition services:

* OAA funding (HCCBG + NSIP)
* PEAS Project Funding

This tool has four parts, each with its own instructions:

* Part I: Overview of Nutrition Services
* Part II: On-site / On-route Observations
* Part III: Site-Visit Related Documentation Review
* Part IV: Provider Documentation Review

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SERVICE CODE** | **Funding Source** | **NAME** | **Accompanying Attachment(s)** | **Compliance Supplement** | **Funding End Date** |
| 020 | HCCBG | Home-Delivered Meals III-C2 | B2, C | Title III-C - 93.045  NSIP - 93.053 | N/A |
| 021 | Other | Home-Delivered Meals – NSIP-only | B2, C | NSIP - 93.053 | N/A |
| 022 | HCCBG | Home-Delivered Meals Liquid Nutritional Supplement III-C2 | B2, C | Title III-C - 93.045  NSIP - 93.053 | N/A |
|  |  |  |  |  |  |
| 180 | HCCBG | Congregate Meals III-C1 | B1, C | Title III-C - 93.045  NSIP - 93.053 | N/A |
| 181 | Other | Congregate Meals – NSIP-only | B1, C | NSIP - 93.053 | N/A |
| 182 | HCCBG | Congregate Meals Liquid Nutritional Supplement III-C1 | B1, C | Title III-C - 93.045  NSIP - 93.053 | N/A |
|  |  |  |  |  |  |
| 620 | SFRF | PEAS Project Meals | D & E | N/A | 09/30/2026 |
| 630 | SFRF | PEAS Project Food Boxes | D & E | N/A | 09/30/2026 |
| 680 | SFRF | PEAS Project Non-Client Expenses | D | N/A | 09/30/2026 |
| 690 | SFRF | PEAS Project Administrative Expenses | D | N/A | 09/30/2026 |

**PEAS Project Monitoring Requirements**

Complete the following sections to monitor SFRF PEAS Project services.

* Part I: Questions 1 and 2 (page 1)
* Part IV: Attachment D – Fiscal verification
  + 620 - Home-delivered meals
  + 630 - Grocery/Food boxes
  + 680 - Non-client expenses
  + 690 - Administrative Expenses
* Part IV: Attachment E – PEAS Project Client and Unit Verifications
  + 620 - Home-delivered meals
  + 630 - Grocery/Food boxes

**PART I: Overview of Nutrition Services**

Provider Agency:       Provider Code:       Assessment Date:

Agency Staff Interviewed:

AAA Interviewer:

**1. Check all nutrition services reimbursed through the Division in SFY 2026 (refer to ZGA 517-3 report):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Service | Code | Yes | No | Comments |
| Congregate Nutrition Meals | 180 |  |  |  |
| Congregate Nutrition Meals – NSIP-only | 181 |  |  |  |
| Congregate Liquid Nutritional Supplement | 182 |  |  |  |
| Home-delivered Nutrition | 020 |  |  |  |
| Home-delivered Nutrition – NSIP-only | 021 |  |  |  |
| Home-delivered Liquid Nutritional Supplement | 022 |  |  |  |
| PEAS Project Meals | 620 |  |  |  |
| PEAS Project Food Boxes | 630 |  |  |  |
| PEAS Project Non-Client Expenses | 680 |  |  |  |
| PEAS Project Administrative Expenses | 690 |  |  |  |

**2. Check all service delivery styles supported by the HCCBG or SFRF (PEAS) funding:**

|  |  |  |  |
| --- | --- | --- | --- |
| Service Style | Yes | No | Comments (funding source, frequency) |
| Hot meals |  |  |  |
| Frozen meals |  |  |  |
| Shelf-stable meals |  |  |  |
| Liquid nutritional supplements |  |  |  |
| Additional meals: morning meal |  |  |  |
| Additional meals: evening meal |  |  |  |
| Additional meals: weekend meals |  |  |  |
| Therapeutic diet meals |  |  |  |
| Grocery/food boxes |  |  |  |

**3. Check all service delivery styles supported by other funding and reported for NSIP-only reimbursement:**

|  |  |  |  |
| --- | --- | --- | --- |
| Service Style | Yes | No | Comments (funding source, frequency) |
| Hot meals |  |  |  |
| Frozen meals |  |  |  |
| Shelf-stable meals |  |  |  |
| Additional meals: morning, evening, weekend |  |  |  |
| Therapeutic diet meals |  |  |  |

**4. The following questions apply to both congregate and home-delivered meals providers. Answer in the charts below:**

|  |  |  |
| --- | --- | --- |
| **Meals and Menus** | **Yes** | **No** |
| 5. Except for holidays or emergencies, meals are offered 5 days per week, 52 weeks per year, or DAAS has approved a waiver for lesser frequency. [Standards p. 33] |  |  |
| 6. If applicable, please list any waivers and most recent approval date for serving meals less than 5 days/week: |  |  |
| 7. Is food prepared by the provider on-site? If not, write the current vendor for food preparation and delivery: |  |  |
| 8. The nutrition provider arranges for the services of a licensed dietitian/ nutritionist. [Standards p. 29] |  |  |
| 9. Describe the arrangements for the dietitian/nutritionist's involvement in the nutrition program (for example, who employs the dietitian, does the dietitian develop the menus and recipes, how often does the dietitian review menus, how does the dietitian receive menu substitutions for approval, etc.) |  |  |
| 10. Nutrition provider offers nutrition counseling as part of nutrition services. If yes, please describe how services are delivered. [Standards p. 27] (not required) |  |  |
| 11. Nutrition provider does not serve therapeutic meals without a physician's order on file and unless the program has the capability to provide the service. [Standards p. 35] |  |  |
| An annual survey of participants soliciting menu suggestions and client satisfaction is on file. [Standards p. 12] Comments? |  |  |
| 12. Nutrition provider staff and volunteers do not provide unapproved meals (meals or other food that does not follow the approved menu, except menu substitutions when necessary) to participants. [Standards p. 35] |  |  |
| 13. Nutrition provider does not provide meals to ineligible people without reimbursement of the full cost of the meal. [Standards p. 35]  Ineligibility criteria on Standards p. 6:   * People whose dietary needs cannot be met through the meals offered. * People residing in long-term care facilities or enrolled in care- providing programs (including adult day care/day health, except that people attending day care/day health centers may receive meals on the days they do not participate in the adult day program). |  |  |

