

Section III – Appendix

**Kitchen Monitoring Evaluation Forms**  
**(On Site Preparation and Catered Sites)**

SUFFOLK COUNTY OFFICE FOR THE AGING  
 NUTRITION PROGRAM FOR THE ELDERLY  
 EVALUATION – ON SITE PREPARATION

AGENCY: \_\_\_\_\_ DATE: \_\_\_\_\_

SITE: \_\_\_\_\_

SITE MANAGER: \_\_\_\_\_

|                                | <u>BUDGETED</u> | <u>ACTUAL</u> |
|--------------------------------|-----------------|---------------|
| MENU: _____ TOTAL MEALS: _____ | _____           | _____         |
| _____ CONGREGATE: _____        | _____           | _____         |
| _____ HOME DELIVERED: _____    | _____           | _____         |

YES NO

|   |       |       |
|---|-------|-------|
| Have menus been approved by SCOFA?  | _____ | _____ |
| Are menus posted in food preparation and dining rooms?  | _____ | _____ |
| Have menus been changed?  | _____ | _____ |
| If so, have changes been approved by SCOFA RD?  | _____ | _____ |
| Are standardized recipes followed and on file?  | _____ | _____ |
| Are foods containing artificial trans fat, with the exception of food served directly to consumers in a manufacturer's original sealed package, stored, distributed, held for service, or used in the preparation of any menu item? | _____ | _____ |

CERTIFICATES                      Expiration Date: \_\_\_\_\_

Food Service Permit: \_\_\_\_\_

Food handlers' Certificates:  
 Are all certificates current? \_\_\_\_\_

(List any expired certifications on a separate sheet, attach to this form & advise site manager)

What is the date of the current Food Establishment Inspection Report from the SC Department of Health Services?(and review report) \_\_\_\_\_

SIGNS/DOCUMENTATION

- |    |  |       |       |
|----|--|-------|-------|
| 1. | Hand wash signs  | _____ | _____ |
| 2. | Have fire extinguishers been inspected within the last year?<br>(see copy of inspection) | _____ | _____ |
| 3. | Date of fire drill and attendance list _____   |       |       |
| 4. | Is fire evacuation plan posted?<br>(see copy)  | _____ | _____ |

YES

NO

- 5. Is the procedure for filing grievances posted? \_\_\_\_\_
- 6. Is the Availability of CPR Equipment Poster Posted? \_\_\_\_\_
- 7. Are copies of driving licenses for HDM drivers on file? \_\_\_\_\_
- 8. Safety Training (required quarterly)/Sign in Sheets \_\_\_\_\_

MEAL SERVICE

Serving Time: \_\_\_\_\_

Condition of equipment: \_\_\_\_\_

Food ordered by: \_\_\_\_\_

Food received and checked by: \_\_\_\_\_

Food temperatures recorded by: \_\_\_\_\_

Food tested by: \_\_\_\_\_

YES

NO

- Does food appear neat & attractive on plate when served to participants? \_\_\_\_\_
- Are correct utensils and sizes used? \_\_\_\_\_
- Is milk served from original containers? \_\_\_\_\_
- Are uniform portions served? \_\_\_\_\_

SANITATION AND STORAGE

Are thermometers in refrigerators and freezers readily visible and at the proper temperature? \_\_\_\_\_

Temperatures \_\_\_\_\_

Do potentially hazardous foods meet temperature requirements during transport, holding & service? \_\_\_\_\_

Are facilities adequate to maintain proper temperature? \_\_\_\_\_

Are food temperatures being taken upon arrival and/or before being served to participants? \_\_\_\_\_

|  | <u>YES</u> | <u>NO</u> |
|--|------------|-----------|
| <p>the temperatures within recommended standards?<br/>                     Temperatures _____</p>    | _____      | _____     |
| Is a daily log book being kept of food temperatures?   | _____      | _____     |
| Are temperature records reviewed by the RD or someone working under the direction of the RD?         | _____      | _____     |
| Are leftover meals frozen with the date, meal and packaging temperature before freezing?             | _____      | _____     |
| Is a log book of food thermometer calibrations being kept?   | _____      | _____     |
| Are wiping cloths clean and is their use restricted?   | _____      | _____     |
| Are trash cans clean & properly covered?   | _____      | _____     |
| Are dated, complete meals (including soup, gravies and dessert) held in the refrigerator for 5 days? | _____      | _____     |
| Is food from approved sources, wholesome and unadulterated?  | _____      | _____     |
| Is food in original container, properly labeled and dated for storage?                               | _____      | _____     |
| Are toxic items properly stored, labeled and used?   | _____      | _____     |
| Is stock rotated and labeled properly?   | _____      | _____     |
| Are food and non-food contact surfaces of equipment and utensils clean?                              | _____      | _____     |
| Are dishwashing facilities operating properly?   | _____      | _____     |
| Are dishes, utensils, pots and pans properly scraped, rinsed, soaked and racked?                     | _____      | _____     |
| Is a three compartment sink utilized for pot and pan washing?  | _____      | _____     |
| Are proper procedures being followed?  | _____      | _____     |
| Is all food stored 6" off the floor and 18" from the ceiling?  | _____      | _____     |

