**Instructions for Completing SFY26 Senior Nutrition Program Monitoring Tool**

This tool has been modified to include monitoring for the traditional OAA funding (HCCBG + NSIP) as well as for PEAS Project (SFRF) funding of nutrition services.

|  |  |
| --- | --- |
| SERVICE CODE | NAME |
| 020 | HCCBG Home-Delivered Meals III-C2 |
| 021 | HCCBG Home-Delivered Meals – NSIP-only |
| 022 | HCCBG Home-Delivered Meals Liquid Nutritional Supplement III-C2 |
| 180 | HCCBG Congregate Meals III-C1 |
| 181 | HCCBG Congregate Meals – NSIP-only |
| 182 | HCCBG Congregate Meals Liquid Nutritional Supplement III-C1 |
| 620 | SFRF PEAS Meals |
| 630 | SFRF PEAS Food Boxes |
| 680 | SFRF PEAS Non-Client Expenses |
| 690 | SFRF PEAS Administrative Expenses |

**If the agency has used service codes 020, 021, 022, 180, 181, 182, 620, 630, 680, or 690:**

* For high-risk assessments of providers or services, regardless of funding source, full programmatic monitoring with record reviews and unit verifications is required.
	+ Complete pages 2-16 of the monitoring tool, plus the appropriate Attachment C for services monitored.
* For providers or services with assessments that are not high risk, regardless of funding source, the AAA may choose to do full programmatic monitoring as above, may choose to do unit verifications only, or may choose not to monitor per the guidance in Administrative Letter 22-01.
	+ For unit verifications only, complete the appropriate Attachment C for services monitored.

**If the agency has used service codes 620, 630, 680, or 690:**

* For non-unit services that require a sample month review (codes 620, 630, 680, or 690), complete Attachment D.
* For non-unit services that require a sample month review and unit verification (codes 620, 630), complete Attachment E.

# NC DIVISION OF AGING AND NC AREA AGENCIES ON AGING (AAA)

**2026 NUTRITION SERVICES ASSESSMENT TOOL**

**PART I**

**Staff Interviews and Review of Related Documentation**

Provider Agency:       Assessment Date: Click or tap to enter a date.

Agency Staff Interviewed:

Signature of AAA Interviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Nutrition Service Reimbursements:

## Check all nutrition services reimbursed through the Division

|  |  |  |  |
| --- | --- | --- | --- |
|  |  Yes | No | Service Codes/Comments |
| Congregate Nutrition  |[ ]  [ ]  |       |
| Congregate Nutrition – NSIP-only  |[ ]  [ ]  |       |
| Congregate Liquid Nutritional Supplement  |[ ]  [ ]  |       |
| Home-delivered Nutrition  |[ ]  [ ]  |       |
| Home-delivered Nutrition – NSIP-only  |[ ]  [ ]  |       |
| Home-delivered Liquid Nutritional Supplement  |[ ]  [ ]  |       |

**Meal Options:**

1. Check all options for service delivery supported by the Home and Community Care Block Grant and/or SFRF PEAS Project:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Frequency?(e.g., 5 days/wk, emergencies, as funding allows, occasionally) |
| Hot lunches |[ ]  [ ]  |       |
| Frozen meals |[ ]  [ ]  |       |
| Shelf-stable meals |[ ]  [ ]  |       |
| Liquid nutritional supplements |[ ]  [ ]  |       |
| Additional meals: morning meal |[ ]  [ ]  |       |
| Additional meals: evening meal |[ ]  [ ]  |       |
| Additional meals: weekend meals |[ ]  [ ]  |       |
| Therapeutic diet meals |[ ]  [ ]  |       |

1. Check all options for service delivery supported by other funding sources and reported for NSIP-only reimbursement:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Frequency?(e.g., 5 days/wk, emergencies, as funding allows, occasionally) |
| Hot lunches |[ ]  [ ]  |       |
| Frozen meals |[ ]  [ ]  |       |
| Shelf-stable meals |[ ]  [ ]  |       |
| Additional meals: morning meal |[ ]  [ ]  |       |
| Additional meals: evening meal |[ ]  [ ]  |       |
| Additional meals: weekend meals |[ ]  [ ]  |       |
| Therapeutic diet meals |[ ]  [ ]  |       |