|  |
| --- |
| **Meals and Menus (cont.)** |
| Corrective Action: |
| Technical Assistance: |

|  |  |  |
| --- | --- | --- |
| **Food Safety and Administrative** | **Yes** | **No** |
| 14. There is a paid nutrition program director. [Standards p. 29] |  |  |
| 15. The nutrition program director participated within the first 12 months of employment in DAAS training on nutrition program management. [Standards p. 29] (*NOTE: N.A. for new directors per DAAS Edmisten email guidance 10/6/2020 – no training was provided in 2020)* |  |  |
| 16. The nutrition program director successfully passed an approved American National Standards Institute (ANSI) accredited program exam within the first 12 months of employment at least 15 hours of instruction in food service sanitation. [effective 1-1-14; NC Food Code 2-102.12; passing exam good for 5 yrs.] |  |  |
| 17. If applicable, does the nutrition provider have written procedures prepared in advance for Time as a Public Health Control (TPHC) and is supporting documentation available (example: food delivery tickets; food discard date & time labeling)? [Standards p. 21] If so, explain: |  |  |
| 18. The nutrition provider notifies the AAA if the sanitation grade at any nutrition site falls below "A" or 90%. [Standards p. 20] (Check here if all grades are 90% and higher. ) |  |  |
| 19. Food is received by staff or trained volunteers. Meal arrival time is documented, signed by the person receiving the food. If food is held prior to serving in warming or refrigeration equipment, temperatures are taken and recorded at the time of food delivery. [Standards p. 21] List any exceptions noted by nutrition staff: |  |  |
| 20. The nutrition staff can demonstrate efforts to train current volunteer staff. [Standards p. 29] |  |  |
| 21. Nutrition provider staff and volunteers do not administer medical treatment or medications. [Standards p. 35] |  |  |
| Corrective Action: | | |
| Technical Assistance: | | |

|  |  |  |
| --- | --- | --- |
| **Consumer Contributions (Program Income Verification)** |  |  |
| 22. Two individuals open, count, and record consumer contributions. |  |  |
| 23. The person making deposits is different from the people counting and recording contributions. |  |  |
| 24. Verify program income reported in ARMS:  The amount of program income in ARMS for the month of is the same as the program amount in the agency's General Ledger for the same referenced date. If not, explain. |  |  |
| 25. Program Income Verification: The purpose of this question is to verify the amount of program income (cost sharing) collected at the provider’s nutrition site equals the amount recorded in the provider’s accounting records. With assistance from nutrition/agency staff, trace one or more sample transactions from the point of collecting program income through recording in the General Ledger:  $     Amount collected at Nutrition Site on      (date)  $     Amount counted and recorded at location  (if the administrative offices are a different location from nutrition site)  $     Amount recorded on deposit slip for the sample date.  $     Amount recorded in General Ledger or accounting records of the provider.  There should be a clear audit trail from the point of counting program income to the point of deposit and recording in the General Ledger. Explain any difference in these amounts: |  |  |

|  |  |  |
| --- | --- | --- |
| **Fiscal** | **Yes** | **No** |
| 26. Congregate Utilization levels for the HCCBG budget at the time of the AAA assessment are consistent with budget projections for the fiscal year. If not, describe appropriate adjustments. |  |  |
| 27. Home-delivered meals Utilization levels for the HCCBG budget at the time of the AAA assessment are consistent with budget projections for the fiscal year. If not, describe appropriate adjustments. |  |  |
| 28. Nutrition provider does not use HCCBG funds to purchase vehicles to deliver meals. [Standards p. 35] |  |  |
| 29. Nutrition provider staff and volunteers do not carry out financial transactions except those related to donations. [Standards p. 35] |  |  |
| 30. Nutrition provider staff and volunteers do not accept gifts. [Standards p. 35] |  |  |
| Corrective Action: | | |
| Technical Assistance: | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Congregate-Only** | **N/A** | **Yes** | **No** |
| 31. Congregate meal provider offers at least one hot or other appropriate meal per day in a congregate setting |  |  |  |
| 32. Congregate nutrition sites are not closed or combined on a temporary or permanent basis (except in an emergency) without the prior written approval of the AAA administrator assuring that options for maintaining services have been considered. [Standards p. 35] |  |  |  |
| Corrective Action: | | | |
| Technical Assistance: | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Home-Delivered Nutrition-Only** | **N/A** | **Yes** | **No** |
| 33. Home-delivered meal provider delivers at least one hot, cold, frozen, dried, canned, or supplemental meal per day to homebound older adults. [Standards p. 3] |  |  |  |
| 34. Nutrition provider has written procedures for reporting changes in the eligibility of home-delivered meal clients (i.e., termination of services). [Standards p. 7] |  |  |  |
| 35. Nutrition provider has procedures to document eligible home- delivered meal clients receive telephone client reassessments every other 6 months. [DAAS Adm Ltr No. 05-13] |  |  |  |
| Corrective Action: | | | |
| Technical Assistance: | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **36.** **Reconciliation of Units:** The purpose of this question is to reconcile the total number of units, by service, reimbursed from ARMS to the total number of units recorded on the provider’s daily meal tracking records (e.g., the ZGA- 903 [turnaround documents], ServTracker meal attendance information, etc.)  With nutrition staff, reconcile a sample month of units by completing the following:   |  |  |  | | --- | --- | --- | | **Sample month and year:** | **Congregate Nutrition** | **Home-delivered Meals** | | 1. The total units reimbursed by ARMS – use the ZGA 370 - Provider Reimbursement Report or the ZGA 542 - Units of Service Verification Report |  |  | | B. Total units documented on provider’s meal tracking records |  |  | | 1. Difference between units reimbursed by ARMS (A) and total units documented on the provider’s meal tracking record (B) |  |  |  1. Explain any difference (C) between units reimbursed by ARMS (A) and total units documented on the provider’s meal tracking records (B):   F. Explain any difference between units reimbursed by ARMS (A) and adjusted units recorded (E): Click or tap here to enter text. |

