

Adult Family Home Application

Applicant

Name: _____ Social Security # _____

Mailing Address: _____

Location Address: _____

Contact Person: _____

Contact Phone _____

Applicant has been in business since: _____

Applicant licensed as: ____ Adult Family Home ____ Boarding Home

Applicant is ____ Individual ____ Partnership ____ Corporation ____ Other describe _____

Applicant is ____ For Profit ____ Not for Profit _____ Medicare Certified _____ Medicaid Certified

Number of Licensed Beds: _____ Number of Occupied Beds: _____

How many AFH locations do you have? _____

Do you have any plans for mergers, acquisitions, new services, sale of business or other changes within the next 12 months? ____ Yes ____ No (if yes describe on a separate sheet of paper)

Services Provided

	# Ambulatory	# Semi-Ambulatory	# Non-ambulatory
Adult Residential Care			
Enhanced Residential Care			
Dementia Care Services			

How many residents are not mentally or physically capable of responding to an electronic fire alarm and exiting the facility without any help or verbal or physical prompting. _____

Are you in compliance with all regulations governing the written procedures, storage, handling and dispensing of all patient medications? _____ Yes ____ No

Dementia Care: Do you have patients with Stage 5 - moderately severe Alzheimer's symptoms? ____ Yes ____ No

If yes, describe: _____

Other Services - do you have any residents not described above? (describe below)

Are current written services plans available for each resident? _____ Yes ____ No

How often are service plans re-evaluated? _____

Any residents confined to bed or require 24 hour supervision? _____ Yes ____ No

If yes, describe: _____

Any residents known to Wander? _____ Yes ____ No

Are residents required to sign out when leaving and returning? _____ Yes ____ No

Are there any residents with a record of sexual abuse or molestation? _____ Yes ____ No

Are there alarms on exterior doors to alert staff? _____ Yes ____ No

Are residents' whereabouts electronically monitored? _____ Yes ____ No

If yes, describe: _____

Staffing	Day	Eve	Night
Resident Manager / Shift Care Givers			
Substitute Care Givers			
Nurses or other licensed staff.			
Others - describe			
Number of staff or family on premises			

Are Staff awake at all times during the night? ___ Yes ___ No

Are you in compliance with all Regulations regarding Caregiver eligibility requirements? ___ Yes ___ No

Are you in compliance with all Regulations regarding Caregiver background check requirements? ___ Yes ___ No

Are you in compliance with all Regulations regarding Caregiver training requirements? ___ Yes ___ No

How long have your staff members worked for you? If you have more than 7 employees list as below on the other side.

Employee #1	Employee #2	Employee #3	Employee #4	Employee #5	Employee #6	Employee #7
_____ Years	_____ Years	_____ Years	_____ Years	_____ Years	_____ Years	_____ Years

Physical Premises

Building Construction

Year Built _____ Number of Stories _____

Total building area _____ Square Feet

Distance to Fire Hydrant Feet _____ Distance to Fire Station Miles _____

Building Improvements – when were last updates done for:

Wiring year _____

Plumbing year _____

Heating year _____

Roofing year _____

Location of Smoke Detectors Hallways Resident Rooms Hallways

Are smoke alarms battery powered? or wired?

Does the building have sprinklers or other fire protection? Yes No

Does the building meet the current life safety code? Yes No

Are handrails provided in hallways? Yes No

Are handrails provided in bathrooms? Yes No

Are there any non-ambulatory residents above the grade floor? Yes No

Is there a written evacuation plan? Yes No

How often are fire drills conducted to test the plan? _____