|  |  |  |  |
| --- | --- | --- | --- |
| **C = Congregate only HD = Home-delivered only None = Both** | N.A. | Yes | No |
| C-4. Nutrition provider has on file a completed Attachment A: Site Review for each nutrition site.  |[ ]  [ ]  |[ ]
| C-5. Congregate meal provider offers at least one hot or other appropriate meal per day in a congregate setting. [Standards p. 3] |[ ]  [ ]  |[ ]
| C-6. Documentation is on file that fire drills are conducted quarterly at each congregate nutrition site. [Standards p. 34] List exceptions:       |[ ]  [ ]  |[ ]
| C-7. A current fire department inspection report has been completed for all sites according to the local fire code inspection schedule, or agency can show efforts to have inspection completed. [Standards p. 34] List exceptions:       |[ ]  [ ]  |[ ]
| C-8. There are paid site managers, and they are paid for no more than 4 hours per day out of the Home and Community Care Block Grant. [Standards p. 29] |[ ]  [ ]  |[ ]
| C-9. Site managers are responsible for activities at their sites and post a calendar of activities at the beginning of each month at each site. [Standards p. 27] |[ ]  [ ]  |[ ]
| C-10. Documentation is on file that site managers have received training or are knowledgeable because of previous experience about site operations, record-keeping requirements, community resources and referral procedures, food safety, and food portioning. [Standards p. 29] |[ ]  [ ]  |[ ]
| C-11. Each nutrition site has an emergency plan for medical emergencies and evacuation in case of fire or explosion. [Standards p. 34] |[ ]  [ ]  |[ ]
| C-12. Each nutrition site has posted in at least one visible location a written plan that describes procedures to follow in case a participant becomes ill or injured. [Standards p. 34] |[ ]  [ ]  |[ ]
| 13. Except for holidays or emergencies, meals are offered 5 days per week, 52 weeks per year, or the Division has approved a waiver for lesser frequency. [Standards p. 33] |[ ]  [ ]  |[ ]
| 14. Nutrition provider offers nutrition counseling as part of nutrition services. If yes, please describe how services are delivered. [Standards p. 27] |[ ]  [ ]  |[ ]

|  |  |  |  |
| --- | --- | --- | --- |
|  | N.A. | Yes | No |
| 15. Food is prepared on-site. If not, name the current vendor for food preparation and delivery:       |[ ]  [ ]  |[ ]
| 16. An annual survey of participants soliciting menu suggestions and client satisfaction is on file. [Standards p. 12] Comments?       |[ ]  [ ]  |[ ]
| 17. The nutrition provider arranges for the services of a licensed dietitian/ nutritionist. [Standards p. 29] |[ ]  [ ]  |[ ]
| 18. 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.)       |
|  | N.A. | Yes | No |
| 19. 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:       |[ ]  [ ]  |[ ]
| 20. The nutrition provider notifies the AAA if the sanitation grade falls below "A" or 90%. [Standards p. 20] |[ ]  [ ]  |[ ]
| 21. 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:       |[ ]  [ ]  |[ ]
| 22. There is a paid nutrition program director. [Standards p. 29] |[ ]  [ ]  |[ ]
| 23. 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.] |[ ]  [ ]  |[ ]

|  |  |  |  |
| --- | --- | --- | --- |
|  | N.A. | Yes | No |
| 24. 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)* |[ ]  [ ]  |[ ]
| 25. The nutrition staff can demonstrate efforts to train current volunteer staff. [Standards p. 29] |[ ]  [ ]  |[ ]

|  |  |  |  |
| --- | --- | --- | --- |
| **Answer the following as true/false statements.** | N.A. | True | False |
| 26. Nutrition provider does not use funds to purchase vehicles to deliver meals. [Standards p. 35] |[ ] [ ] [ ]
| 27. 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).
 |[ ] [ ] [ ]
| 28. 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] |[ ] [ ] [ ]
| 29. Nutrition provider staff and volunteers do not administer medical treatment or medications. [Standards p. 35] |[ ] [ ] [ ]
| 30. Nutrition provider staff and volunteers do not carry out financial transactions except those related to donations. [Standards p. 35] |[ ] [ ] [ ]
| 31. Nutrition provider staff and volunteers do not provide unapproved meals to participants. [Standards p. 35] |[ ] [ ] [ ]
| 32. Nutrition provider staff and volunteers do not accept gifts. [Standards p. 35] |[ ] [ ] [ ]
| 33. 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] |[ ] [ ] [ ]

|  |  |  |  |
| --- | --- | --- | --- |
|  | N.A. | Yes | No |
| 34. 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.       |[ ]  [ ]  |[ ]