**PART II: On-Site Observations**

**Directions:** This section has two parts – Part A covers the observations made at the congregate site visited, and Part B covers the observations made on the home-delivered meal route ridden. Both sections must be completed when a nutrition provider serves both types of meals. If the provider only serves congregate meals or home-delivered meals, skip the section that is not applicable to them.

|  |  |  |
| --- | --- | --- |
| **Part II-A: Congregate On-Site Observations** | **Yes** | **No** |
| **Name of Site Visited and Date:** |  |  |
| 37. Congregate meal provider offers at least one hot or other appropriate meal per day in a congregate setting. |  |  |
| 38. The areas where food is handled or served are clean and in good repair. |  |  |
| 39. The Health Department sanitation permit is posted in a visible location at nutrition site. |  |  |
| 40. A written plan is posted in at least one visible location that describes procedures to follow in case a participant becomes ill or injured. |  |  |
| 41. A calendar of activities for the month is posted on-site. |  |  |
| 42. There is a contribution system in full view. |  |  |
| 43. Contributions are counted and recorded at the site by two individuals. If Home delivered only, may be counted at a central office. If not, describe the procedures observed: |  |  |
| 44. Obtain copy of agency's Attachment A: Site Review. AAA's observations on-site agree with provider's assessment. If not, note exceptions: |  |  |
| 45. Approved menu is posted in meal serving area. |  |  |
| 46. Approved menu is posted in meal preparation area of nutrition site. |  |  |
| 47. Approved menu is served on day of site visit. |  |  |
| 48. If the approved menu is not served on day of visit, reviewer observes that caterer has sent appropriate notification of menu changes. |  |  |
| 49. Congregate food temperatures are taken immediately before serving on the day of the site visit, and serving time is recorded. |  |  |
| 50. Food temperatures taken on day of congregate site visit:       Meat/meat alternative (specify      )       Grains or other carbohydrates (specify      )       Vegetable or Fruit (specify Vegetable or Fruit (specify       )       Milk (if other source of calcium, specify      )       Other (specify      ) |  |  |
| **Part II-A: Congregate On-Site Observations (continued from previous page)** | **Yes** | **No** |
| 51. On day of visit, food prepared off-site is received by staff or a trained volunteer, who document meal arrival time and sign the delivery ticket. Food temperatures are taken and recorded if food is held in warming or refrigeration equipment prior to serving. |  |  |
| 52. Prior to serving congregate meals, home-delivered meals are individually plated, packaged, and transported immediately. *(Check here if this is Not Applicable to this site* ) |  |  |
| 53. Note observations about food presentation and palatability based on direct experience or interactions with clients on day of site visit. |  |  |
| 54. Identify the names of 3-5 individuals who received a meal on the day of the site visit:  (At least 2 names must be included in client record review or verify these names are included in provider’s client database.) |  |  |
| 55. Note observations about the perceived eligibility of clients in attendance on day of site/route visit: |  |  |
| 56. In general, packaging and transport equipment appears to be clean, in good repair, and capable of maintaining food temperatures and protecting food from potential contamination. Comments? |  |  |
| 57. If frozen meals are provided, they are dated with the date delivered to the nutrition program.  *(Check here if this is Not Applicable – site does not provide frozen meals* ) |  |  |
| 58. On day of site visit, compare meals prepared or received, meals served, and meals unserved:  \_\_     \_\_\_\_\_\_Meals ordered  \_\_     \_\_\_\_\_\_Meals prepared or received  \_\_     \_\_\_\_\_\_Meals served  \_\_     \_ \_\_\_Meals unserved |  |  |
| Corrective Action: | | |
| Technical Assistance: | | |

**PART II-B: On-Site Observations (continued)**

|  |  |  |
| --- | --- | --- |
| **Part II-B: Home-Delivered Meals** | **Yes** | **No** |
| **Name of Route Ridden and Date:** |  |  |
| 59. Identify the names of 3-5 individuals who received a meal on the day of the route visit:  (At least 2 names must be included in client record review or verify these names are included in provider’s client database.) |  |  |
| 60. Clients receiving meals on the route appear to need service. (If perception raises question, reviewer should include this client in desk review of client records.) |  |  |
| 61. Volunteers accept contributions and take them back to nutrition site or central office. |  |  |
| 62. If frozen meals are provided, they are dated with the date delivered to the nutrition program. *(Check here if this is Not Applicable – site does not provide frozen meals* ) |  |  |
| 63. Food temperatures taken on day of home-delivered meals route observation:       Meat/meat alternative (specify      )       Grains or other carbohydrates (specify      )       Vegetable or Fruit (specify Vegetable or Fruit (specify       )       Milk (if other source of calcium, specify      )       Other (specify      ) |  |  |
| 64. On day of route, compare meals prepared or received, meals served, and meals unserved:  \_\_     \_\_\_\_\_\_Meals ordered  \_\_     \_\_\_\_\_\_Meals prepared or received  \_\_     \_\_\_\_\_\_Meals served  \_\_     \_ \_\_\_Meals unserved |  |  |
| Corrective Action: | | |
| Technical Assistance: | | |

**PART III: Site-Visit Related Documentation Review**

There are three parts in this section, which requires documentation review for congregate and/or home-delivered routes. This section may be completed either on-site or remotely as long as results are covered in an exit interview.

