MONITORING REPORT
ADULT DAY CARE AND ADULT DAY HEALTH

DATE OF VISIT: _____

I. PROGRAM: _____ COUNTY: _____

II. TYPE OF PROGRAM: ☐ ADC ☐ ADH ☐ ADC/ADH

III. TYPE OF VISIT: (☐) Announced (☐) Unannounced TIME OF VISIT: _____

IV. ENROLLMENT: # Full-time ___ # Part-Time ___ Month Reviewed _____

ATTENDANCE: # Participants at time of visit _____ # of Staff at time of visit_____

V. CONCERNS FROM PREVIOUS VISIT: _____

_____

_____

Have these concerns been resolved? (☐) YES (☐) NO (If no, complete DSS Form 6215)

VI. AREA REVIEWED:

Program Evaluation [10A NCAC 06R .0509 and 06S .0401] – Standards, Page 23

Review the program's evaluation plan for the following components, and check to be sure that the evaluation is being completed each year.

Yes	No	
(☐)	(☐)	Plan for evaluation of operation and services is in writing, includes the timetable for initiating and completing the annual evaluation, the parties to be involved, the areas which will be addressed and the methods to be used in conducting the evaluation.
(☐)	(☐)	A formal evaluation is being conducted at regular intervals, at least annually.
(☐)	(☐)	Specific parties involved, as appropriate, in evaluation process (see pg. 23).
(☐)	(☐)	Evaluation focuses on the following three areas: ☐ The extent to which the program is achieving its goals; ☐ The extent to which the program is meeting the needs and interests of participants; ☐ The extent to which the program is efficient and effective in its operation, including the extent to which the program is cost efficient.
(☐)	(☐)	Written report of evaluation on file.

VII. COMMENTS/CONCERNS _____

_____

_____

Attach an additional sheet if needed

VIII. PROGRAM DIRECTOR'S COMMENTS _____

_____

_____

IX. Continued by (☐) DSS-6215 (____ # of forms)

X. Signatures:

_____ _____ _____ _____

Coordinator Date Program Director Date

Make copies for DSS file; Program Director, and State Adult Day Services Consultant.