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 35. 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 ZGA- 903 (turnaround documents). With nutrition staff, reconcile a sample month of units by completing the following:

|  |  |  |
| --- | --- | --- |
|  | Congregate Nutrition | Home-delivered Meals |
| 1. =The total units reimbursed by ARMS for the month of

 (See the ZGA 370 or the Units of Service Verification Report) |       |       |
| B. =Total units submitted for keying from the ZGA 903 to  ARMS for the month chosen above.  |       |       |
| C. - Less units not accepted by ARMS for the chosen  month (see error report, if applicable. If the provider keys  directly into ARMS, enter zero) |       |       |
| D. + Add units keyed and accepted by ARMS in the month  chosen above that were disallowed in a previous  month(s).  |       |       |
| E. =Total (B – C+ D): Item A (total units reimbursed) and E  (adjusted units recorded) should equal.  |       |       |

 F. Explain any difference between units reimbursed by ARMS (A) and adjusted units  recorded (E):      F. Explain any difference between units reimbursed by ARMS (A) and adjusted units recorded (E): Click or tap here to enter text. |
|  | N.A. | Yes | No |
| 36. Two individuals open, count, and record consumer contributions. |[ ] [ ] [ ]
| 37. The person making deposits is different from the people counting and recording contributions. |[ ] [ ] [ ]
| 38. 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.       |[ ] [ ] [ ]

|  |
| --- |
| 39. 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:       |
|  | N.A. | Yes | No |
| HD-40. 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] |[ ]  [ ]  |[ ]
| HD-41. Nutrition provider has written procedures for reporting changes in the eligibility of home-delivered meal clients (i.e., termination of services). [Standards p. 7] |[ ]  [ ]  |[ ]
| HD-42. 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] *NOTE: During the major disaster**Declaration all reassessments maybe conducted by telephone.* |[ ]  [ ]  |[ ]
| Corrective Action/Technical Assistance:       |

**NC DIVISION OF AGING AND NC AREA AGENCIES ON AGING**

**NUTRITION SERVICES ASSESSMENT TOOL**

**PART II**

**AAA Observations and Review of Activities**

**at Nutrition Site(s) and on Home-delivered Meal Route(s)**

|  |
| --- |
|  (make additional copies of this section as necessary for each site or route) |
| **Name of nutrition site visited and date:** |
| Please document the current meal service process (e.g., “Agency is providing frozen meal carry-out meal service to congregate nutrition program participants in senior center parking lot daily. Home-delivered meals clients are delivered 5 frozen meals each Monday. Meals continue to be prepared by local hospital in compliance with a certified menu. Participants are called once a week by staff/volunteers for a safety check and for socialization. Consumer contributions are accepted.”).      |

|  |  |  |  |
| --- | --- | --- | --- |
|  | N.A. | Yes | No |
| C-1. Obtain copy of agency's Attachment A: Site Review. AAA's observations on-site agree with provider's assessment. If not, note exceptions:       |[ ]  [ ]  |[ ]
| C-2. Identify the names of 3-5 individuals who received a meal on the day of the site visit:      [Include 2 or more of these names in the client record reviews OR verify that these names are included in the agency's client database during Part III: Desk Review.][Include 2 or more of these names in the client record reviews OR verify that these names are included in the agency's client database during Part III: Desk Review.] |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | N.A. | Yes | No |
| C-3. A calendar of activities for the month is posted on-site. |[ ]  [ ]  |[ ]
| C-4. There is a contribution system in full view. |[ ]  [ ]  |[ ]
| C-5. A written plan is posted in at least one visible location that describes procedures to follow in case a participant becomes ill or injured. |[ ]  [ ]  |[ ]
| C-6. Congregate food temperatures are taken immediately before serving on the day of the site visit, and serving time is recorded. |[ ]  [ ]  |[ ]
| C-7. 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      ) |
| C-8. Approved menu is posted in meal serving area. |[ ]  [ ]  |[ ]

|  |  |  |  |
| --- | --- | --- | --- |
|  | N.A. | Yes | No |
| 9. Approved menu is posted in meal preparation area of nutrition site. |[ ]  [ ]  |[ ]
| 10. Approved menu is served on day of site visit. |[ ]  [ ]  |[ ]
| 11. If the approved menu is not served on day of visit, reviewer observes that caterer has sent appropriate notification of menu changes. |[ ]  [ ]  |[ ]
| 12. 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. |[ ]  [ ]  |[ ]
| 13. The areas where food is handled or served are clean and in good repair. |[ ]  [ ]  | [ ]  |
| 14. The Health Department sanitation permit is posted in a visible location at nutrition site. |[ ]  [ ]  |[ ]
| 15. Prior to serving congregate meals, home-delivered meals are individually plated, packaged, and transported immediately. |[ ]  [ ]  |[ ]
| 16. 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?       |[ ]  [ ]  |[ ]
| 17. If frozen meals are provided, they are dated with the date delivered to the nutrition program. |[ ]  [ ]  |[ ]