1. **Meals Ordered and Meals Served**

**Directions:** Select 5 random dates and compare number of meals ordered and number of meals served for **either** congregate **or** home-delivered clients at the site/route.

Congregate site name/Home-delivered route:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | #1 | #2 | #3 | #4 | #5 |
| Date: |  |  |  |  |  |
| Site or route: |  |  |  |  |  |
| Meals ordered (skip if caterer not used): |  |  |  |  |  |
| Meals received or prepared: |  |  |  |  |  |
| Meals served: |  |  |  |  |  |
| Meals unserved: |  |  |  |  |  |

**Notes:**

1. **Approved Menus**

**Directions:** Review the menu for the month in which the on-site review is occurring from **either** one site **or** route. Note whether the following requirements are met.

|  |  |  |
| --- | --- | --- |
| **Meals and Menus** | **Yes** | **No** |
| Menus are changed at least two times per year. [Standards p. 13] |  |  |
| Each page of menus has been signed by a licensed dietitian/nutritionist to certify that the menus meet all federal and state requirements [Standards p. 12]. |  |  |
| A nutrient analysis is on file with each certified menu [Standards p. 12]. |  |  |
| Menu change forms are on file with each certified menu to document:   * date of delivery, * specific food substitution, and * signature of the production manager and/or dietitian authorizing the menu change. [Standards p. 12] |  |  |
| Menu substitutions are approved by the dietitian/nutritionist within 90 days or no later than July 31st. [Standards p. 12] If not, list exceptions: |  |  |
| Corrective Action: | | |
| Technical Assistance: | | |

**PART III: Site-Visit Related Documentation Review (continued)**

1. **Meal delivery tickets – For catered meals only (skip section if food is prepared on site)**

**Directions:** Select one week of meal delivery tickets or comparable documentation from **either** one site **or** route. Meal tickets document each food item that was delivered, record the end of preparation time, and are signed by the food production manager.

Congregate site name/Home delivered route:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 |
| Date: |  |  |  |  |  |
| Site or route: |  |  |  |  |  |
| Meal tickets document each food item delivered |  |  |  |  |  |
| Meal tickets record the end of preparation time |  |  |  |  |  |
| Meal tickets signed by food production manager |  |  |  |  |  |
| Approved menu is followed or menu changes are appropriately documented |  |  |  |  |  |
| Describe how the caterer communicates menu substitutions to the provider when the food is delivered. | | | | | |

**Notes:**

**PART IV: Nutrition Provider Documentation Review**

In this section, required documentation for congregate sites and/or home-delivered routes beyond the site and route visited in-person will be reviewed. This section may be completed either on-site or remotely as long as results are covered in an exit interview. Required topics include:

1. Congregate nutrition sites review – must include **all** the provider’s congregate sites (Attachment A included for reference, not for monitor to fill out)
2. Temperature documentation – must review **50%** of the provider’s congregate sites (Att. B1) and/or home-delivered meals routes (Att. B2)
3. Client record reviews and unit verification – choose sample size based on policy in Section 308 AAA Policy and Procedure Manual.
4. **Congregate meal site health and safety requirements – Review ALL of providers’ congregate sites.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Name of Congregate Site | Date of last health inspection | Last health inspection grade | Attachment A on File | Documentation that fire drills have been conducted quarterly | Current fire inspection report (according to local fire code inspection schedule) (p.34) | Site has emergency plan for medical emergencies and evacuation in case of fire or explosion (p.34) | Site has clearly posted written plan on procedures if participant becomes ill or injured (p. 34) | Site has a paid site manager, paid for no more than 4 hours per day out of the HCCBG (Standards p. 29) | Site manager is responsible for site activities and posts an activities calendar at the start of each month | Documentation on file that site manager has received training on site operations, recordkeeping, resources and referrals, food safety and food portioning | Notes |
| 1 |  |  |  |  |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |  |  |  |  |  |

**PART IV: Nutrition Provider Documentation Review - Continued**

1. **Congregate meal site health and safety requirements – Review ALL of providers’ congregate sites.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Name of Congregate Site | Date of last health inspection | Last health inspection grade | Attachment A on File | Documentation that fire drills have been conducted quarterly | Current fire inspection report (according to local fire code inspection schedule) (p.34) | Site has emergency plan for medical emergencies and evacuation in case of fire or explosion (p.34) | Site has clearly posted written plan on procedures if participant becomes ill or injured (p. 34) | Site has a paid site manager, paid for no more than 4 hours per day out of the HCCBG (Standards p. 29) | Site manager is responsible for site activities and posts an activities calendar at the start of each month | Documentation on file that site manager has received training on site operations, recordkeeping, resources and referrals, food safety and food portioning | Notes |
| 11 |  |  |  |  |  |  |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |  |  |  |  |  |  |
| 13 |  |  |  |  |  |  |  |  |  |  |  |  |
| 14 |  |  |  |  |  |  |  |  |  |  |  |  |
| 15 |  |  |  |  |  |  |  |  |  |  |  |  |

**Notes:**

**Attachment A: Congregate Nutrition Site Review**

Attachment A must be on file for each nutrition site and available for review by the AAA during the assessment process.