|   | <u>YES</u> | <u>NO</u> |
|---|------------|-----------|
| Is bulk food removed from containers, stored in appropriate containers with covers and labeled? | _____      | _____     |
| Are there any signs of dented, damaged or swelled cans?   | _____      | _____     |
| Is the trash area maintained properly?  | _____      | _____     |
| Are hand sinks provided in the kitchen or conveniently located areas?                           | _____      | _____     |
| Are supplies (soap, towels, toilet paper) available?  | _____      | _____     |

|                           | <u>YES</u> | <u>NO</u> | <u>LOCATION</u> |
|---------------------------|------------|-----------|-----------------|
| Is storage available for: |            |           |                 |
| Supplies?                 | _____      | _____     | _____           |
| Personal belongings?      | _____      | _____     | _____           |
| Cleaning supplies?        | _____      | _____     | _____           |

Date and chemicals used at last insect and rodent inspection \_\_\_\_\_

OVERALL EVALUATION OF PROGRAM

Improvements Since Last Monitoring: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Problems/Recommendation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Prepared by: \_\_\_\_\_ Reviewed by: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

SUFFOLK COUNTY OFFICE FOR THE AGING  
MONTHLY CONTRIBUTION MONITORING

AGENCY: \_\_\_\_\_

SITE: \_\_\_\_\_

SITE MANAGER: \_\_\_\_\_

YES

NO

1. What is the suggested contribution? \$ \_\_\_\_\_

2. How are the contributions collected?

Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Monthly \_\_\_\_\_ Other \_\_\_\_\_

3. Are contributions deposited by participants into a locked box? \_\_\_\_\_

4. Are envelopes provided to protect confidentiality of contributions? \_\_\_\_\_

5. Is a sign describing the amount, purpose and use of contributions posted? \_\_\_\_\_

6. Date: \_\_\_\_\_

Total Contribution Collected: \$ \_\_\_\_\_

Congregate: \$ \_\_\_\_\_ Home Bound: \$ \_\_\_\_\_ Guest: \$ \_\_\_\_\_

7. Are contributions deposited on a daily basis? \_\_\_\_\_

8. Has the agency posted the actual food cost of the meal? \_\_\_\_\_

9. Was the price of the meal for guests posted? \_\_\_\_\_

10. Were the above two (2) prices posted near the locked box? \_\_\_\_\_

11. How is the homebound senior notified of the suggested contribution?

Letter \_\_\_\_\_ Driver \_\_\_\_\_ Site Manager \_\_\_\_\_ Other \_\_\_\_\_

12. Describe the method used for collecting contributions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SUFFOLK COUNTY OFFICE FOR THE AGING  
 NUTRITION PROGRAM FOR THE ELDERLY EVALUATION  
 CATERERED SITES

AGENCY: \_\_\_\_\_ DATE: \_\_\_\_\_

SITE: \_\_\_\_\_

SITE MANAGER: \_\_\_\_\_

|             |                 | <u>BUDGETED</u> | <u>ACTUAL</u> |
|-------------|-----------------|-----------------|---------------|
| MENU: _____ | TOTAL MEALS:    | _____           | _____         |
| _____       | CONGREGATE:     | _____           | _____         |
| _____       | HOME DELIVERED: | _____           | _____         |

| CATERER PROVIDED: | #CONG MEALS _____ | HDM MEALS _____ |           |
|-------------------|-------------------|-----------------|-----------|
|                   |                   | <u>YES</u>      | <u>NO</u> |

|   |       |       |
|---|-------|-------|
| Have menus been approved by SCOFA?  | _____ | _____ |
| Are menus posted in food preparation and dining rooms:  | _____ | _____ |
| Have menus been changed?  | _____ | _____ |
| If so, have changes been approved by SCOFA RD?  | _____ | _____ |
| Are foods containing artificial trans fat, with the exception of food served directly to consumers in a manufacturer's original sealed package, stored, distributed, held for service, or used in the preparation of any menu item? | _____ | _____ |

CERTIFICATES

Food service permit \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Food handlers' Certificates:

Are all certificates current? \_\_\_\_\_  
 (List any expired certifications on a separate sheet, attach to this form and advise Site Manager)

What is the date of the current Food Establishment Inspection Report from the SC Department of Health Services? (and review report) \_\_\_\_\_

SIGNS/DOCUMENTATION

1. Hand wash signs \_\_\_\_\_
2. Have fire extinguishers been inspected within the last year? (see copy of inspection) \_\_\_\_\_
3. Date of fire drill and attendance list \_\_\_\_\_
4. Is fire drill evacuation plan posted? (see copy) \_\_\_\_\_
5. Is the procedure for filing grievances posted? \_\_\_\_\_

YES

NO

- Is the Availability of CPR Equipment Poster posted? \_\_\_\_\_
- 7. Are copies of driving licenses for HDM drivers on file? \_\_\_\_\_
- 8. Safety Training (required quarterly)/Sign In sheets \_\_\_\_\_