|  |
| --- |
| 18. Note observations about food presentation and palatability based on direct experience or interactions with clients on day of site visit.       |
| 19. Note observations about the perceived eligibility of clients in attendance on day of site/route visit:       |
| 20. On day of site/route visit, compare meals prepared or received, meals served, and meals unserved:\_\_     \_\_\_\_\_\_Meals ordered\_\_     \_\_\_\_\_\_Meals prepared or received Meals served\_\_     \_ \_\_\_Meals unserved |
|  | N.A. | Yes | No |
| 21. 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:       |[ ]  [ ]  |[ ]

**Home-delivered Meal Route:**

Name of route that AAA rides and date:

|  |  |  |  |
| --- | --- | --- | --- |
|  | N.A. | Yes | No |
| HD-22. 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.] |[ ]  [ ]  |[ ]
| HD-23. Volunteers accept contributions and take them back to nutrition site or central office. |[ ]  [ ]  |[ ]
| HD-24. Home-delivered meal temperatures taken on route:\_     \_\_\_\_\_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       ) |

|  |
| --- |
| Corrective Action:       |
| Technical Assistance:       |

# NC DIVISION OF AGING AND NC AREA AGENCIES ON AGING

**NUTRITION SERVICES ASSESSMENT TOOL**

**PART III**

**Desk Review**

|  |
| --- |
| **Desk review of Health Department permits:** |
| 1. The nutrition provider has on file copies of current Environmental Health permits for each nutrition site. List the site, date of inspection, and grade for each site:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Site | Date of Inspection | Grade |  | Site | Date of Inspection | Grade |
|       |       |       |  |       |       |       |
|       |       |       |  |       |       |       |
|       |       |       |  |       |       |       |
|       |       |       |  |       |       |       |
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|       |       |       |  |       |       |       |
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 |

|  |  |  |  |
| --- | --- | --- | --- |
| **Desk review of clients observed receiving meals:** | N.A. | Yes | No |
| 2. Unless two or more of the client names recorded during the site visits are included in the client record review/unit verification, verify that the names are included in the agency's client database. Identify selected clients:       |[ ]  [ ]  |[ ]

|  |  |  |  |
| --- | --- | --- | --- |
| **Comparison of one week of approved menus****and one week of meal delivery tickets at one site/route:** | N.A. | Yes | No |
| 3. Select one week of meal delivery tickets or comparable documentation. Meal tickets document each food item that was delivered, record the end of preparation time, and are signed by the food production manager. If not, list exceptions:       |[ ]  [ ]  |[ ]
| 4. Compare the selected week of meal tickets or comparable documentation to approved menus for that week. The approved menus were followed, or menu changes are documented on menu change forms. List exceptions:       |[ ]  [ ]  |[ ]
| 5. In what form does the caterer provide to the agency on the date food is delivered written notification that emergency menu substitutions have been made? Examples include meal delivery ticket notation or menu change form.       |

|  |  |  |  |
| --- | --- | --- | --- |
| **Desk review of menu files:** | N.A. | Yes | No |
| 6. Menus are changed at least two times per year. [Standards p. 13] |[ ]  [ ]  |[ ]
| 7. 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] or comply with Pandemic Guidance. |[ ]  [ ]  |[ ]
| 8. A nutrient analysis is on file with each certified menu [Standards p. 12] or comply with Pandemic Guidance. |[ ]  [ ]  |[ ]
| 9. 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]
 |[ ]  [ ]  |[ ]
| 10. Menu substitutions are approved by the dietitian/nutritionist within 90 days or no later than July 31st. [Standards p. 12] If not, list exceptions:       |[ ]  [ ]  |[ ]

|  |
| --- |
| **Desk review of meals ordered and meals served:** |
| 11. Select 5 random dates and compare meals ordered and meals served for either congregate or home-delivered clients:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | #1 | #2 | #3 | #4 | #5 |
| Date:  |       |       |       |       |       |
| Site or route:  |       |       |       |       |       |
| Meals ordered:  |       |       |       |       |       |
| Meals received or prepared:  |       |       |       |       |       |
| Meals served:  |       |       |       |       |       |
| Meals unserved:  |       |       |       |       |       |