Name of Nutrition Site:

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Yes | No |
| 1 | The site is located to be accessible to people eligible for services and targeted by the Older Americans Act. |  |  |
| 2 | The site is an attractive facility where all eligible persons feel free to visit and where their cultural and ethnic background will not be offended. |  |  |
| 3 | The site has at least 12-14 square feet per person excluding halls, bathrooms, and kitchen areas. |  |  |
| 4 | The site has an adequate number of sturdy tables for the number of individuals on the attendance roll and chairs appropriate for older adults. |  |  |
| 5 | The site has at least one table surrounded by adequate aisle space (3 ft. 8 in.) to allow for persons with canes, walkers, crutches, or wheelchairs to move with ease. When necessary, this table shall be of sufficient height (2 ft. 8 in.) to permit persons in fixed-arm wheelchairs to dine comfortably. |  |  |
| 6 | The site has at least 2 exits which are unlocked during hours of operation. |  |  |
| 7 | Emergency and evacuation plans are posted. |  |  |
| 8 | Visible, usable fire extinguishers are in place, and instructions for use are posted. |  |  |
| 9 | The site is heated during colder months to at least 72 degrees Fahrenheit while participants are present. |  |  |
| 10 | The approved menus are posted in both the congregate serving area and the meal preparation area of the site. |  |  |
| 11 | A calendar of activities and programs is posted at the beginning of each month. |  |  |
| 12 | A current permit from the Health Department is posted. |  |  |
| 13 | The site has a system for voluntary, confidential donations by participants. |  |  |
| 14 | Parking is available. |  |  |
| 15 | The site has a safe and appropriate place to mount and dismount from vans or other group transportation vehicles. |  |  |

Name of provider staff who completed form:

Title:      Date form completed:

Signature:

**Attachment B1 - Congregate Meals Temperature Documentation Review – Review 50% of the providers’ sites. Check the box to answer YES.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Name of Congregate Site | Food temps are recorded for each food item, as appropriate. | Arrival times are recorded (and temps if warming/ refrig. equip. used) | Serving time & temps are recorded daily | Review **cold** foods - State percentage out of compliance for month. | Review **hot** foods - State percentage out of compliance for month. | Notes |
| 1 |  |  |  |  | % | % |  |
| 2 |  |  |  |  | % | % |  |
| 3 |  |  |  |  | % | % |  |
| 4 |  |  |  |  | % | % |  |
| 5 |  |  |  |  | % | % |  |
| 6 |  |  |  |  | % | % |  |
| 7 |  |  |  |  | % | % |  |
| 8 |  |  |  |  | % | % |  |

Technical assistance:

Corrective action:

**Attachment B2. Home-Delivered Meals Temperature Documentation Review – Review 50% of the providers’ routes. Check the box to answer YES.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Name of Route | Food temps are recorded for each food item, as appropriate. | Arrival times are recorded (and temps if warming/ refrig. equip. used) | Food temps are recorded at least monthly on each route. | Review **cold** foods - State percentage out of compliance for month. | Review **hot** foods - State percentage out of compliance for month. | Notes |
| 1 |  |  |  |  | % | % |  |
| 2 |  |  |  |  | % | % |  |
| 3 |  |  |  |  | % | % |  |
| 4 |  |  |  |  | % | % |  |
| 5 |  |  |  |  | % | % |  |
| 6 |  |  |  |  | % | % |  |
| 7 |  |  |  |  | % | % |  |
| 8 |  |  |  |  | % | % |  |

Technical assistance:

Corrective action:

# ATTACHMENTS C & E: Client Record Review and Unit Verification

Directions:

1. Choose a random sample of clients, and be sure sample includes clients from each Site/Route/Worker (SRW) code. Include at least 2 people observed at the congregate site visit, and one or more special eligibility clients (if any). Sample size should be based total clients served by the provider, using the policy in Section 308 AAA Policy and Procedure Manual.
   1. If sample size exceeds space on page, make more copies of the page for the rest of the sample.
   2. The Notes column is optional and may be used as needed.
2. Attach Units of Service Verification Report (ZGA-542) used to select sample of clients and units. Highlight clients sampled. UV sample size may be split between 2 funding sources over a 2-month period. If the number served is greater than 150 unduplicated clients, the sample may be split between 3 codes with Division approval.
3. If unverified units are found, share a copy of this completed worksheet with the provider during the exit interview. Also attach copies of other worksheets, such as copies of the ZGA-903 or comparable meal tracking documents.

|  |  |
| --- | --- |
| Service | Code |
| Congregate Nutrition Meals | 180 |
| Congregate Nutrition Meals – NSIP-only | 181 |
| Congregate Liquid Nutritional Supplement | 182 |
| Home-delivered Nutrition | 020 |
| Home-delivered Nutrition – NSIP-only | 021 |
| Home-delivered Liquid Nutritional Supplement | 022 |
| PEAS Project Meals | 620 |
| PEAS Project Food Boxes | 630 |
| PEAS Project Non-Client Expenses | 680 |
| PEAS Project Administrative Expenses | 690 |

# ATTACHMENT C: Client Record Review and Unit Verification Page      of

# CONGREGATE NUTRITION

# DATE OF ASSESSMENT:       NUTRITION PROVIDER:

# MONTH AND YEAR REVIEWED:       FUND SOURCE (HCCBG, ARPA):

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Client Name | S/R/W Code | Eligible client? Write in DOB and if applicable documentation reviewed for special eligibility. | Date of most recent CRF? | Is CRF complete? | Has CRF been updated at least every 12 months? | # units reported (A) | # units verified (B) | # units unverified (C) | Notes (Dates of unverified units, as applicable, other comments, etc.) |
| 1 |  |  |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |  |  |  |
| 11 |  |  |  |  |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |  |  |  |  |
| 13 |  |  |  |  |  |  |  |  |  |  |
| 14 |  |  |  |  |  |  |  |  |  |  |
| 15 |  |  |  |  |  |  |  |  |  |  |
|  | | | | | | Totals |  |  |  |  |
|  | | | | | | Percent of unverified units = Total unverified units (C)       ÷ Total units  reported (A)       x 100 =      % | | | | |
|  | | | | | | If 10% or more, expand sample and select another month for review. | | | | |