MEAL SERVICE

Delivery time: \_\_\_\_\_ Serving Time: \_\_\_\_\_

Condition of delivery truck: \_\_\_\_\_

Condition of equipment: \_\_\_\_\_

Food ordered by: \_\_\_\_\_

Food received and checked by: \_\_\_\_\_

Food temperatures recorded by: \_\_\_\_\_

Food tested by: \_\_\_\_\_

YES

NO

- Does food appear neat and attractive on plate when served to participants? \_\_\_\_\_
- Are correct utensils and sizes being used? \_\_\_\_\_
- Is milk being served from original containers? \_\_\_\_\_
- Are uniform portions being served? \_\_\_\_\_

SANITATION AND STORAGE

Are thermometers in refrigerators and freezers readily visible and at the proper temperature? \_\_\_\_\_

Temperatures \_\_\_\_\_

Do potentially hazardous foods meet temperature requirements during transport, holding and service? \_\_\_\_\_

Are facilities adequate to maintain proper temperatures? \_\_\_\_\_

Are food temperatures being taken upon arrival and/or before being served to participants? \_\_\_\_\_

Are the temperatures within recommended standards? \_\_\_\_\_

Temperatures \_\_\_\_\_

YES

NO

Is a daily log book being kept of food temperatures?

\_\_\_\_\_

\_\_\_\_\_

Are temperature records reviewed by the RD or someone working under the direction of the RD?

\_\_\_\_\_

\_\_\_\_\_

Are leftover meals frozen with the date, meal and packaging temperature before freezing?

\_\_\_\_\_

\_\_\_\_\_

Is a log book of food thermometer calibrations being kept?

\_\_\_\_\_

\_\_\_\_\_

Are wiping cloths clean and is their use restricted?

\_\_\_\_\_

\_\_\_\_\_

Are trash cans clean and properly covered?

\_\_\_\_\_

\_\_\_\_\_

Are hand sinks provided in the kitchen or conveniently located areas?

\_\_\_\_\_

\_\_\_\_\_

YES

NO

LOCATION

Is storage available for:

Supplies?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Personal belongings?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Cleaning supplies?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date and chemicals used at last insect and rodent inspection \_\_\_\_\_

OVERALL EVALUATION OF PROGRAM

Improvements Since Last Monitoring: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Problems/Recommendations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Prepared by: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

SUFFOLK COUNTY OFFICE FOR THE AGING  
MONTHLY CONTRIBUTION MONITORING

AGENCY: \_\_\_\_\_

SITE: \_\_\_\_\_

SITE MANAGER: \_\_\_\_\_

YES                      NO

1. What is the suggested contribution? \$ \_\_\_\_\_

2. How are the contributions collected?

Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Monthly \_\_\_\_\_ Other \_\_\_\_\_

3. Are contributions deposited by participants into a locked box? \_\_\_\_\_

4. Are envelopes provided to protect confidentiality of contributions? \_\_\_\_\_

5. Is a sign describing the amount, purpose and use of contributions posted? \_\_\_\_\_

6. Date: \_\_\_\_\_

Total Contribution Collected: \$ \_\_\_\_\_

Congregate: \$ \_\_\_\_\_ Home Bound: \$ \_\_\_\_\_ Guest: \$ \_\_\_\_\_

7. Are contributions deposited on a daily basis? \_\_\_\_\_

8. Has the agency posted the actual food cost of the meal? \_\_\_\_\_

9. Was the price of the meal for guests posted? \_\_\_\_\_

10. Were the above two (2) prices posted near the locked box? \_\_\_\_\_

11. How is the homebound senior notified of the suggested contribution?

Letter \_\_\_\_\_ Driver \_\_\_\_\_ Site Manager \_\_\_\_\_ Other \_\_\_\_\_

12. Describe the method used for collecting contributions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Programmatic Monitoring  
Evaluation Forms**

# PROGRAMMATIC MONITORING REPORT

Program/Service Provider  
Name/Address

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Amount of  
Contract: \_\_\_\_\_

Services:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Contract  
Period: \_\_\_\_\_

Date of Site Visit: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Area Agency on Aging Monitor:

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Program Director: \_\_\_\_\_

Others Participating in Monitoring:

\_\_\_\_\_  
Name/Title/Agency/Phone No.

\_\_\_\_\_  
Name/Title/Agency/Phone No.

\_\_\_\_\_  
Name/Title/Agency/Phone No.

