ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT
**Adult Day Health**

A. List the date of your most recent certification (attach copy).

B. List the total number of slots for program.

C. What is the average time between ASAP referral and the start of service to the consumer?

D. Describe your procedure for action in case of the following emergencies:
1. Fire

2. Loss of power (lights and/or heat)

3. Hurricanes and snowstorms

4. Consumer wandering away

5. Consumer health crisis

If emergency policies are written, attach a copy of policy(ies)

E. Describe your policy for admission to your program. Cite any restrictions. How many "slots" are available for ADH, and ADH dementia (if applicable)?

F. Describe restrictions (if any) for an elder to continue in your program.

G. How many employees have had CPR and/or Basic First Aid training?

H. In order to meet the needs of the participant, list who provides the following:
- Health care and supervision
- Counseling
- Restorative services
- Socialization Maintenance
- Therapy services

I. Are prescription or non-prescription medications dispensed or administered?If Yes, who is responsible for supervising the administration of medications?

J. Describe how you assure that the required participants-to-staff ratio is maintained.

K. Who is responsible for ensuring that meals meet government standards of nutrition?

L. Are meals prepared on site?

M. List the special diets that your site can accommodate.

N. List the AM & PM snacks served during the average week.

**Dementia/Related Illnesses Providers**

A. List your requirements for admission.

B. Describe how activities are designed to meet the needs of high and low functioning groups.

C. If your program is combined with other programs, such as Adult Day Health or Supportive Day Care, areactivities provided in separate locations?

D. Describe how you assure that the required participants-to-staff ratio is maintained.

Provider employee who completed this form

Name:_____ Date: _____

## Adult Day Health

Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On Site Evaluation

| EMPLOYEE Record Review | | | | | |
|---|---|---|---|---|---|
| Provider<br><br>Date<br><br>Monitor | | | | | |
| Start Date<br>& Termination Date, if applicable | | | | | |
| Number of reference checks | | | | | |
| CORI Check | | | | | |
| Orientation Date | | | | | |
| Job Description in file? | | | | | |
| License(s)/ Certificate(s) Current/expired? | | | | | |
| Physical: Most recent | | | | | |
| TB: Most recent | | | | | |
| CPR/First Aid: Most recent | | | | | |
| OIG monthly checks | | | | | |
| Ongoing training: dates | | | | | |
| Annual Performance Appraisal: Date | | | | | |
| Comments | | | | | |

## Adult Day Health

Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On Site Evaluation

| CONSUMER Record Review | | | | | |
|---|---|---|---|---|---|
| Provider<br><br>Date<br><br>Monitor | | | | | |
| ASAP Authorization | | | | | |
| name; address; phone; DOB, SAMS ID | | | | | |
| Emergency contact(s) name and phone | | | | | |
| Physician(s) name and phone | | | | | |
| Preferred hospital name and phone | | | | | |
| Medical/social diagnosis | | | | | |
| Current CM/RN and phone | | | | | |
| Service start date<br>& Termination Date, if applicable | | | | | |
| Service plan | | | | | |
| Care Plan<br>Signed and dated | | | | | |
| Consumer agreement | | | | | |
| Comments | | | | | |
| NOTE: Shaded data elements are only required in the Consumer File if provider is not on Provider Direct. Otherwise the PD Demonstrator will be asked to illustrate “on screen”. | | | | | |

| **Name and Position of Provider Direct Demonstrator** | |
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