**Notes:**

# Signature of reviewer(s)       Date

# ATTACHMENT C: Client Record Review and Unit Verification Page      of

# CONGREGATE THERAPEUTIC DIET MEALS

# DATE OF ASSESSMENT:       NUTRITION PROVIDER:

# MONTH AND YEAR REVIEWED:       FUND SOURCE:

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Client Name | S/R/W Code | Eligible client? Write in DOB and if applicable documentation reviewed for special eligibility. | Date of most recent CRF? | Is CRF complete? | Has CRF been updated at least every 12 months? | MD prescription on file? | Prescription reordered every 6 mos? Write date of most recent | # units reported (A) | # units verified (B) | # units unverified (C) | Notes (Dates of unverified units, as applicable, other comments, etc.) |
| 1 |  |  |  |  |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |  |  |  |  |  |
| 11 |  |  |  |  |  |  |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |  |  |  |  |  |  |
| 13 |  |  |  |  |  |  |  |  |  |  |  |  |
| 14 |  |  |  |  |  |  |  |  |  |  |  |  |
| 15 |  |  |  |  |  |  |  |  |  |  |  |  |
|  | | | | | | | | Totals |  |  |  |  |
|  | | | | | | | | Percent of unverified units = Total unverified units (C)       ÷  Total units reported (A)       x 100 =      % | | | | |
|  | | | | | | | | If 10% or more, expand sample and select another month for review. | | | | |

**Notes:**

# Signature of reviewer(s)       Date

# ATTACHMENT C: Client Record Review and Unit Verification Page      of

# CONGREGATE – NSIP ONLY

# DATE OF ASSESSMENT:       NUTRITION PROVIDER:

# MONTH AND YEAR REVIEWED:       FUND SOURCE:

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Client Name | S/R/W Code | Eligible client? Write in DOB and if applicable documentation reviewed for special eligibility. | Date of most recent CRF? | Is CRF complete? | Has CRF been updated at least every 12 months? | # units reported (A) | # units verified (B) | # units unverified (C) | Notes (Dates of unverified units, as applicable, other comments, etc.) |
| 1 |  |  |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |  |  |  |
| 11 |  |  |  |  |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |  |  |  |  |
| 13 |  |  |  |  |  |  |  |  |  |  |
| 14 |  |  |  |  |  |  |  |  |  |  |
| 15 |  |  |  |  |  |  |  |  |  |  |
|  | | | | | | Totals |  |  |  |  |
|  | | | | | | Percent of unverified units = Total unverified units (C)       ÷ Total units  reported (A)       x 100 =      % | | | | |
|  | | | | | | If 10% or more, expand sample and select another month for review. | | | | |

**Notes:**

# Signature of reviewer(s)       Date

# ATTACHMENT C: Client Record Review and Unit Verification Page      of

# CONGREGATE LIQUID NUTRITION SUPPLEMENT

# DATE OF ASSESSMENT:       NUTRITION PROVIDER:

# MONTH AND YEAR REVIEWED:       FUND SOURCE:

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Client Name | S/R/W Code | Eligible client? Write in DOB and if applicable documentation reviewed for special eligibility. | Date of most recent CRF? | Is CRF complete? | Has CRF been updated at least every 12 months? | Professional authorization on file? | Prof. auth. every 6 mos? Write date of most recent | # units reported (2 cans = 1 meal) (A) | # units verified (B) | # units unverified (C) | Notes (Dates of unverified units, as applicable, other comments, etc.) |
| 1 |  |  |  |  |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |  |  |  |  |  |
| 11 |  |  |  |  |  |  |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |  |  |  |  |  |  |
| 13 |  |  |  |  |  |  |  |  |  |  |  |  |
| 14 |  |  |  |  |  |  |  |  |  |  |  |  |
| 15 |  |  |  |  |  |  |  |  |  |  |  |  |
|  | | | | | | | | Totals |  |  |  |  |
|  | | | | | | | | Percent of unverified units = Total unverified units (C)       ÷  Total units reported (A)       x 100 =      % | | | | |
|  | | | | | | | | If 10% or more, expand sample and select another month for review. | | | | |

**Notes:**

# Signature of reviewer(s)       Date

# ATTACHMENT C: Client Record Review and Unit Verification Page      of

# HOME-DELIVERED MEALS

# DATE OF ASSESSMENT:       NUTRITION PROVIDER:

# MONTH AND YEAR REVIEWED:       FUND SOURCE:

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Client Name | S/R/W Code | Eligible HDM client? Write in DOB and if applicable documentation reviewed for special eligibility. | | Date of most recent CRF? | Is CRF complete? | Has CRF been updated at least every 6 months? | Has CRF been updated IN HOME at least every 12 months? | # units reported (A) | # units verified (B) | # units unverified (C) | Notes (Dates of unverified units, as applicable, other comments, etc.) |
| 1 |  |  |  | |  |  |  |  |  |  |  |  |
| 2 |  |  |  | |  |  |  |  |  |  |  |  |
| 3 |  |  |  | |  |  |  |  |  |  |  |  |
| 4 |  |  |  | |  |  |  |  |  |  |  |  |
| 5 |  |  |  | |  |  |  |  |  |  |  |  |
| 6 |  |  |  | |  |  |  |  |  |  |  |  |
| 7 |  |  |  | |  |  |  |  |  |  |  |  |
| 8 |  |  |  | |  |  |  |  |  |  |  |  |
| 9 |  |  |  | |  |  |  |  |  |  |  |  |
| 10 |  |  |  | |  |  |  |  |  |  |  |  |
| 11 |  |  |  | |  |  |  |  |  |  |  |  |
| 12 |  |  |  | |  |  |  |  |  |  |  |  |
| 13 |  |  |  | |  |  |  |  |  |  |  |  |
| 14 |  |  |  | |  |  |  |  |  |  |  |  |
| 15 |  |  |  | |  |  |  |  |  |  |  |  |
|  | | | | Totals | | | | |  |  |  |  |
|  | | | | | | | | | Percent of unverified units = Total unverified units (C)       ÷  Total units reported (A)       x 100 =      % | | | |
|  | | | | | | | | | If 10% or more, expand sample and select another month for review. | | | |

