EXHIBIT III

VOLUNTARY PREKINDERGARTEN PROVIDER MONITORING TOOL

Coalition staff/monitor: ____________________ **Monitoring date:** ________________
Program year: ____________________

PROVIDER PROGRAM INFORMATION

Time in: __________________ **Time out:** ____________________

Provider name: ____________________________ Provider ID: ___________

Location address: ____

Phone #: ____________

Director: ____________________ Director credential current: **Yes** ☐ **No** ☐

Indicate expiration date: ____________________

Current level two background screening clearance on file for director(s): **Yes** ☐ **No** ☐

Low performing provider: **Yes** ☐ **No** ☐

Implementing Improvement Plan, if applicable: **Yes** ☐ **No** ☐

AP2 Completed: **Yes** ☐ **No** ☐ **N/A** ☐

Curriculum name on OEL-VPK 11A: ______________________________________

Using curriculum indicated on OEL-VPK 11A: **Yes** ☐ **No** ☐

License/Gold Seal/Accreditation current (OEL-VPK 10): **Yes** ☐ **No** ☐

Indicate expiration date: ____________________

Files compliant with VPK Provider Contract record maintenance requirements

The provider maintains the following records for audit purposes for a period of five (5) years from the date of the last payment for that fiscal year or until the resolution of any audit findings or any litigation related to this Contract, whichever occurs last:

VPK instructor, substitute instructor and VPK director records: **Yes** ☐ **No** ☐

VPK attendance records: **Yes** ☐ **No** ☐

Records are backed up on a regular basis to safeguard against loss: **Yes** ☐ **No** ☐

VPK child records: **Yes** ☐ **No** ☐

EXHIBIT III

VOLUNTARY PREKINDERGARTEN PROVIDER MONITORING TOOL

Coalition staff/monitor: ______________________ **Monitoring date:** ____________

Program year: ___________________

VPK CLASS REVIEW (Duplicate this page for each class reviewed)

Program type: **School year** ☐ **Summer** ☐

Class being monitored: _____________________

Class schedule/a.m.-p.m. hours (as on OEL-VPK 11B):______________to___________

Operating within approved schedule: **Yes** ☐ **No** ☐

Instructor/substitute name: ____________________________

Instructor listed on OEL-VPK 11A: **Yes** ☐ **No** ☐ Credentials current: **Yes** ☐ **No** ☐

Current level two background screening clearance on file for lead instructor(s): **Yes** ☐ **No** ☐

Secondary/substitute name: ____________________________

Secondary/substitute listed on OEL-VPK 11A: **Yes** ☐ **No** ☐

Secondary/substitute credentials current: **Yes** ☐ **No** ☐

Current level two background screening clearance on file for secondary/substitute instructor(s):
Yes ☐ **No** ☐

Total VPK students: _____________________

Total other students: ____________________

Meets instructor/student ratio: **Yes** ☐ **No** ☐

Form OEL-VPK 02 on file for all VPK children included in the sample: **Yes** ☐ **No** ☐

Implementation of pre- and post-assessment as required (review Bright Beginnings System and child assessment booklets): **AP1: Yes** ☐ **No** ☐ **AP3: Yes** ☐ **No** ☐

Comment:____

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EXHIBIT III

ATTENDANCE REVIEW

Month(s) being reviewed: ________________________

Daily attendance (evidence of daily record of VPK children's attendance in the program: sign-in or sign-out log or electronic attendance-tracking system): **Yes** ☐ **No** ☐

Monthly attendance verification (OEL-VPK 03S or OEL-VPK 03L): **Yes** ☐ **No** ☐

If No, indicate names of children with missing forms:

________________________________ ____________________________________

________________________________ ____________________________________

INSURANCE VALIDATION

Worker's Compensation Insurance

Does the private provider have Worker's Compensation Insurance in accordance with paragraph 8 of Form OEL-VPK 20PP (October 2016) that covers the term of the contract?

Yes ☐ **No** ☐ **N/A** ☐

Reemployment Compensation Assistance

Does the private provider have Reemployment Compensation Assistance or Unemployment Compensation as required in accordance with paragraph 8 of Form OEL-VPK 20PP (October 2016) that covers the term of the contract?

Yes ☐ **No** ☐ **N/A** ☐

General Liability Insurance

Does the private provider have proof that it maintained general liability insurance (including transportation coverage if applicable) in accordance with paragraphs 6 and 7 of Form OEL-VPK 20PP (October 2016) that covers the term of the contract? **Yes** ☐ **No** ☐

If no for any of the above that apply, please determine and document the dates of lapsed coverage:

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EXHIBIT III

All Requirements Met: Yes ☐ **No** ☐ If no, mark number of requirements not met below and indicate corrective action plan (CAP) due date.

Number of requirements not met: ___________

CAP DUE DATE: _____________

CAP RECEIVED DATE: _____________

CAP APPROVED DATE: __________

TECHNICAL ASSISTANCE PROVIDED: Yes ☐ **No** ☐ **NA** ☐ **DATE:** _______

Comments:

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Provider Representative Printed Name and Title: ______________________________

Provider Representative Signature: _____________________ Date: ________________

Coalition Representative Printed Name and Title: _____________________________

Coalition Representative Signature: _____________________ Date: ________________