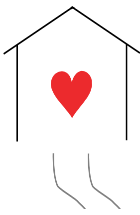

CALIFORNIA CONSUMER INFORMATION QUESTIONNAIRE FOR RESIDENTIAL CARE FACILITIES FOR THE ELDERLY

FACILITY NAME AND CONTACT INFORMATION

Add / Change as Needed

Facility Name : ______

Address: ______

City: ______ Zip: ______

Phone: ( ) ______ Fax: ( ) ______ TDD Number (if any): ( ) ______

E-mail Address: ______ Web Address (URL): ______

FACILITY LICENSING INFORMATION

Licensee Name: ______ Since (Mo/Yr): ______

License Number: ______

Number of Licensed Beds: ______ Number of Non-Ambulatory Licensed Beds: ______

Number of Private Rooms: ______ Number of Shared Rooms: ______ Number of Bathrooms for Residents: ______

❑ Yes ❑ No Does the Facility have an automated fire sprinkler system?

❑ Yes ❑ No Does the facility have a hospice waiver?

ADMISSIONS: TYPES OF RESIDENTS ACCEPTED

❑ Yes ❑ No Persons with Canes or Walkers

❑ Yes ❑ No Persons in Wheelchairs

❑ Yes ❑ No Persons Needing Assistance With Transferring

❑ Yes ❑ No Incontinent (Bladder)

❑ Yes ❑ No Incontinent (Bowel)

❑ Yes ❑ No Persons Needing Assistance With Bathing

❑ Yes ❑ No Persons Needing Assistance Dressing or Grooming

❑ Yes ❑ No Persons Needing Assistance With Eating

❑ Yes ❑ No Persons with Mental Illness

❑ Yes ❑ No Persons with Dementia

❑ Yes ❑ No Persons with Other Cognitive Impairments

❑ Yes ❑ No Persons who Wander

❑ Yes ❑ No Persons who Exhibit “Combative Behaviors”

❑ Yes ❑ No Persons Requiring Hospice Care

❑ Yes ❑ No Persons Under 60 Years of Age Allowed

Other health conditions (specify): ______

______

______

SERVICES

❑ Yes ❑ No Special Activities Prog. for Dementia

❑ Yes ❑ No Secured Dementia Unit

❑ Yes ❑ No Wander Alert

❑ Yes ❑ No Door System Delays Exit (“Delayed Egress”)

❑ Yes ❑ No Fenced Yard or Enclosed Perimeter

❑ Yes ❑ No Locked Perimeter (External Doors or Yard)

❑ Yes ❑ No Respite Stays (e.g. weekend to 2 weeks)

❑ Yes ❑ No Call-Bell/Intercom System

❑ Yes ❑ No Transportation to Routine Medical Services

❑ Yes ❑ No Transportation to Other Services / Outings

❑ Yes ❑ No Special Diets

❑ Yes ❑ No Ethnically-Oriented Menu ______

❑ Yes ❑ No Formal Activity Program

❑ Yes ❑ No Allow Personal Pets

❑ Yes ❑ No Smoking Area

❑ Yes ❑ No Resident Council

❑ Yes ❑ No Family Council

Other services: ______

______

Continue on 2nd Page -->

STAFFING

Administrator: ______________________ Since (Mo./Yr.): ______________________

Total Number of Direct Care Staff: ________

No. During Day: ______ No. During Evening: ______ No. at Night: ______ No. Awake at Night: ______

❑ Yes ❑ No Nurse (RN/LVN) staff or consultant? How many hours per week? ______________________

What languages does direct care staff speak, other than English?:

❑ Spanish ❑ Tagalog ❑ Cantonese ❑ Mandarin ❑ Japanese

❑ Italian ❑ Russian ❑ German ❑ Sign Language (ASL)

Other languages, not listed above (separate by commas): ______________________

COSTS

❑ Yes ❑ No Does facility charge a preadmission fee? — Purpose of fee? ______________ Amount? $________

❑ Yes ❑ No Is the preadmission fee refundable? — If so, is it totally or partially refundable? ______________

❑ Yes ❑ No Are any other deposits required (e.g. last month's rent)? If so, please specify: ______________

❑ Yes ❑ No Accept SSI?—Number of SSI residents accepted: ________

❑ Yes ❑ No Is the facility an approved Assisted Living Waiver Pilot Project (ALWPP) provider?

Monthly Cost Ranges:	From	To
Private Room:	$________	$________
Shared or Semi-Private:	$________	$________
Dementia Care:	$________	$________
Hospice Care:	$________	$________
Other care services? Please specify: ________	$________	$________
________	$________	$________

OWNERSHIP INFORMATION

Principal Owner: ______________________ Since (Mo./Yr): ______________

❑ Yes ❑ No Does licensee operate more than 1 facility?

Other facility name(s) or license number(s): ______________________

____

Parent Corporation (if applicable): ______________________

Address: ______________________ Zip ______________

Phone: ( ) Fax: ( ) Web Address (URL): ______________

PERSON COMPLETING QUESTIONNAIRE *(Required)*

Full Name: Position: Date:

0702

What else makes your facility great? Our online questionnaire form gives you room to say more!

Please Complete Online -- (www.residentialcareguide.org)

If you cannot complete online, please mail to California Consumer RCFE Project, 650 Harrison Street, 2nd Floor, San Francisco, CA 94107, or fax to (415) 777-2904