RESIDENTIAL SUMMARY

Business Name: _____

Please complete one form per residential facility

Facility Name: _____

Facility Address: _____

Facility Contact Person(s): _____

Contact Title: _____

Contact Phone Number: _____

Contact 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

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 *(must match license)*:

Gender	☐ **M**	☐ **F**	Irreversible Dementia /Alzheimer's	☐ **Y**	☐ **N**
Advanced Age	☐ **Y**	☐ **N**	Physically Disabled	☐ **Y**	☐ **N**
Alcohol/Drug Dependent	☐ **Y**	☐ **N**	Terminally Ill	☐ **Y**	☐ **N**
Correctional Clients	☐ **Y**	☐ **N**	Traumatic Brain Injury	☐ **Y**	☐ **N**
Developmentally Disabled	☐ **Y**	☐ **N**			
Emotionally Disturbed /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.

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

Do you have a Registered Nurse in the facility? ☐ Yes ☐ No

How many hours per week is the RN on site?

How many of your facilities do they service?

Capabilities:

☐ Tracheotomy Care *(Must be performed by a Registered Nurse)*

☐ Sliding-scale Insulin-Dependent Diabetic *(Must be Registered Nurse Delegated)*
☐ Tube-Feeding *(Must be Registered Nurse Delegated)*
☐ Ventilator Care *(Must be Registered Nurse Delegated)*
☐ Wound Care *(Must be Registered Nurse Delegated)*
☐ Tube and Drain Care *(Must be Registered Nurse Delegated)*
☐ Ostomy Care *(Must be Registered Nurse Delegated)*

☐ Diabetic Blood Sugar Monitoring
☐ Insulin-Dependent Diabetic
☐ Bariatric (up to 500 lbs)
☐ Bariatric (over 500 lbs)
☐ Memory Care
☐ Elopement

☐ Hoyer *(provider attests to following manufacturer's recommendations for Hoyer use)*
☐ Track System
☐ Delayed Egress
☐ Mag Locks

***Licensed Adult Family Home (AFH) Ambulation*:** (check one)

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

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

***Community Based Residential Facility (CBRF) Class*:** (check one)

☐ Class A Ambulatory (AA)
☐ Class A Semi-Ambulatory (AS)
☐ Class A Non-Ambulatory (ANA)
☐ Class C Ambulatory (CA)
☐ Class C Semi-Ambulatory (CS)
☐ Class C Non-Ambulatory (CNA)

***Consumer Transportation Options*:**

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

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: _____

_____

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.**