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| **Temperature documentation review:** |
| C-12. Congregate:Review a month of temperature records for at least 50% of nutrition sites and attach a completed **Attachment B: Congregate Temperature Review.**  |
| HD-13. Home-delivered:Review a month of temperature records for at least 50% of nutrition routes and attach a completed **Attachment B: Home-delivered Temperature Review.** |

|  |
| --- |
| **Client record reviews and unit verifications:** |
| C-14. Congregate:Select a sample of clients for record review and conduct unit verifications for meals received by these clients. Attach all appropriate **Attachment C** worksheets and related documentation for congregate, congregate supplement, and/or congregate therapeutic diet meals. |
| HD-15. Home-delivered:Select a sample of clients for record review and conduct unit verifications for meals received by these clients. Attach all appropriate **Attachment C** worksheets and related documentation for HD, HD supplement, and/or HD therapeutic diet meals. |

# NC DIVISION OF AGING AND NC AREA AGENCIES ON AGING

**NUTRITION SERVICES ASSESSMENT TOOL**

**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. |[x]  [ ]  |
| 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: Click or tap to enter a date.

Signature:

# NC DIVISION OF AGING AND NC AREA AGENCIES ON AGING NUTRITION SERVICES ASSESSMENT TOOL

**Attachment B: Congregate Meals Temperature Review**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | 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 for a chosen month. State percentage of cold foods out of compliance for month. | Review hot foods for a chosen month. State percentage of hot foods out of compliance for month. |
| Site# 1 |[ ] [ ] [ ] [ ]        % |[ ]        % |
| Site#2 |[ ] [ ] [ ] [ ]        % |[ ]        % |
| Site#3 |[ ] [ ] [ ] [ ]        % |[ ]        % |
| Site#4 |[ ] [ ] [ ] [ ]        % |[ ]        % |
| Site#5 |[ ] [ ] [ ] [ ]        % |[ ]        % |
| Site#6 |[ ] [ ] [ ] [ ]        % |[ ]        % |
| Site#7 |[ ] [ ] [ ] [ ]        % |[ ]        % |

**NC DIVISION OF AGING AND NC AREA AGENCIES ON AGING NUTRITION SERVICES ASSESSMENT TOOL**

**Attachment B: Home-delivered Meals Temperature Review**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Food temps are recorded for each food item, as appropriate. | Food temps are recorded at least monthly on each route. | Review cold foods for a chosen month. State percentage of cold foods out of compliance for month. | Review hot foods for a chosen month. State percentage of hot foods out of compliance for month. |
| Route #1 |[ ] [ ]        %  |       % |
| Route #2 |[ ] [ ]        % |       % |
| Route#3 |[ ] [ ]        % |       % |
| Route#4 |[ ] [ ]        % |       % |
| Route#5 |[ ] [ ]        % |       % |
| Route#6 |[ ] [ ]        % |       % |
| Route#7 |[ ] [ ]        % |       % |

# ATTACHMENT C: CLIENT RECORD REVIEW AND UNIT VERIFICATION WORKSHEET Page      of       CONGREGATE NUTRITION

# DATE OF ASSESSMENT: Click or tap to enter a date. AGENCY:

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

Reviewer should select a random sample of clients from each Site/Route/Worker Code and include one or more special eligibility clients (if any).

* + Attach to this worksheet the Units of Service Verification Report used to select the sample of clients and units. Identify on this report the persons sampled and the month(s) reviewed. Also attach copies of other worksheets, such as copies of the ZGA-903 or comparable document.
	+ List on the reverse side of this worksheet the clients and specific dates for which units could not be verified, if applicable.
	+ Provide a copy to the agency during the exit interview of both sides of this completed worksheet if unverified units are found.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CLIENT NAME | S/R/W Code | Eligible client?If special eligibility, state documentation reviewed. | Date of most recent CRF? | DOA-101CRF is complete? | CRFupdated at least every 12 months? | # units reported | # units verified | # units to be adjusted in ARMS |
|        |        |  [ ]        |        | [ ]  | [ ]  |        |        |        |
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| TOTAL UNITS NOT VERIFIED =      Total units reported for all clients in month reviewed =       | THIS REPRESENTS       % OF TOTAL UNITS REPORTED FOR THE MONTHREVIEWED. If 10% or more, expand sample and select another month to review. |

# Signature of reviewer(s)       Date

**ATTACHMENT C: CLIENT RECORD REVIEW AND UNIT VERIFICATION WORKSHEET** **Page      of       CONGREGATE LIQUID NUTRITIONAL SUPPLEMENT**

# DATE OF ASSESSMENT: Click or tap to enter a date. AGENCY:

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

 Reviewer should select a random sample of clients from each Site/Route/Worker Code and include one or more special eligibility clients (if any).

