



Residential Provider Service Form

Facility Name: _____

Address Name: _____

City, State, and Zip: _____

Contact Person: _____ Title: _____

Phone Number: _____ E-mail: _____

Contact Person: _____ Title: _____

Phone Number: _____ E-mail: _____

Home/Facility Fax Number: _____

Home/Facility Characteristics

Facility Type (check all that apply)

- AFH
- CBRF
- Owner-Occupied
- RCAC
- Respite Provider
- Supportive Apartment
- Supportive Home Care Days

Pets (check all that apply)

- Home/Facility has dog(s)
- Home/Facility has cat(s)
- Other pet/specify: _____
- Willing/able to accept member's pet(s)/specify: _____

Bed Capacity: _____

Bed Availability: _____

(check all that apply)

- Female Only
- Male Only
- Private
- Respite
- Shared

Facility Security

- Facility is alarmed
- Facility is locked

Narrative about the home/facility:

Member Characteristics

Target Group Served (check all that apply):

- Elderly
- Intellectually Disabled
- Mental Illness
- Physically Disabled

Ability to Accommodate the Following Member Behaviors/Characteristics (check all that apply):

- Languages spoken other than English/specify: _____
- Memory impairment
- Offensive language
- Physically aggressive
- Self-injurious behavior
- Smokeless tobacco use (chewing tobacco)
- Smoking inside
- Smoking outside only
- Substance use/abuse
- Wandering/elopement risk
- Other behaviors/specify: _____

Personal Care

Bathing (check all that apply):

- Has roll-in shower
- Provides bathing as often as needed or requested by member
- Provides partial assistance as needed
- Provides total assistance if needed
- Provides verbal cueing as needed

Grooming (check all that apply):

- Provides fingernail/toenail care
- Provides grooming upon request of member
- Provides partial assistance as needed
- Provides total assistance if needed
- Provides verbal cueing as needed
- Provides grooming only during specific times of day

Indicate times: _____

Dressing (check all that apply):

- Provides dressing upon request of member
- Provides partial assistance as needed
- Provides total assistance if needed
- Provides verbal cueing as needed
- Provides dressing only during specific times of day

Indicate times: _____

Toileting (check all that apply):

- Able to accommodate excessive care needs related to toileting (laundering, cleaning, etc.)
- Able to accommodate members needing assistance with use of incontinence products
- Able to accommodate members with high care needs (supervision, hands-on assistance, fecal smearing, etc.).
- Able to accommodate persons incontinent of bladder
- Able to accommodate persons incontinent of bowel

Able to accommodate the following (check all that apply):

- Bowel/Bladder Programs
- Catheter
- Commodes
- Ostomy
- Other/specify: _____

Nutritional Services (check all that apply):

- Able to accommodate mechanical diets (soft, pureed, thicket, etc.)
- Able to accommodate special diet requirements (diabetic, low sodium, etc.)
- Able to accommodate tube feeding
- Members have input into menus
- Provides feeding for members as needed
- Provides hands-on assistance with eating as needed
- Provides supervision and set-up with meals as needed
- Residents can access the kitchen in between meals

Mobility/Accessibility (check all that apply):

- Able to accommodate individuals needing transfer assistance (one person assists)
- Able to accommodate individuals needing two-person assists for transfers (non-weight bearing)
- Able to accommodate moderate assistance with mobility (walkers, canes, grab bars, etc.)
- Home/facility has a Hoyer/mechanical lift
- Home/Facility has a wheelchair equipped vehicle
- Home/facility is handicap accessible

Able to accommodate the following equipment (check all that apply):

- Hoyer/mechanical lifts
- Transfer board/trapeze
- Wheelchairs
- Other/specify: _____

Supervision (check all that apply):

- Has submitted/will submit a staffing pattern schedule (provide ability for ATTACHMENT of staffing pattern form HERE)
- Provides overnight awake supervision
- Provides overnight sleep staff

Medical and Health Care Services

Health Monitoring (check all that apply):

- Consult RN on call
- Corporate RN
- RN on site and available

Medication Management (check all that apply):

- Able to accommodate inhaled medications
- Able to accommodate injectable medication needs
- Able to accommodate oral medications
- Able to accommodate topical medications
- Able to assist in the administration/delivery of injectable medications
- Provides full services of medication administration if needed
- Provides set-up and cueing of medication administration as needed

Specialized Nursing Service

Provides the following nursing services (check all that apply):

- Blood sugar monitoring
- Catheter care
- Catheter changes
- Fluid monitoring
- IV fluids/Medications
- Ostomy care
- Oxygen/nebulizer
- Sliding scale diabetic needs
- Suction/Trachea care
- Tube feeding (G or J tubes)
- Ventilator/Respiratory care
- Wound care

Transportation (check all that apply):

- Arranges and pays for transportation
- Provides transportation

Activities (check all that apply):

- Arranges for member to attend the church of their choice, if requested
- Members involved in planning of activities
- Provides planned activity schedule
- Provides planning activities outside of the facility (Frequency: _____)