# I. PAST PERFORMANCE/PREVIOUS RECOMMENDATIONS

## 1. Review Findings

Was your last monitoring in compliance? Yes \_\_\_\_\_ No \_\_\_\_\_

Review findings from prior or current year monitoring and corrective actions taken to address areas of non-compliance. Were all findings from the Area Agency on Aging (AAA's) previous monitoring efforts satisfactorily addressed?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

If no, please describe: \_\_\_\_\_

# II. SERVICE ACTIVITY REVIEW

## 1. Units of Service

| Name of Service | Projected Units | YTD Units | Percent of Projection | Percent of Year Elapsed |
|-----------------|-----------------|-----------|-----------------------|-------------------------|
| Congregate      |                 |           |                       |                         |
| Home Delivered  |                 |           |                       |                         |
|                 |                 |           |                       |                         |

1a. Describe reason(s) for any variances: \_\_\_\_\_

## 2. Expenditures

*(Review expenditures with Suffolk County Office for the Aging (SCOFA) fiscal staff. Complete this section prior to on-site monitoring. Discuss the findings with the contractor.)*

| Name of Service | Projected Expenditures | YTD Expenditures | Percent of Projection | Percent of Year Elapsed |
|-----------------|------------------------|------------------|-----------------------|-------------------------|
| Congregate      |                        |                  |                       |                         |
| Home Delivered  |                        |                  |                       |                         |
|                 |                        |                  |                       |                         |

2a. Describe reason(s) for any variance: \_\_\_\_\_

### 3. Verification of Reported Units and Clients

*(The person monitoring the service program will randomly select a report submitted by the program to SCOFA and will verify the documentation supporting the reported units of service and reported clients.)*

Report Reviewed \_\_\_\_\_

#### 3a. Units of Service

| Name of Service | Number of Units Reported to SCOFA | Documented Units |
|-----------------|-----------------------------------|------------------|
| Congregate      |                                   |                  |
| Home Delivered  |                                   |                  |
|                 |                                   |                  |

Note any discrepancies and apparent reasons: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Note supporting documentation reviewed: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### 3b. Clients Served (Unduplicated Count)

| Name of Service | Number of Cases Reported to SCOFA | Documented Clients |
|-----------------|-----------------------------------|--------------------|
| Congregate      |                                   |                    |
| Home Delivered  |                                   |                    |
|                 |                                   |                    |

Note any discrepancies and apparent reasons: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Note supporting documentation reviewed: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3c. **Outreach Units** N/A \_\_\_\_\_

| <b>Outreach</b> | <b>Number of Units Reported to SCOFA</b> | <b>Documented Units</b> |
|-----------------|--|-------------------------|
|                 |  |                         |
|                 |  |                         |
|                 |  |                         |

Note any discrepancies and apparent reasons: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Note supporting documentation reviewed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3d. **Transportation Units** N/A \_\_\_\_\_

| <b>Name of Service</b> | <b>Number of Units Reported to SCOFA</b> | <b>Documented Units</b> |
|------------------------|--|-------------------------|
| Regular Transportation |  |                         |
| AAA Transportation     |  |                         |
|                        |  |                         |

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there a contribution required for transportation? Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

How is client informed? **Attach copy**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If so, what is the amount of the contribution? \_\_\_\_\_

Note any discrepancies and apparent reasons: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Note supporting documentation reviewed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3e. **Electronic Reporting** Month \_\_\_\_\_ Year \_\_\_\_\_

| <b>Name of Service</b>     | <b>Electronic Numbers of Units Reported</b> | <b>Documented Units</b> |
|----------------------------|---|-------------------------|
| Unduplicated Count - Cong. |   |                         |
| Unduplicated Count - HDM   |   |                         |
| Shelf Stable Meals - Cong  |   |                         |
| Shelf Stable Meals - HDM   |   |                         |
| Transportation - Reg.      |   |                         |
| Transportation - AAA       |   |                         |
| Units Served - Cong        |   |                         |
| Units Served - HDM         |   |                         |
|                            |   |                         |
| Eligible Guests            |   |                         |
| Ineligible Guests          |   |                         |
| Outreach                   |   |                         |

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is data being input in a timely fashion? (12<sup>th</sup> of the month)

Yes \_\_\_\_\_ No \_\_\_\_\_

If no, please describe reasons for lateness and any actions being taken by the program/service provider to improve the timeliness of reporting: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**4. Timeliness of Reporting**

| <b>Due Date for Reports in this Contract/Project Period</b> | <b>Actual Dates When Reports Were Received by SCOFA</b> |
|---|---|
|   |   |
|   |   |
|   |   |

4a. Are reports received in a timely fashion?

Yes \_\_\_\_\_ No \_\_\_\_\_

If no, please describe reasons for lateness and any actions being taken by the program/ service provider to improve the timeliness of reporting: \_\_\_\_\_

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### III. TARGETING COMPLIANCE

*(Complete the charts prior to on-site monitoring visits utilizing targeting data for their service area. Refer to proposal that was submitted to SCOFA prior to signing contract and 2010 census data. Discuss the findings with the contractor).*

#### 1. **Minority Elderly Served**

Describe the outreach activities utilized by the program service provider to satisfy the needs of minority elderly served:

- Use census data (as reviewed with SCOFA) to identify target neighborhoods.
- Translated program brochures and pamphlets into appropriate languages (use LEP device when necessary).
- Prominent location of senior sites to maximize potential such as within senior complex.
- Conduct door-to-door or group presentations in senior housing facilities.
- Locate information racks at churches and community centers clubs, senior housing etc.
- Arrange for speaking engagements to organizations that include minorities.
- Publicize services through press releases, radio, television, local publication and newsletters.
- Use minority staff and interns on local programs or in conducting outreach.