* + Attach to this worksheet the Units of Service Verification Report used to select the sample of clients and units. Identify on this report the persons sampled and the month(s) reviewed. Also attach copies of other worksheets, such as copies of the ZGA-903 or comparable document.
	+ List on the reverse side of this worksheet the clients and specific dates for which units could not be verified, if applicable.
	+ Provide a copy to the agency during the exit interview of both sides of this completed worksheet if unverified units are found.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CLIENT NAME | S/R/W Code | Eligible?If special eligibility, state documentation reviewed. | Professional authorization on file? | Professional authorization updated every 6 months? | DOA-101CRF is complete? | DOA-101 CRF isupdated every 12 months if services are on- going? | [ 2 cans = 1 meal]# units reported | # units verified | # units to be adjusted in ARMS |
|        |        | [ ]        | [ ]  | [ ]  | [ ]  | [ ]  |        |        |        |
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| TOTAL UNITS NOT VERIFIED =      Total units reported for all clients in month reviewed =       | THIS REPRESENTS       % OF TOTAL UNITS REPORTED FOR THE MONTHREVIEWED. If 10% or more, expand sample and select another month to review. |

# Signature of reviewer(s)       Date

**ATTACHMENT C: CLIENT RECORD REVIEW AND UNIT VERIFICATION WORKSHEET Page      of       CONGREGATE NUTRITION – NSIP ONLY**

# DATE OF ASSESSMENT: Click or tap to enter a date. AGENCY:

# MONTH AND YEAR REVIEWED:

* + Attach to this worksheet the Units of Service Verification Report used to select the sample of clients and units. Identify on this report the persons sampled and the month(s) reviewed. Also attach copies of other worksheets, such as copies of the ZGA-903 or comparable document.
	+ List on the reverse side of this worksheet the clients and specific dates for which units could not be verified, if applicable.
	+ Provide a copy to the agency during the exit interview of both sides of this completed worksheet if unverified units are found.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CLIENT NAME | S/R/W Code | Eligible client?If special eligibility, state documentation reviewed. | Date of most recent CRF? | DOA-101CRF is complete? | CRFupdated at least every 12 months? | # units reported | # units verified | # units to be adjusted in ARMS |
|        |        | [ ]        |        | [ ]  | [ ]  |        |        |        |
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| TOTAL UNITS NOT VERIFIED =      Total units reported for all clients in month reviewed =       | THIS REPRESENTS       % OF TOTAL UNITS REPORTED FOR THE MONTHREVIEWED. If 10% or more, expand sample and select another month to review. |

# Signature of reviewer(s)       Date

**ATTACHMENT C: CLIENT RECORD REVIEW AND UNIT VERIFICATION WORKSHEET** **Page      of       CONGREGATE THERAPEUTIC DIET MEALS**

# DATE OF ASSESSMENT: Click or tap to enter a date. AGENCY:

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

Reviewer should select a random sample of clients from each Site/Route/Worker Code and include one or more special eligibility clients (if any).

* + Attach to this worksheet the Units of Service Verification Report used to select the sample of clients and units. Identify on this report the persons sampled and the month(s) reviewed. Also attach copies of other worksheets, such as copies of the ZGA-903 or comparable document.
	+ List on the reverse side of this worksheet the clients and specific dates for which units could not be verified, if applicable.
	+ Provide a copy to the agency during the exit interview of both sides of this completed worksheet if unverified units are found.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CLIENT NAME | S/R/W Code | Eligible?If special eligibility, state documentation reviewed. | DOA-101CRF is complete? | DOA-101CRF is updated every 12 months? | Physician's prescription on file? | Physician's prescription reordered every 6 months? | # units reported | # units verified by source doc. | # units to be adjusted in ARMS |
|        |        | [ ]        | [ ]  | [ ]  | [ ]  | [ ]  |        |        |        |
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| TOTAL UNITS NOT VERIFIED =      Total units reported for all clients in month reviewed =       | THIS REPRESENTS       % OF TOTAL UNITS REPORTED FOR THE MONTHREVIEWED. If 10% or more, expand sample and select another month to review. |

# Signature of reviewer(s)       Date

# ATTACHMENT C: CLIENT RECORD REVIEW AND UNIT VERIFICATION WORKSHEET Page      of       HOME-DELIVERED NUTRITION

# DATE OF ASSESSMENT: Click or tap to enter a date. AGENCY:

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

Reviewer should select a random sample of clients from each Site/Route/Worker Code and include one or more special eligibility clients (if any).

