

RESIDENTIAL SUMMARY

Provider: _____

Please complete one form per residential facility

Facility Name: _____

Facility Address: _____

Facility Contact Person (s): _____

Title: _____

Contact Phone Number: _____

E-mail: _____

Site Phone Number: _____

Site Fax Number: _____

Facility Licensed or Certified (list CBRF, AFH, etc.): _____

Live-in staff: Yes No

Owner-occupied: Yes No

Corporate: Yes No

List Class if CBRF: _____

Number of licensed or certified beds: _____

Number of years in operation: _____

Facility Licensed/Certified to Serve

Check as Appropriate:

Gender	<input type="checkbox"/> M	<input type="checkbox"/> F	Physically Disabled	<input type="checkbox"/> Y	<input type="checkbox"/> N
Advanced Age	<input type="checkbox"/> Y	<input type="checkbox"/> N	Alzheimer's/Dementia	<input type="checkbox"/> Y	<input type="checkbox"/> N
Traumatic Brain Injury	<input type="checkbox"/> Y	<input type="checkbox"/> N	Serious & Persistent Mental Illness	<input type="checkbox"/> Y	<input type="checkbox"/> N
Developmental Disabilities	<input type="checkbox"/> Y	<input type="checkbox"/> N			

Facility Capabilities

Behavioral Needs: (check one box in each category to indicate your facility's capability to serve members displaying the described behavior)

Verbal Aggression

- None**
- Mild:** Occasional use of profanity or inappropriate comments. Behavior is easily redirected with verbal cues.
- Moderate:** A moderate use of profanity, inappropriate comments and/or screaming and/or yelling. Behaviors can be redirected with verbal cues.
- Severe:** Frequent screaming and/or yelling that is not easily redirected and/or verbal threats to harm others that are not acted upon.

Physical Aggression

- None**
- Mild:** Self injurious and/or self stimulating behavior that is mild and easily redirected verbally.
- Moderate:** Self injurious and/or self stimulating behaviors that may cause injury to self or others such as hair pulling, kicking, slapping, and punching that is able to be verbally redirected with one or multiple cues.
- Severe:** Self injurious and/or self stimulating behaviors that may cause serious injury to self or others such as hair pulling, kicking, slapping and punching that is not easily/not redirected verbally.

Property Destruction

- None**
- Mild:** Easily verbally-redirected behavior such as fist pounding, tearing clothes, and door slamming.
- Moderate:** Verbally redirected behavior that destroys property such as punching walls, throwing and/or breaking objects without causing harm to others.
- Severe:** Property destruction that requires modification to the environment to avoid injury to self or others such as recessed lighting, unbreakable windows, and/or special furniture not easily destroyed.

Sexual Behaviors

- None**
- Mild:** Inappropriate sexual comments that are easily redirected verbally and/or masturbation that requires verbal redirection to be done in privacy (this does not include public masturbation).
- Moderate:** Flashing, stripping, and/or frequent inappropriate sexual comments that can be verbally redirected and occurs within the home and not in public.
- Severe:** Flashing, stripping and/or masturbation that may occur within the home and may not be easily redirected verbally. Acts of flashing, stripping and/or masturbation that occur in public that may or may not be easily verbally redirected. The individual may exhibit predatory type sexual behaviors towards peers and/or others. The individual may have a need for an environment that is all male/all female peers and/or all male/all female staff due to sexually inappropriate behaviors. The individual may be a registered sex offender.

Medical Needs: (please check all boxes that apply to indicate your facility's capability to serve members with the listed medical need)

- Diabetic Blood Sugar Monitoring
- Insulin-Dependent Diabetic
- Sliding-scale Insulin-Dependent Diabetic
- Tracheotomy Care
- Tube-Feeding
- Incontinence

Wheelchair accessible entrances? (two entrances to grade) Yes No

Hoyer lift? Yes No

Transfer Status (check one) Independent Assist of One Assist of Two

Number of bedrooms: _____	Number of wheelchair accessible bedrooms? _____
Number of shared bedrooms: _____	Number of wheelchair accessible shared bedrooms? _____
Number of bathrooms: _____	Number of wheelchair accessible bathrooms? _____

Is the facility alarmed? Yes No

Does the facility have pets? Yes No

List types of pet(s):

Are members allowed to smoke? Yes No

Consumer transportation options:

Agency vehicle(s): Agency Van Agency Car Staff Vehicle
 Public Transit Lift Equipped

or other options: _____

Consumer Resources:

Please provide the available community resources to members residing in the home: _____

Staff Information: _____

Owner/Operator Name: _____

Academic preparation: _____

Relevant experience or training: _____

Has the owner/operator ever been convicted of a crime? Yes No

If Yes, please explain: _____

On-Site Manager Name: _____

Academic preparation: _____

Relevant experience or training: _____

Has the on-site manager ever been convicted of a crime? Yes No

If Yes, please explain: _____

Please list required staff trainings: _____

Additional facility expertise/experience not identified above:

Attestation Statement:

I certify that the information completed on this long-term care program summary is true and accurate as of its completion.

If the long-term care program summary information changes at any time, I will submit a new long-term care program summary.

Name of Person Completing Form: _____

Date Completed: _____

Signature: _____