Targeting Activities Stated in Proposal: \_\_\_\_\_

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Other Activities Conducted: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

| Name of Service | Percentage of Minority Elderly In Elderly Population in Catchment Area | Total Clients Served YTD | Total Minority Clients Served YTD | Percentage of Minority Elderly Among Total Client Served YTD |
|-----------------|--|--------------------------|-----------------------------------|--|
|                 |  |                          |                                   |  |
|                 |  |                          |                                   |  |
|                 |  |                          |                                   |  |

1a. Is the program/service provider meeting its goals of providing services to minority elders at least in proportion to their representation in the total elderly population within the service provider's catchment area?

Yes \_\_\_\_\_ No \_\_\_\_\_

If no, please describe reasons for any variances as well as any actions being taken by the program/service provider to increase participation by minority elderly:

\_\_\_\_\_  
 \_\_\_\_\_

## 2. Access to Telephonic Interpretation Services

1. Has the program/service provider set up a contract with a telephonic interpretation provider?

Yes \_\_\_\_\_ Name of Contractor \_\_\_\_\_ No \_\_\_\_\_

If no, please explain the steps that are being taken to comply with this service:

\_\_\_\_\_  
 \_\_\_\_\_

2. Is the program/service provider staff trained to access this service?

Yes \_\_\_\_\_ No \_\_\_\_\_

If no, please explain the training plan:

\_\_\_\_\_

Name of staff who demonstrated the ability to access this service \_\_\_\_\_

\_\_\_\_\_

Describe how staff accessed this service: \_\_\_\_\_

\_\_\_\_\_

3. Is there a written notice in languages that Limited English Proficiency (LEP) persons will understand at service locations?

Yes \_\_\_\_\_ No \_\_\_\_\_

Please describe:

\_\_\_\_\_

\_\_\_\_\_

#### IV. COORDINATION

1. Has the program/service provider worked effectively with other providers and organizations to facilitate coordination and minimize possible duplication of effort?

Yes \_\_\_\_\_ No \_\_\_\_\_

1a. Activities undertaken by the program/service provider to facilitate coordination include:

- Participating in inter-agency meetings to plan and coordinate services
- coordination of funding proposals with other human services organizations
- Memorandum of Understanding (MoU) or agreements with other organizations (for example agreements on coordination of transportation routes, recreational activities or meal production)

- working with other providers to update service directories or listings of available services
- coordination of referrals and follow-ups with other local service providers

Other activities: \_\_\_\_\_  
 \_\_\_\_\_

Documentation reviewed (agendas or notes from inter-agency meetings, protocols for referrals, copies of MoUs or agreements with other organizations, documentation of efforts to develop a central assessment unit or update services listings).

## V. STAFFING

1. Does the program have adequate staff to perform the activities required under its contract/agreement with SCOFA?

Yes \_\_\_\_\_ No \_\_\_\_\_

If no, please explain the impact on the program and any steps being taken to improve staffing levels: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Are qualified case managers or assessors employed to complete necessary assessments (Congregate-NAPIS Short Form; HDM-COMPASS long form)?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Documentation reviewed (staff resumes, documentation of certification, food manager certificate or degree): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Does the program have a training plan for service staff designed to assist staff in carrying out assigned tasks such as Food Manager's Course, Licensed Drivers, Seminars, SAMS Training, LEP (Limited English Proficiency) Training, HDM Assessment Education Level and Training?

Yes \_\_\_\_\_ No \_\_\_\_\_

Documentation reviewed (training plans, training agendas): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Does a random check of the service provider's files verify the type of training actually provided for staff, the date, the presenter and his/her qualifications, and the material covered?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please note the documentation that was reviewed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Compliance with Affirmative Action and Equal Employment Opportunity (EEO) guidelines

5a. Do staffing patterns reflect the minority representation in the total population?

Yes \_\_\_\_\_ No \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_

5b. Is an EEO sign posted in a prominent location?

Yes \_\_\_\_\_ No \_\_\_\_\_

Please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5c. Are reasonable accommodations made for staff and volunteers with disabilities?

Yes \_\_\_\_\_ No \_\_\_\_\_

Please describe accommodations observed or documented: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## VI. ADMINISTRATION/MANAGEMENT

1. Is this program open to the public?

Yes \_\_\_\_\_ No \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_

Documentation reviewed (statements on program materials that activities are open to the general public, on-site observation of the activities): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Are the facilities where client activities and services take place free from political posters and other evidence of advancing ones political candidate over another?

Yes \_\_\_\_\_ No \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Are the services/activities carried out under this contract or program secular in nature (that is, provided without evidence of any religious services, counseling or religious instruction)?

Yes \_\_\_\_\_ No \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Documentation reviewed (signs, posters or program materials announcing that services are available to all eligible individuals regardless of religious affiliation, on-site observation): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*\* *Prior to the on-site monitoring, review the funding logo stated in the contract.*

4. Has the program/service provider given due recognition to SCOFA and the appropriate agency (see individual contracts), as appropriate, in program/service brochures, flyers and other printed materials?

