Program Name: _____ Location: _____ Date:_____

Registry ID: _____ Fiscal Year: _____

Section 1: Desk Audit

Early Start CT Ages Served	☐Infant & Toddler ☐Preschool ☐School-Age	**OEC License Number:** (as written on the license)		**NAEYC/NAFCC Valid Until Date:**	
Applicable Funding Stream(s):	☐Early Start CT ☐ESCT SHS ☐Smart Start	**LIC-EXEMPT Health/Safety Inspection Data:**		**Accredit by date:** (If not yet accredited)	
# of Total Classrooms		**Head Start Approved** (Yes/No)		**ERS Completed** (If applicable)	

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June
ECE Monthly Reports												

ESCT Program Status Summary **(Completed in ECE Reporter)**												
E-license Verification												
Registry Verification												
Notes As Needed												

Section 2: Desk Audit

Contractual Requirements	Documentation Verified	Documentation Not Verified	Notes
The program has identified the assessment tool to be used for tracking and documenting the child's progress.			

Written documentation of the child screening and assessment tools and processes are shared with the families.			
Program schedules and conducts Parent Meetings.			
Written documentation for each child's learning and development is on file.			
60% of the children enrolled in state-funded spaces are at or below 75% of the state median income.			

Section 3: On-Site

Operations Checks (Every Visit) *By putting in the date of visit, the monitor is acknowledging they have verified the items listed.	**Date of Visit**				**Notes**
	Q1	**Q2**	**Q3**	**Q4**	
Attendance (Sign-In Sheets)					
Daily Schedule Posted					
Menu Posted					
Staff/Child Ratio					

Section 4: Desk Audit

*If there is not an assigned DQSM teacher in a classroom, the Liaison should review if there is an Individual Plan of Study in place toward achieving QSM status.

Classroom Name (All ESCT Classrooms on site)	**Age of Children**	**QSM** (Yes/No)	**Notes**

Section 5: On-Site

Classroom Observation

Learning experience plan is posted ☐ Yes ☐ No

I See	I Wonder

Section 6: On-Site

*Verification of information provided in children's files reviewed

Component	Date of Visit	Notes/Concerns/Action Plan Needed?
Collaboration		
Parent involvement		
Health & Safety		
Nutrition		
Family Literacy		
Admissions		
Transition		

Professional Development		
Sliding Fee Scale		
Evaluation		
Serving Children with Disabilities		

Section 7: On-Site

*Include all required Correction Action Plans from visits

Action Item(s)	Person Responsible	Timeline	Status
			☐ **Completed** ☐ **Follow-Up Needed**
			☐ **Completed** ☐ **Follow-Up Needed**
			☐ **Completed** ☐ **Follow-Up Needed**

Section 8: Follow-Up & Notifications

*Attach all supporting documentation

Other Notifications	Date of Notification	Date of Resolution	Notes

Section 9: Acknowledgement

This document has been completed by the assigned monitor and reviewed by program staff. All sections have been reviewed, and any follow-ups and/or corrections that are requested have been given a reasonable time frame for completion.

_____ _____

Monitored by Reviewed by (Program Staff)

Date: _____ Date: _____