

MICHIGAN CAMPAIGN FOR QUALITY CARE

ASSISTED LIVING DISCLOSURE FORM

Facility: _____ Address: _____

Phone: _____

Resident Capacity: _____ Private Bedrooms: _____

A. LICENSURE (If licensed: information available at: www.michigan.gov/dhs)

Facility is: ___ Not Licensed or ___ Licensed ___ Adult Foster Care ___ Home for the Aged

(please check one)

B. STAFFING

Are criminal background checks completed prior to hiring staff? ___ Yes ___ No

Number of direct care staff on duty: Days/Evenings _____ Overnight _____

· Are staffs required to be awake while on duty, during all shifts? ___ Yes ___ No

· Is a nurse (RN or LPN) present in the facility: Days/Evenings? ___ Yes ___ No

Overnight? ___ Yes ___ No

C. TRAINING

Training is provided to direct care staff in: *(check all that apply)*

___ Dementia Care ___ First Aid ___ CPR

___ Fire Safety & Emergency Evacuation Procedures ___ Medication Administration

· Does staff administer medications? ___ Yes ___ No

D. SAFEGUARDS

	<i>In Resident Rooms</i>	<i>In Other Areas</i>
Smoke Detectors	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sprinkler Systems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Air conditioning	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Door Alarms	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

- Are alarms audible to staff 24 hours? Yes No
 - What other forms of supervision/monitoring do you have in place for individuals with dementia?
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E. QUALITY OF LIFE

- Are there regular therapy, exercise, and/or social activities at the facility? Yes
 No
- Do you provide a copy of the facilities activities calendar upon request? Yes No
- Does the facility provide transportation to activities, appointments, etc? Yes No
- Can resident choose/select/retain: Own Pharmacy? Yes No
Hospice Provider? Yes No
- Can Residents retain their own physician? Yes No
- Is there a care planning process to address each resident's needs and preferences?

Yes No

If yes, please describe your care planning process: _____

F. FEES

Is a written fee schedule for all costs given to each resident/family member upon request?

Yes No

What is the facility's policy for billing a resident during a temporary absence from the facility?

Does the facility provide a full refund for any paid interval if the resident leaves the facility permanently for any reason? Yes No

G. DISCHARGE AND GRIEVANCE PROCEDURE

What are your discharge and grievance procedures?

Are there circumstances under which the facility will involuntarily discharge or refuse to readmit a resident? If yes, please specify

In the event of involuntary discharge, does the facility provide assistance finding another facility? Yes No

Does the facility has a written appeal or grievance procedure for: *(please check all that apply)*

involuntary discharge

Fees and/or billing

Care plan and/or changes to level of care

If so, are the policies given to each resident/family member?

H. AGENCY CONTACTS

Ombudsman Contact: _____

Licensing Agency Contact: _____