**Notes:**

# Signature of reviewer(s)       Date

# ATTACHMENT C: Client Record Review and Unit Verification Page      of

# HOME-DELIVERED THERAPEUTIC DIET MEALS

# DATE OF ASSESSMENT:       NUTRITION PROVIDER:

# MONTH AND YEAR REVIEWED:       FUND SOURCE:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Client Name | | S/R/W Code | Eligible HDM client? Write in DOB and any documentation reviewed for special eligibility. | Date of most recent CRF? | Is CRF complete? | Has CRF been updated at least every 6 months? | CRF updated IN HOME at least every 12 months? | MD prescription on file? | Prescription reordered every 6 mos? Write date of most recent | # units reported (A) | # units verified (B) | # units unverified (C) | Notes (Dates of unverified units, as applicable, other comments, etc.) |
| 1 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 2 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 3 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 4 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 5 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 6 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 7 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 8 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 9 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 10 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 11 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 12 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 13 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 14 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 15 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
|  | |  | | | | | | | | Totals |  |  |  |  |
|  | |  | | | | | | | | Percent of unverified units = Total unverified units (C)       ÷ Total units reported (A)       x 100 =      % | | | | |
|  | |  | | | | | | | | If 10% or more, expand sample and select another month for review. | | | | |

**Notes:**

# Signature of reviewer(s)       Date

# ATTACHMENT C: Client Record Review and Unit Verification Page      of

# HOME-DELIVERED MEALS – NSIP-ONLY

# DATE OF ASSESSMENT:       NUTRITION PROVIDER:

# MONTH AND YEAR REVIEWED:       FUND SOURCE:

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Client Name | S/R/W Code | Eligible HDM client? Write in DOB and if applicable documentation reviewed for special eligibility. | | Date of most recent CRF? | Is CRF complete? | Has CRF been updated at least every 6 months? | Has CRF been updated IN HOME at least every 12 months? | # units reported (A) | # units verified (B) | # units unverified (C) | Notes (Dates of unverified units, as applicable, other comments, etc.) |
| 1 |  |  |  | |  |  |  |  |  |  |  |  |
| 2 |  |  |  | |  |  |  |  |  |  |  |  |
| 3 |  |  |  | |  |  |  |  |  |  |  |  |
| 4 |  |  |  | |  |  |  |  |  |  |  |  |
| 5 |  |  |  | |  |  |  |  |  |  |  |  |
| 6 |  |  |  | |  |  |  |  |  |  |  |  |
| 7 |  |  |  | |  |  |  |  |  |  |  |  |
| 8 |  |  |  | |  |  |  |  |  |  |  |  |
| 9 |  |  |  | |  |  |  |  |  |  |  |  |
| 10 |  |  |  | |  |  |  |  |  |  |  |  |
| 11 |  |  |  | |  |  |  |  |  |  |  |  |
| 12 |  |  |  | |  |  |  |  |  |  |  |  |
| 13 |  |  |  | |  |  |  |  |  |  |  |  |
| 14 |  |  |  | |  |  |  |  |  |  |  |  |
| 15 |  |  |  | |  |  |  |  |  |  |  |  |
|  | | | | Totals | | | | |  |  |  |  |
|  | | | | | | | | | Percent of unverified units = Total unverified units (C)       ÷  Total units reported (A)       x 100 =      % | | | |
|  | | | | | | | | | If 10% or more, expand sample and select another month for review. | | | |

**Notes:**

# Signature of reviewer(s)       Date

# ATTACHMENT C: Client Record Review and Unit Verification Page      of

# HOME-DELIVERED LIQUID NUTRITION SUPPLEMENT

# DATE OF ASSESSMENT:       NUTRITION PROVIDER:

# MONTH AND YEAR REVIEWED:       FUND SOURCE:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Client Name | | S/R/W Code | Eligible HDM client? Write in DOB and any documentation reviewed for special eligibility. | Date of most recent CRF? | Is CRF complete? | Has CRF been updated at least every 6 months? | CRF updated IN HOME at least every 12 months? | Professional authorization on file? | Prof. auth. updated every 6 mos? Write date of most recent | # units reported (2 cans = 1 meal) (A) | # units verified (B) | # units unverified (C) | Notes (Dates of unverified units, as applicable, other comments, etc.) |
| 1 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 2 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 3 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 4 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 5 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 6 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 7 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 8 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 9 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 10 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 11 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 12 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 13 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 14 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 15 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
|  | |  | | | | | | | | Totals |  |  |  |  |
|  | |  | | | | | | | | Percent of unverified units = Total unverified units (C)       ÷ Total units reported (A)       x 100 =      % | | | | |
|  | |  | | | | | | | | If 10% or more, expand sample and select another month for review. | | | | |

**Notes:**

# Signature of reviewer(s)       Date

**Attachment D: Fiscal Verification of Non-Unit Expenses for the SFRF PEAS Project**

Nutrition Provider / Agency:       **Page      of**

Provider / Agency Staff Interviewed:

Month and Year Reviewed:

Signature of Reviewer(s):

Date:

1. Check all options for service delivery supported by SFRF PEAS Project funds.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **CODE** | **NAME** | **YES** | **NO** | **CODE** | **NAME** | **YES** | **NO** |
| 620 | SFRF PEAS Meals |  |  | 680 | SFRF PEAS Non-Client Expenses |  |  |
| 630 | SFRF PEAS Food Boxes |  |  | 690 | SFRF PEAS Administrative Expenses |  |  |