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	+ List on the reverse side of this worksheet the clients and specific dates for which units could not be verified, if applicable.
	+ Provide a copy to the agency during the exit interview of both sides of this completed worksheet if unverified units are found.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CLIENT NAME | S/R/W Code | HD eligibility established by in- home assessment?If special eligibility,state documentation reviewed. | DOA-101CRF is complete? | DOA-101 CRFupdated at least every 6 months unless temp status? | In-home reassessment conducted at least every 6 months unless temp status? | # units reported | # units verified | # units to be adjusted in ARMS |
|        |        | [ ]        | [ ]  | [ ]  | [ ]  |        |        |        |
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| TOTAL UNITS NOT VERIFIED =      Total units reported for all clients in month reviewed =       | THIS REPRESENTS       % OF TOTAL UNITS REPORTED FOR THE MONTHREVIEWED. If 10% or more, expand sample and select another month to review. |

# Signature of reviewer(s)       Date

# ATTACHMENT C: CLIENT RECORD REVIEW AND UNIT VERIFICATION WORKSHEET Page      of

# HOME-DELIVERED LIQUID NUTRITIONAL SUPPLEMENT

# DATE OF ASSESSMENT: Click or tap to enter a date. AGENCY:

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

Reviewer should select a random sample of clients from each Site/Route/Worker Code and include one or more special eligibility clients (if any).

* + Attach to this worksheet the Units of Service Verification Report used to select the sample of clients and units. Identify on this report the persons sampled and the month(s) reviewed. Also attach copies of other worksheets, such as copies of the ZGA-903 or comparable document.
	+ List on the reverse side of this worksheet the clients and specific dates for which units could not be verified, if applicable.
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|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CLIENT NAME | S/R/W Code | HD eligibility established by in-home ass't?If special eligibility, state documentation reviewed. | Professional authorization on file? | Professional authorization updated every 6 months? | DOA-101CRF is complete? | DOA-101updated every 6 months if on- going service? | [2 cans = 1 meal]# units reported | # units verified | # units to be adjusted in ARMS |
|        |        | [ ]        | [ ]  | [ ]  | [ ]  | [ ]  |        |        |        |
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| TOTAL UNITS NOT VERIFIED =      Total units reported for all clients in month reviewed =       | THIS REPRESENTS       % OF TOTAL UNITS REPORTED FOR THE MONTHREVIEWED. If 10% or more, expand sample and select another month to review. |

# Signature of reviewer(s)       Date

**ATTACHMENT C: CLIENT RECORD REVIEW AND UNIT VERIFICATION WORKSHEET Page      of**  **HOME-DELIVERED NUTRITION NSIP ONLY**

# DATE OF ASSESSMENT: Click or tap to enter a date. AGENCY:

# MONTH AND YEAR REVIEWED:

Reviewer should select a random sample of clients from each Site/Route/Worker Code and include one or more special eligibility clients (if any).

* + Attach to this worksheet the Units of Service Verification Report used to select the sample of clients and units. Identify on this report the persons sampled and the month(s) reviewed. Also attach copies of other worksheets, such as copies of the ZGA-903 or comparable document.
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|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CLIENT NAME | S/R/W Code | HD eligibility established by in- home assessment?If special eligibility,state documentation reviewed. | DOA-101CRF is complete? | DOA-101 CRFupdated at least every 6 months unless temp status? | In-home reassessment conducted at least every 6 months unless temp status? | # units reported | # units verified | # units to be adjusted in ARMS |
|        |        | [ ]        | [ ]  | [ ]  | [ ]  |        |        |        |
|        |        | [ ]        | [ ]  | [ ]  | [ ]  |        |        |        |
|        |        | [ ]        | [ ]  | [ ]  | [ ]  |        |        |        |
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|        |        | [ ]        | [ ]  | [ ]  | [ ]  |        |        |        |
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|        |        | [ ]        | [ ]  | [ ]  | [ ]  |        |        |        |
| TOTAL UNITS NOT VERIFIED =      Total units reported for all clients in month reviewed =       | THIS REPRESENTS       % OF TOTAL UNITS REPORTED FOR THE MONTHREVIEWED. If 10% or more, expand sample and select another month to review. |

# Signature of reviewer(s)       Date

**ATTACHMENT C: CLIENT RECORD REVIEW AND UNIT VERIFICATION WORKSHEET**

**Page of HOME-DELIVERED THERAPEUTIC DIET MEALS**

# DATE OF ASSESSMENT: Click or tap to enter a date. AGENCY:

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

Reviewer should select a random sample of clients from each Site/Route/Worker Code and include one or more special eligibility clients (if any).

