MONITORING REPORT
ADULT DAY CARE AND ADULT DAY HEALTH

DATE OF VISIT: _____

I. PROGRAM: _____ COUNTY: _____

II. TYPE OF VISIT: ( ) Announced ( ) Unannounced TIME OF VISIT: _____

III. ENROLLMENT: # Full-time ___ # Part-Time ___ Month Reviewed _____
ATTENDANCE: # Participants at time of visit _____ # of Staff _____

IV. CONCERNS FROM PREVIOUS VISIT: _____
_____
_____
Have these concerns been resolved? ( ) YES ( ) NO (If no, complete DSS Form 6215)

DO NOT COMPLETE THIS FORM IF THE PROGRAM
DOES NOT PROVIDE OR CONTRACT FOR TRANSPORTATION

V. AREA REVIEWED:

Transportation [10A NCAC 06R .0503 and 06S .0404] – Standards, Page 20-21

Yes	No	*If applicable, it is recommended you ride with the van as a part of your monitoring visit.*
( )	( )	The program has a transportation policy that includes routine and emergency procedures and addresses the following: ☐ accidents ☐ medical emergencies ☐ weather emergencies ☐ escort issues
( )	( )	A copy of the program's transportation policy is located in all vehicles.
( )	( )	Each person transported has a seat on the vehicle.
( )	( )	Participants offered opportunity for rest stop at least every 30 minutes.
( )	( )	Vehicles used for transportation equipped with seatbelts.
( )	( )	Participants are instructed to use seatbelts while being transported.
( )	( )	Vehicles are equipped with first aid kit and a fire extinguisher.

VI. COMMENTS/CONCERNS _____
_____
_____
Attach an additional sheet if needed

VII. PROGRAM DIRECTOR'S COMMENTS _____
_____
_____

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

IX. Signatures:

_____ _____ _____ _____
Coordinator Date Program Director Date

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

 Check Yes, No, or N/A (not applicable). If no, provide explanation.
*If transportation is provided, N/A is not an option. All Standards must be met.