



# HUMAN SERVICE ZONE OFFICE ON-SITE REVIEW REPORT

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM  
SFN 450 (9-2024)

HSZ/County Name	On-site Review Date
Name of Group Living Arrangement or Treatment Center	Address of Group Living Arrangement or Treatment Center
Signature of Center Personnel Completing Review	Signature of HSZ Personnel Completing Review
Number of Residents Living in the Facility	Number of SNAP Recipients
Is the Facility a FNS Certified EBT Retailer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the facility certified by DHHS? <input type="checkbox"/> Yes <input type="checkbox"/> No

### Check the Appropriate Box

- Confirmed client currently resides or had resided at this facility:  Yes  No  N/A
- Confirmed client departure date as reported:  Yes  No  N/A
- EBT Cards returned to client at departure or HSZ office:  Yes  No  N/A
- Client EBT Cards are:  Kept by the Client  Kept in a secure location at the facility

### Deficiencies Noted

### Corrective Actions Required by the Facility

### State Office Comments