**COMMUNITY DEVELOPMENT**

**PROGRAM MONITORING VISIT TOOL**

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|  |  |
| --- | --- |
| MOHCD Staff Present: |  |
|  |  |
| Date of Visit: |  |
|  |  |
| Agency Name: |  |
|  |  |
| Program Name: |  |
|  |  |
| Site Address: |  |
|  |  |
| Agency Staff Present: |  |

|  |
| --- |
| **MONITORING STANDARDS** |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

1. **Client files are complete.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| File # | Client # or Initials | File Found? | Eligibility Form? | Signed by Client and Staff? | Low-Mod Client? | Income Certification? | Service Notes? | All Required Info Recorded? |
| 1 |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

1. **Agency follows best practices for client eligibility forms.**
2. Staff indicate a correct understanding of family size and income for the purposes of determining eligibility;
3. Information on the eligibility forms is consistent in regards to family size and income;
4. The forms show income verification documentation or best efforts to obtain such documentation;
5. The forms have the race and ethnicity sections filled out accurately;
6. Staff provide guidance to clients in filling out the forms; and
7. Staff attempt to verify family size and income with the parent or guardian of minor clients.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

1. **Agency has a written client grievance procedure which is made available to participants.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

1. **Agency has written policies and procedures to allow people with disabilities to benefit from services and which contain an agency-wide ADA grievance procedure.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

1. **Staff are trained regarding the agency's ADA policies and procedures.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

1. **Program attendance is recorded for contracted activities.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

1. **Program design and implementation accurately reflect the scope of work in the grant agreement.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

1. **Program activities are being implemented on schedule, or there is a reasonable plan for how they will get back on schedule.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

1. **The remaining program budget is appropriate given activities already implemented and those pending.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

1. **Program targets, including activities and outcomes, are still appropriate.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Yes |  | No |  | N/A |

1. **Any equipment or other depreciable assets purchased with federal funds, which have a useful life of more than one year and exceed the lesser of $5,000 or the agency's internal capitalization threshold, are included in the asset inventory with unique identification numbers, descriptions, sources of funding, and acquisition costs.**

|  |
| --- |
| *Notes:*  |

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| **PROGRAM LEARNING** |

1. **Who are the staff members responsible for implementing the program?**

|  |  |  |  |
| --- | --- | --- | --- |
| Staff Name | Title | Description of Role | % of Time Assigned to Program |
|  |  |  | % |
|  |  |  | % |
|  |  |  | % |
|  |  |  | % |
|  |  |  | % |

1. **To whom do program staff report?**

|  |  |  |
| --- | --- | --- |
| Staff Name | Supervisor Name | Supervisor Title |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. **What form(s) of supervision and support are provided to program staff?**

|  |
| --- |
| *Notes:*  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

1. **Is the program operating at capacity (i.e. has a full client load)?**

|  |
| --- |
| *Notes:*  |

1. **What are the most common client needs and issues? What barriers do your clients experience in accessing services?**

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| --- |
| *Notes:*  |

1. **Which community conditions, circumstances, or events have impacted your clients the most? Which agencies and resources have provided the best support for your clients?**

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| --- |
| *Notes:*  |

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| --- | --- | --- | --- |
|  | Yes |  | No |

1. **Are community partnerships established and working well? What mechanisms ensure program participants are linked to other resources within the agency and the community? Do program staff conduct follow-up on service connections?**

|  |
| --- |
| *Notes:*  |

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| --- | --- | --- | --- |
|  | Yes |  | No |

1. **If the program administers a client satisfaction survey or evaluation, does participant feedback suggest desired outcomes are being achieved? If so, provide examples.**

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| --- |
| *Notes:*  |

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| --- | --- | --- | --- |
|  | Yes |  | No |

1. **Do specific activities stand out as being particularly effective? Why?**

|  |
| --- |
| *Notes:*  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

1. **Do specific activities stand out as being challenging or not effective? Why?**

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| --- |
| *Notes:*  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

1. **Have there been organizational changes or circumstances that have positively impacted the program?**

|  |
| --- |
| *Notes:*  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

1. **Have there been organizational changes or circumstances that have negatively impacted the program?**

|  |
| --- |
| *Notes:*  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

1. **Have there been community changes or circumstances that have positively impacted the program?**

|  |
| --- |
| *Notes:*  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

1. **Have there been community changes or circumstances that have negatively impacted the program?**

|  |
| --- |
| *Notes:*  |

1. **What are the program’s top three (3) strengths?**

|  |
| --- |
| *Notes:*  |

1. **What are the program’s top three (3) challenges or areas for improvement?**

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| --- |
| *Notes:*  |

1. **What are the opportunities for the program?**

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| --- |
| *Notes:*  |

1. **What are the threats to the program?**

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| --- |
| *Notes:*  |

1. **What changes to the program would you like to implement (if any)?**

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| --- |
| *Notes:*  |

1. **What supports and resources would build your capacity to improve client outcomes (if any)?**

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| --- |
| *Notes:*  |

1. **In what areas would technical assistance be most helpful (if any)?**

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| --- |
| *Notes:*  |

|  |  |  |  |
| --- | --- | --- | --- |
| MOHCD Staff Signature: |  | Date: |  |