Yes \_\_\_\_\_ No \_\_\_\_\_

Documentation reviewed ("due credit" statements in program materials copies of news articles citing Federal/State funding through SCOFA/appropriate agency): **Attach copies**

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5. Has the program/service provider made provisions for retaining all records pertinent to the program, both program and fiscal, for a period of six years?

Yes \_\_\_\_\_ No \_\_\_\_\_

Documentation reviewed (written policies and procedures covering maintenance of records): \_\_\_\_\_

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6. Has the program/service provider made provisions for treating client information confidentially?

Yes \_\_\_\_\_ No \_\_\_\_\_

- 6a. Ask to see where client and personnel files are kept. Note if there is a lock on the cabinet. Ascertain how many keys there are and who has them. Ask whose responsibility it is for locking up files at the close of the day. \_\_\_\_\_

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Documentation reviewed (written policies covering confidentiality, training agendas noting discussions of confidentiality, on-site observations of staff returning client materials to locked files): \_\_\_\_\_

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7. Does the program/service provider maintain sufficient documentation for equipment purchased with AAA funds?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Documentation (purchase orders, invoices, receiving reports, equipment inventory): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Review the contractor's inventory control system. Compare the contractor's inventory sheet(s) with SCOFA's inventory. Spot check 2-3 items on this list. Is the Suffolk County inventory sticker in place?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Is the equipment purchased with AAA funds identified as such either in property records or fund codes marked on the property?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

10. Is the equipment purchased with AAA funds being used solely to benefit older persons (unless costs are appropriately pro-rated)?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Documentation (equipment inventories, on-site observation of equipment tags): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## VII. SAFEGUARDING FUNDS/PROTECTING ASSETS

1. Are staff who handle monies (with the exception of government employees and attorneys) bonded? \*\*Not applicable if there is no budget, just a rate page.

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Documentation (letters concerning bonding of employees, agreements, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Are individuals who are authorized to sign checks:

a. not involved in processing invoices? Yes \_\_\_\_ No \_\_\_\_

b. different from the person who maintains payroll records?  
Yes \_\_\_\_ No \_\_\_\_

c. is there a corporate/town policy in place? Yes \_\_\_\_ No \_\_\_\_

Documentation (written policies & procedures concerning the issuance/signing of checks): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **VIII. SERVICES/CONTRIBUTIONS/SURVEY LETTERS**

(Both Congregate and Home Delivered Services)

1. Are two individuals involved in the counting of client contributions?

Yes \_\_\_\_ No \_\_\_\_

Documentation (written policies & procedures concerning the handling of contributions, on-site observations of contributions being counted): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Are the daily contributions received entered into a ledger by check number/amount of money (not client names) and co-signed by the two individuals who counted them?

Congregate: HDM:  
Yes \_\_\_\_ No \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_

Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. How often are the contributions deposited in the bank?

Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Other \_\_\_\_\_

If contributions are not deposited daily, in what safe location are they held until they are deposited? Describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**\*\* Prior to the on-site monitoring, review one month's voucher for contributions received. At the time of the monitoring visit, examine that month's daily contribution log and verify that same amount is reported on the voucher.**

Month of: \_\_\_\_\_ Describe: \_\_\_\_\_

\_\_\_\_\_

4. Is a system in place to allow clients to voluntarily and confidentially contribute to the cost of services?

Yes \_\_\_\_\_ No \_\_\_\_\_

Documentation (contribution procedures, statements in letters and program brochures concerning policies, on-site observation of contribution collection practices): **Attach copies of written materials:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

5. Does the program/service provider have a procedure which allows clients or applicants for services to present grievances on the denial of services or to make complaints about the provision methods/quality of services?

Yes \_\_\_\_\_ No \_\_\_\_\_

Documentation reviewed (client satisfaction survey letters, grievance procedures, notices posted in service locations concerning grievances or notices included in program brochures or, if possible, interviews by the monitor with a number of clients concerning their satisfaction with services being provided): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

6. Are client rights posted? Yes \_\_\_\_\_ No \_\_\_\_\_

Where? \_\_\_\_\_

\_\_\_\_\_

7. Does the program/service provider have procedure in place to ensure that only assessed clients are served in the program (Congregate – NAPIS short assessment/HDM-Compass long assessment)?

Yes \_\_\_\_\_ No \_\_\_\_\_

Documentation (screening instruments, written procedures for establishing eligibility):

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8. Does the program/service provider have in place a system for referring clients to other services when a need for such services is identified (both Congregate and HDM)?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, briefly describe system: \_\_\_\_\_

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9. Has the contractor informed each participant of the opportunity to make a voluntary anonymous contribution for congregate meals? Yes \_\_\_\_\_ No \_\_\_\_\_

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How often? \_\_\_\_\_

10. Does the contractor understand he/she may not impose a means test of eligibility and that no income or asset information may be used to determine eligibility for services?

