Ohio Long-Term Care Consumer Guide
Residential Care Facility Entry Page

This form has been provided to you as part of the application process to become an ODA—approved provider of Assisted Living Services. Ohio Department of Aging staff will enter the information provided on this form on the Ohio Long-Term Care Consumer Guide website to be shared with interested consumers as well as be available to the general public.

The first two pages are required for all facilities applying to become an ODA-approved provider of Assisted Living Services. The additional information requested may be completed at the facility’s discretion and is intended to help the consumer make an informed choice regarding the selection of a facility.

The facility may be contacted by Ohio Department of Aging staff to participate in future projects associated with the Long-Term Care Consumer Guide.

Name of the person completing this form: ______________________________________

Telephone number of person completing this form: (          )              -            , Ext:

Facility Name: ___________________________________________ (the name by which the facility is commonly known in your community)

Facility Address:

Address 1:________________________________________________

City: ____________________________

Zip Code: ____________________

Facility Phone Number: (          )              -            , Ext:

Facility Fax Number: (            )             -

Facility Contact’s E-mail Address, if available:____________________________________

Facility Web site address, if available. URL: ______________________________________
The Consumer Guide will link to your site for consumers to learn more about your facility.

Ohio License ID Number:________________________
General Comments: Using no more than 2000 characters, provide general comments describing your facility. Required information includes the facility setting (urban/rural/suburban), general demographics of the residents, ancillary services (ex: on-site beauty/barber shop, library, exercise room and the availability of any specialty units. Information about community integration programs, policies regarding pets/visitors/alcohol, culturally specific practices or the use of Person-Centered care is especially helpful. Attach a separate sheet, if desired.

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Occupancy Information

Total Number of Resident Units available: _______________

Number of Resident Units approved for the Assisted Living Waiver ________

*Approximate Base Rate for Private Pay ____________

*may not include all available services
Optional Information for Assisted Living Waiver Provider Applicants

Staffing Information:

Please enter the total number of nurses, direct care staff (such as aides who assist residents with personal care), and other staff (such as social workers, activity or spiritual staff) that your facility typically has on duty during each shift:

**WEEKDAYS**

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<tr>
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<th>Nurses</th>
<th>Direct Care Staff</th>
<th>Other Staff</th>
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<td>Day</td>
<td>Evening</td>
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**WEEKENDS**

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Other Staffing Comments (You may want to include comments about contract staff your facility uses, such as nurses on-call from an attached nursing facility or therapists used on an as-needed basis, etc.):

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Special Care Services:
Residential Care Facilities provide a wide range of services. Although there are no special standards or requirements in place, some facilities specialize in certain services.

Check the box to indicate your facility provides specialized care in the services listed below. If needed, Circle Yes or No to indicate if the service is provided in a specific unit of the facility.

Provide a description of or more information about the special service, if desired. Note: The text field will accept no more than 1000 characters. Your description should be factual and simple. For example: “We provide Alzheimer Care services in a secure unit that features an enclosed courtyard. Staff receive additional training regarding best practices in dementia care.”

[ ] Alzheimer/Dementia Care
Is the service provided within a specific unit of the facility: Yes / No
Description of Service (You may wish to indicate that secured areas or devices are available if needed):
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
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[ ] Hospice Care
Is the service provided within a specific unit of the facility: Yes / No
Description of Service:
________________________________________________________________________________
[ ] Special Diets
Description of Service:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

[ ] Rehabilitative Therapy (e.g. Physical, Occupational, Speech)
Is the service provided within a specific unit of the facility: Yes / No
Description of Service:
________________________________________________________________________________
________________________________________________________________________________
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[ ] Short-Term Stays for Respite Care
Is the service provided within a specific unit of the facility: Yes / No
Description of Service:
________________________________________________________________________________
________________________________________________________________________________
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[ ] Advanced Skin Care
Is the service provided within a specific unit of the facility: Yes / No
Description of Service:

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[ ] Medication Administration
Description of Service:

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[ ] Assistance with Self-Administration of Medication
Description of Service:

________________________________________________________________________________
________________________________________________________________________________
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________________________________________________________________________________
[  ] 24-Hour Licensed Nursing
Is the service provided within a specific unit of the facility: Yes / No
Description of Service:

[  ] Transfer Assistance
Description of Service:

