RESIDENTIAL SUMMARY

Business Name: _____

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: _____

Site TDD/TTY 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: _____

Languages Spoken in Facility Other than English: _____

Handicapped Parking: ☐ Yes ☐ No

Facility Licensed/Certified to Serve

Check as Appropriate:

Gender	☐ **M**	☐ **F**	Physically Disabled	☐ **Y**	☐ **N**
Advanced Age	☐ **Y**	☐ **N**	Alzheimer's/Dementia	☐ **Y**	☐ **N**
Traumatic Brain Injury	☐ **Y**	☐ **N**	Serious & Persistent		
Developmental Disabilities	☐ **Y**	☐ **N**	Mental Illness	☐ **Y**	☐ **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.

Do you have a nurse on Staff? ☐ Yes ☐ No

If Yes to the previous questions, is your nurse an RN or LPN? ☐ RN ☐ LPN

If you do have a nurse on staff, how many hours per week is your nurse on site?

_____

_____

If you do have a nurse on staff, how many of your facilities are serviced by your nurse?

_____

If you do have a nurse on staff, what are the responsibilities of that nurse?

_____

_____

_____

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 *(Must be Nurse Supervised)*
- ☐ Tracheotomy Care *(Must be Nurse Supervised)*
- ☐ Tube-Feeding *(Must be Nurse Supervised)*
- ☐ Incontinence
- ☐ Bariatric
- ☐ None

Facility Accessibility: (only check one)

☐ **Ambulatory** (members do not use any assistive devices to ambulate)

☐ **Semi-Ambulatory** (accessible to serve members who use canes, walkers, crutches or other assistive devices - excluding wheelchairs)
(must comply with all State licensing and/or certifying regulations)

☐ **Non-Ambulatory** (accessible to serve members who use wheelchairs)
(must comply with all State licensing and/or certifying regulations)

Is facility able to serve members who require a Hoyer? ☐ Yes ☐ No
(Hoyer is provider responsibility)

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

Is the facility alarmed? (All exits are equipped with a system to alert staff if an exit is opened, and can only be turned off with a code or a key. Inter-connected) ☐ Yes ☐ No

Please note - notification by a bell or a chime which sounds when an exit is opened, but not inter-connected to the other exits, and/or could be turned off with a flip of a switch is not considered an alarmed facility and you should not check yes.

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: List available community resources to members residing in the home:

_____

_____

_____

Staff Information:

Owner/Operator Name: _____

Academic preparation: _____

Relevant experience or training: _____

_____

Do the owners/operators have any criminal charges pending against them or have they ever been convicted of a crime? ☐ Yes ☐ No

If Yes, please explain: _____

_____

_____

On-Site Manager Name: _____

Academic preparation: _____

Relevant experience or training: _____

_____

Does the on-site manager have any criminal charges pending against him/her or has he/she 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 residential summary is true and accurate as of its completion. If the residential summary information changes at any time, I will submit a new residential summary.

Print Name of Person Completing Form: _____

Signature: _____

Date: _____

- **Electronic signature is considered valid only when document is submitted by e-mail from the signer's email address.**
- **If mailing or faxing application, signature must be handwritten.**