Yes \_\_\_\_\_ No \_\_\_\_\_

10a. Is this policy carried out? Yes \_\_\_\_\_ No \_\_\_\_\_

How? \_\_\_\_\_

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11. FOR CONGREGATE SERVICES:

For Congregate Services, is there a sign posted stating the suggested amount of the voluntary contribution? \_\_\_\_\_

Date: \_\_\_\_\_ Total Contribution Collected: \$ \_\_\_\_\_ Reported to Fiscal: \_\_\_\_\_

Congregate: \$ \_\_\_\_\_ Homebound: \$ \_\_\_\_\_ Guest: \$ \_\_\_\_\_

11a. What is the suggested voluntary contribution amount? \_\_\_\_\_

11b. Does the sign give credit to the appropriate funding sources? \_\_\_ Yes \_\_\_ No

11c. Does the sign: state the actual cost of the meal? \_\_\_ Yes \_\_\_ No

state the price of the meal for guests?  
(actual cost of meal/see contract) \_\_\_ Yes \_\_\_ No

voluntary anonymous contribution amount  
(suggested) \_\_\_ Yes \_\_\_ No

11d. Are the above prices posted near the locked box? \_\_\_ Yes \_\_\_ No

11e. Are contributions deposited by participants into a locked box? \_\_\_ Yes \_\_\_ No

11f. Are envelopes provided to protect confidentiality of contributions? \_\_\_ Yes \_\_\_ No

12. HOME DELIVERED SERVICES:

12a. Attach a copy of any written material used to inform participants of the opportunity to make a voluntary contribution (HDM programs). Does this written material state:

- |         |        |  |
|---------|--------|--|
| ___ Yes | ___ No | voluntary and anonymous                                |
| ___ Yes | ___ No | no one is denied service because unable or unwilling   |
| ___ Yes | ___ No | all contributions are used to expand the service       |
| ___ Yes | ___ No | opportunity to make comments on the quality of service |

12b. What is the suggested contribution amount? \_\_\_\_\_

12c. Does the program have a waiting list for home delivered meals?

Yes \_\_\_ No \_\_\_

If yes, please indicate the number of clients currently awaiting services and any efforts to refer clients to other service providers:

Service \_\_\_\_\_ # of people on waiting list \_\_\_\_\_

Referring clients to other programs/providers: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# **Vehicle Mileage Report**



# **Vehicle Monitoring Form**

**Suffolk County Office for the Aging**

**Vehicle Monitoring Report**

Agency: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Contact: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ E-Mail: \_\_\_\_\_

Date of Monitoring: \_\_\_\_\_

Vehicle Make/Model: \_\_\_\_\_

Vehicle VIN #: \_\_\_\_\_

License Plate #: \_\_\_\_\_

Current Mileage: \_\_\_\_\_

Decal – Yes/No: \_\_\_\_\_ Which Decal: \_\_\_\_\_

Overall Condition (i.e. accidents not reported etc.): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Vehicle Inspection Date (Sticker): \_\_\_\_\_

Vehicle Registration Expiration Date and Copy: \_\_\_\_\_

Vehicle ID Card & Copy: \_\_\_\_\_

Vehicle Used For: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Signature of Person Completing Information: \_\_\_\_\_

\_\_\_\_\_  
(Print Name)

# **CPR Poster**

# Availability of CPR Equipment

**In the event of an emergency call 911**

**or**

**at**

Insert name of local emergency medical services (EMS)

Insert phone number of local EMS system

**Resuscitation masks and disposable gloves are available at**

Insert name of location where resuscitation equipment is provided

**Learn CPR. For more information contact**

Insert name(s) of organization(s) qualified to offer CPR training, which may include but are not limited to American Red Cross and American Heart Association.

**Client Registration/Blue Card  
Short Form/NAPIS**

**Confidential Participant Registration 2016-17**

(Site) \_\_\_\_\_

Name of Client: \_\_\_\_\_ Registration Date: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Estimate Age (if no DOB): \_\_\_\_\_ Gender: M/F \_\_\_\_\_

**Please Circle Responses**

Do you understand English? Yes No (Limited English Proficiency) Primary Language \_\_\_\_\_

Do you live alone? Yes No

Select current living arrangement: Live Alone Live with spouse only Live with relatives

Number in the household: \_\_\_\_\_ Live with non-relatives, Domestic Partner Live with spouse and others Live with Others

Are you a veteran? Yes No Do you receive VA benefits? Yes No

Marital Status: Married Widowed Divorced Never Married Domestic Partner

What is your ethnicity? Hispanic or Latino Not Hispanic or Latino

What is your race? White, not Hispanic (not minority) White-Hispanic Black/African American  
American Indian/Alaska Native Asian Native Hawaiian/Other Pacific Islander  
Two or More Races Other Race Unknown

Income Status 100% poverty Level 150% Poverty Level

Please circle your family size. Then, please circle your income level if it is at or below your household income.

|             |                |                 |               |
|-------------|----------------|-----------------|---------------|
| Family Size | 1 (Live Alone) | <b>\$11,880</b> | <b>17,820</b> |
|             | 2              | <b>16,020</b>   | <b>24,030</b> |
|             | 3              | <b>20,160</b>   | <b>30,240</b> |
|             | 4              | <b>24,300</b>   | <b>36,450</b> |

Is your income level above 150% of the poverty level (See the table above for 150% poverty level)? Yes No

Are you ... Frail/Disabled Yes No Age 85+ Yes No

Age 75 - 84? Yes No Live In a Rural Area Yes No

How will you get to the site?