[  ] Transportation
Description of Service:
[ ] Formalized Wellness Programs
Is the service provided within a specific unit of the facility: Yes / No
Description of Service:
________________________________________________________________________________
________________________________________________________________________________
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[ ] Total Incontinence Care
Is the service provided within a specific unit of the facility: Yes / No
Description of Service:
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Services to Non-Residents provided in affiliation with the facility:
Check the services your facility offers to members of the community.
[ ] Adult Day Care [ ] Hospice Care [ ] Transportation
[ ] Home Health Care [ ] Short-Term Stays for Respite
[ ] Outpatient Therapies (Occupational, Physical, Speech)
[ ] Independent Living Care [ ] Skilled Nursing Facility (on the premises)
[ ] Other Community Services (see below)

List other services to non-residents provided by your facility or in affiliation with your facility, which are not in the above groups. Provide a description of each service, up to 1000 characters. Use additional pages if needed.

Service:________________________________________

Description:____________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Methods of Payment:
Check all methods of payment your facility accepts.

[ ] Self Pay        [ ] Residential State Supplement

(Please note: The Medicaid Waiver for Services program, when implemented in July 2006, will be listed as another payment option on the Consumer Guide.)

Facility Policies:
Check the boxes below regarding policies if appropriate for your facility.

[ ] Pets Allowed    [ ] Smoking Allowed    [ ] Alcohol Allowed

[ ] Honor Do Not Resuscitate    [ ] Have a Family Council in existence

Write other policies of your facility you wish to highlight in this area. You may write up to 1000 characters total. Other Policies: (Examples: Visiting hours, discharge policies, etc.)

________________________________________________________________________________

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Senior Staff Positions:
These pages allow you the opportunity to present the senior staff of your facility. Use them to let consumers know of the expertise and qualifications the staff member brings to the facility. In addition to the areas for education and certifications, there is an area where you may include additional information, perhaps philosophy of care, what they like best about their job, the rewards of working with older adults, etc.

1. Administrator

Name: ____________________________________________

Title, if other than “Administrator”: ____________________________________________

# of years employed as a long-term care administrator: _____

# of years employed at this facility as the administrator: _____

Education and degrees:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Special certifications or awards:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Additional Descriptive Information (up to 1000 characters).

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1. Nursing Director/Health Care Coordinator/Medical Director/Etc.

Name:________________________________________________________________________

Title:________________________________________________________________________

# of years employed in long-term care in the above position: ____.

# of years employed at your facility in the above position: ____.

Education and degrees:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

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________________________________________________________________________________

Special certifications or awards:

________________________________________________________________________________

________________________________________________________________________________
Additional Descriptive Information (up to 1000 characters).

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Other Senior Staff (This is optional. You may highlight any staff member positions, i.e. Volunteer Coordinator, Dietician, Social services, etc.)
Staff Title:_______________________________________________
Name:__________________________________________________
Descriptive Information:  _______________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Religious Affiliation:  
Check the boxes regarding any religious affiliations of your facility.

[ ] Catholic       [ ] Lutheran       [ ] Jewish       [ ] Presbyterian
[ ] Brethren       [ ] Mennonites     [ ] Protestant    [ ] United Church of Christ
[ ] Episcopalians  [ ] Methodist     [ ] Other religion ____________

Fraternal Affiliations: List any fraternal or other organizational affiliations of the facility. If your facility is privately accredited, you may wish to provide the name of the accrediting body and its website or other contact information.
Facility Picture: If you send a picture of your facility, it will be posted at your facility page.

For more information: Erin Pettigrew
Consumer Guide Team Leader
Ohio Department of Aging
50 West Broad Street, 9th fl.
Columbus, OH 43215

See the next page for record keeping tips and update planning.
PLAN FOR DATA UPDATES

<table>
<thead>
<tr>
<th>Area of Information</th>
<th>Date / Frequency</th>
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<tbody>
<tr>
<td>Facility Picture</td>
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<tr>
<td>License and Certification numbers:</td>
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<td>Facility comments:</td>
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<td>Facility Address</td>
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<tr>
<td>Primary Contact for updates:</td>
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<tr>
<td>Family Survey Coordinator</td>
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<tr>
<td>Resident Satisfaction Coordinator</td>
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<td>Phone, fax, e-mail</td>
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<tr>
<td>Owner / Operator data</td>
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<td>Beds and Staff</td>
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<td>Special Care Services</td>
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<td>Community Services:</td>
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<td>Methods of Payment:</td>
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<td>Policies:</td>
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For more information or assistance:
Long-Term Care Consumer Guide Team Leader
Ohio Department of Aging
50 W. Broad St., 9th floor
Columbus, OH 43215.
(614)466-5500