* + Attach to this worksheet the Units of Service Verification Report used to select the sample of clients and units. Identify on this report the persons sampled and the month(s) reviewed. Also attach copies of other worksheets, such as copies of the ZGA-903 or comparable document.
	+ List on the reverse side of this worksheet the clients and specific dates for which units could not be verified, if applicable.
	+ Provide a copy to the agency during the exit interview of both sides of this completed worksheet if unverified units are found.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CLIENT NAME | S/R/W Code | HD eligibility established through in-home assessment?If special eligibility, state documentation reviewed. | DOA-101CRF is complete? | DOA-101 CRFupdated at least every 6 months unless temp status? | Physician's prescription on file? | Physician's prescription reordered every 6 months? | # units reported | # units verified | # units to be adjusted in ARMS |
|        |        | [ ]        | [ ]  | [ ]  | [ ]  | [ ]  |        |        |        |
|        |        | [ ]        | [ ]  | [ ]  | [ ]  | [ ]  |        |        |        |
|        |        | [ ]        | [ ]  | [ ]  | [ ]  | [ ]  |        |        |        |
|        |        | [ ]        | [ ]  | [ ]  | [ ]  | [ ]  |        |        |        |
|        |        | [ ]        | [ ]  | [ ]  | [ ]  | [ ]  |        |        |        |
|        |        | [ ]        | [ ]  | [ ]  | [ ]  | [ ]  |        |        |        |
|        |        | [ ]        | [ ]  | [ ]  | [ ]  | [ ]  |        |        |        |
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|        |        | [ ]        | [ ]  | [ ]  | [ ]  | [ ]  |        |        |        |
| TOTAL UNITS NOT VERIFIED =      Total units reported for all clients in month reviewed =       | THIS REPRESENTS       % OF TOTAL UNITS REPORTED FOR THE MONTHREVIEWED. If 10% or more, expand sample and select another month to review. |

# Signature of reviewer(s)       Date

**Attachment D: Fiscal Verification of Non-Unit Expenses for the Senior Nutrition Program**

**SRFR PEAS Project Codes 620, 630, 680, and 690**

Agency:

Agency Staff Interviewed:

Signature of Reviewer(s):

Date: Click or tap to enter a date.

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

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

1. Agency budget shows SFRF PEAS Project monies used to support nutrition services. Select a month of reimbursement in ARMS and document that reimbursement correlates with actual expenses (e.g., PEAS Project monthly tracking sheet, receipts, invoices, time sheets, etc.) and that clients were eligible for the service (Client Registration Forms).

Yes [ ]  No [ ]  NA [ ]

Documentation reviewed/Comments:

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

**PEAS PROJECT MEALS Page      of**

DATE OF ASSESSMENT: **Click or tap to enter a date.** AGENCY:

MONTH AND YEAR REVIEWED:       FUND SOURCE: PEAS Project (SFRF)

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 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? |  |  | # units reported | # units verified | Dates of unverified units, if applicable | # unverified units |
| 1 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 2 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 3 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 4 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 5 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 6 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 7 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 8 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 9 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 10 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 11 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 12 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 13 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 14 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 15 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
|  | Totals |       |        |  Total unverified units |        |
|  | (Divide unverified units by total units reported) x 100 =  |       % |
|  | If 10% of 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 FOOD BOXES Page      of**

DATE OF ASSESSMENT: **Click or tap to enter a date.** AGENCY:

MONTH AND YEAR REVIEWED:       FUND SOURCE: PEAS Project (SFRF)

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 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? |  |  | # units reported | # units verified | Dates of unverified units, if applicable | # unverified units |
| 1 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
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| 3 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 4 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 5 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 6 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 7 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
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| 9 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 10 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 11 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 12 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 13 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 14 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
| 15 |        |        | [ ]        |        | [ ]  |  |  |        |        |        |        |
|  | Totals |       |        |  Total unverified units |        |
|  | (Divide unverified units by total units reported) x 100 =  |       % |
|  | If 10% of more, expand sample and select another month for review. |  |

 **Notes:**

**Signature of reviewer(s)       Date**