1. Select a month of PEAS reimbursement in ARMS and document that reimbursement correlates with actual expenses (e.g., PEAS Project monthly tracking sheet, receipts, invoices, time sheets, etc.). Make additional copies of this page as needed.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Service Code** | **Expense Type (meals, groceries, mileage, wages, etc.)** | **Expense amount in ARMS (A)** | **Expense amount in Excel Tracking Sheet (B)** | **Amount verified with supporting documentation (receipts, invoices, timesheets, etc.) (C)** | **Source Documentation Reviewed** | **Reimbursement correlates with actual expenditure.** | **Expenditures are allowable and can be attached to a function of the service.** | **Notes – required if NO is answered** |
|  |  |  |  |  |  | Yes  No | Yes  No |  |
|  |  |  |  |  |  | Yes  No | Yes  No |  |
|  |  |  |  |  |  | Yes  No | Yes  No |  |
|  |  |  |  |  |  | Yes  No | Yes  No |  |
|  |  |  |  |  |  | Yes  No | Yes  No |  |
|  |  |  |  |  |  | Yes  No | Yes  No |  |
|  |  |  |  |  |  | Yes  No | Yes  No |  |
|  |  |  |  |  |  | Yes  No | Yes  No |  |
|  |  |  |  |  |  | Yes  No | Yes  No |  |
|  |  |  |  |  |  | Yes  No | Yes  No |  |
|  |  |  |  |  |  | Yes  No | Yes  No |  |

Comments:

**ATTACHMENT E: PEAS Project Client Record Review and Unit Verification Page      of**

**PEAS PROJECT MEALS**

# DATE OF ASSESSMENT:       NUTRITION PROVIDER:

# MONTH AND YEAR REVIEWED:

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Client Name | S/R/W Code | Eligible PEAS client? Write in DOB and check CRF to confirm eligibility (frail and/or functionally impaired). | | Date of most recent CRF? | Is CRF complete? | Has CRF been updated at least every 6 months? | Has CRF been updated IN HOME at least every 12 months? | # units (meals) reported (A) | # units verified (B) | # units unverified (C) | Notes (Dates of unverified units, as applicable, other comments, etc.) |
| 1 |  |  |  | |  |  |  |  |  |  |  |  |
| 2 |  |  |  | |  |  |  |  |  |  |  |  |
| 3 |  |  |  | |  |  |  |  |  |  |  |  |
| 4 |  |  |  | |  |  |  |  |  |  |  |  |
| 5 |  |  |  | |  |  |  |  |  |  |  |  |
| 6 |  |  |  | |  |  |  |  |  |  |  |  |
| 7 |  |  |  | |  |  |  |  |  |  |  |  |
| 8 |  |  |  | |  |  |  |  |  |  |  |  |
| 9 |  |  |  | |  |  |  |  |  |  |  |  |
| 10 |  |  |  | |  |  |  |  |  |  |  |  |
| 11 |  |  |  | |  |  |  |  |  |  |  |  |
| 12 |  |  |  | |  |  |  |  |  |  |  |  |
| 13 |  |  |  | |  |  |  |  |  |  |  |  |
| 14 |  |  |  | |  |  |  |  |  |  |  |  |
| 15 |  |  |  | |  |  |  |  |  |  |  |  |
|  | | | | Totals | | | | |  |  |  |  |
|  | | | | | | | | | Percent of unverified units = Total unverified units (C)       ÷  Total units reported (A)       x 100 =      % | | | |
|  | | | | | | | | | If 10% or more, expand sample and select another month for review. | | | |

**Notes:**

# Signature of reviewer(s)       Date

**ATTACHMENT E: PEAS Project Client Record Review and Unit Verification Page      of**

**PEAS PROJECT BOXES**

# DATE OF ASSESSMENT:       NUTRITION PROVIDER:

# MONTH AND YEAR REVIEWED:

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Client Name | S/R/W Code | Eligible PEAS client? Write in DOB and check CRF to confirm eligibility (frail and/or functionally impaired). | | Date of most recent CRF? | Is CRF complete? | Has CRF been updated at least every 6 months? | Has CRF been updated IN HOME at least every 12 months? | # units (food boxes) reported (A) | # units verified (B) | # units unverified (C) | Notes (Dates of unverified units, as applicable, other comments, etc.) |
| 1 |  |  |  | |  |  |  |  |  |  |  |  |
| 2 |  |  |  | |  |  |  |  |  |  |  |  |
| 3 |  |  |  | |  |  |  |  |  |  |  |  |
| 4 |  |  |  | |  |  |  |  |  |  |  |  |
| 5 |  |  |  | |  |  |  |  |  |  |  |  |
| 6 |  |  |  | |  |  |  |  |  |  |  |  |
| 7 |  |  |  | |  |  |  |  |  |  |  |  |
| 8 |  |  |  | |  |  |  |  |  |  |  |  |
| 9 |  |  |  | |  |  |  |  |  |  |  |  |
| 10 |  |  |  | |  |  |  |  |  |  |  |  |
| 11 |  |  |  | |  |  |  |  |  |  |  |  |
| 12 |  |  |  | |  |  |  |  |  |  |  |  |
| 13 |  |  |  | |  |  |  |  |  |  |  |  |
| 14 |  |  |  | |  |  |  |  |  |  |  |  |
| 15 |  |  |  | |  |  |  |  |  |  |  |  |
|  | | | | Totals | | | | |  |  |  |  |
|  | | | | | | | | | Percent of unverified units = Total unverified units (C)       ÷  Total units reported (A)       x 100 =      % | | | |
|  | | | | | | | | | If 10% or more, expand sample and select another month for review. | | | |

**Notes:**

# Signature of reviewer(s)       Date