Walk Drive own Car Public Transportation In need of Transportation Other \_\_\_\_\_

Do you need a special diet (as prescribed by your physician)? Yes No

If yes... What kind of diet? \_\_\_\_\_

Do you have any known food allergies? Yes No If yes, what foods? \_\_\_\_\_

**Please Complete the Reverse**

# NAPIS Registration

## Client

### A.. Provider Information

Provider ID

- Declined to Disclose
- No
- Unknown
- Yes

### Client Information

DOB:

\_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name:

\_\_\_\_\_

First Name:

\_\_\_\_\_

Mid Init:

\_\_\_\_\_

Address:

\_\_\_\_\_

City:

\_\_\_\_\_

St:

\_\_\_\_\_

Zip:

\_\_\_\_\_

Co:

\_\_\_\_\_

Phone:

\_\_\_\_\_

Gender:

- Female
- Male

Does the client understand English?

- No
- Yes

Does the Client live alone?

Select the client's current living arrangement.

- Lives Alone
- Lives with spouse only
- Lives with relatives
- Lives with non-relatives
- Lives with spouse and others
- Others

Is the client a veteran?

- No
- Yes
- Unknown

VA Benefits

- No
- Yes

Marital Status:

- Married
- Widowed
- Divorced
- Never Married

Number in Household:

What is the client's ethnicity?

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown

What is the client's race?

- American Indian/Native Alaskan
- Asian
- Black/African American
- Native Hawaiian/Other Pacific Islander
- White, not Hispanic
- Other
- Two or More Races
- Unknown
- White-Hispanic

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**Is the client's income level at or below 100% of the poverty threshold?**

**Household Size = 1 / \$11,880**

**Household Size = 2 / \$16,020**

**Household Size = 3 / \$20,160**

**Household Size = 4 / \$24,300**

**Household Size = 5 / \$28,440**

**Household Size = 6 / \$32,580**

No

Yes

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**Is the client's income level at or below 150% of the poverty threshold?**

**Household Size = 1 / \$17,820**

**Household Size = 2 / \$24,030**

**Household Size = 3 / \$30,240**

**Household Size = 4 / \$36,450**

**Household Size = 5 / \$42,660**

**Household Size = 6 / \$48,870**

No

Yes

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**Frail / Disabled:**

No

Yes

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**Emergency Contact:**

\_\_\_\_\_

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**Emergency Contact Phone:**

\_\_\_\_\_

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**Services Information**

**Services Information**

**Intake Date:**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Cluster II & III Services**

**Is the client participating in any of the following services or programs?**

- Congregate meals (Cluster II)
- Nutritional Counseling (Cluster II)
- Escort (Cluster II)
- Info & Referral (Cluster III)
- Legal services (Cluster III)
- Transportation (Cluster III)
- Nutrition education (Cluster III)
- Outreach (Cluster III)
- Other (Cluster III)

## Determining Nutritional Health

### Nutrition Questions

**I have an illness/condition that made me change the kind/amount of food I eat.**

- Don't know  
 No  
 Yes

**I eat fewer than 2 meals a day.**

- No  
 Yes

**Does the client eat few (less than 5) vegetables or fruits, or milk products per day?**

- No  
 Yes

**I have tooth or mouth problems that make it hard for me to eat.**

- No  
 Yes

**I don't always have enough money to buy the food I eat.**

- No  
 Yes

**I eat alone most of the time.**

- No  
 Yes

**I take 3 or more different prescribed or over-the-counter drugs a day.**

- No  
 Yes

**Without wanting to, I have lost or gained 10 pounds in the past 6 months.**

- No  
 Yes

**I am not always physically able to shop, cook and/or feed myself.**

- No  
 Yes

**I have 3 or more drinks of beer, liquor or wine almost every day.**

- No  
 Yes

**What is the client's nutritional risk score?**

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Title :

Date

Title :

Date

## **Contribution Letter (sample)**

Dear Congregate Meal Participant:

The \_\_\_\_\_ Nutrition Program, funded by Suffolk County Office for the Aging, New York State Office for the Aging and \_\_\_\_\_ (Town, if applicable) is pleased to be of service to you.

All individuals are encouraged to make a voluntary and anonymous contribution towards the cost of the meal. Persons with a self-declared income at or above 185% of the Federal Poverty Level are encouraged to make a contribution equal to the actual cost of the meal. Contributions signs are posted at the nutrition site which includes the suggested donation and actual cost of the meal. No one will be denied a meal due to inability or unwillingness to contribute. All contributions are used to expand and enhance the program.

At this time, we would invite your comments about the quality of service provided, or suggestions regarding ways to improve the service.

Sincerely,