

**PRE-OPERATION VISIT
FOR
FAMILY DAY CARE HOMES**

1. Provider Name _____
 Address _____

 County _____ Phone _____

2. Provider's own children:

Full Name	Age
_____	_____
_____	_____
_____	_____

3. Is the provider claiming his/her own children? Yes No

4. Is the provider claiming related children over capacity? Yes No

If Yes, list children's names and relationship to the provider

Child's Name	Relationship to the Provider

5. Type of provider: Registered Certified Licensed

6. License capacity: _____ Expiration Date ___/___/___

7. Have record keeping requirements been explained to and discussed with the provider?
 Yes No

8. Is the provider willing to and capable of maintaining the required daily CACFP records?
 Yes No

9. Is kitchen equipment suitable for food service?
 Yes No

10. Is kitchen clean and well organized?
 Yes No

11. Is dining area suitable for children?
 Yes No

12. Are thermometers available for both refrigerator and freezer?
 Yes No

13. Does the provider wish to participate in the Child Care Food Program?
 Yes No

15. Describe plan for correcting deficiencies identified in this visit:

16. Has the provider ever been terminated or determined "seriously deficient" by another sponsoring organization?
 Yes No

Signature of Sponsor Representative Date Signature of Provider Date