

AFC QUESTIONNAIRE

Provider: _____

AFC License #: _____

Site Phone: _____

Site Address: _____

If you have any of the information in this form in a different document, you can say see attached and attach it to this questionnaire.

I. Housing/Community:

1) Changes to home or property (remodeling, additions, bedroom arrangements, etc.):

2) Neighborhood issues/concerns due to home/clients being here:

	Number in Home	Locations	Last Test Date
3) Fire Extinguishers Tag Date:			
4) Smoke Detectors			
5) Carbon Monoxide Detectors <i>(not required)</i>			

6) City or well water?

- Last well water test for coliform bacteria and nitrate nitrogen:
(attach water test)

7) Household pets?

- Kinds of pets:
- Attach Pet Health Certificates:
- Describe animal temperament:

8) Supplemental Heat:

- Kerosene Heater? Wood Burning Appliance?

II. Health/Safety/Emergency Practices:

1) Caregiver/Household Emergency Backup Plan:

- 2) Designated safe area for
 - Fire:
 - Severe weather:
- 3) Fire Drill Log:
 - Dates of Fire Drills:
 - Dates of Severe weather drills:
 - Where are the escape routes posted?
 - Lessons learned from drills???

III. Program:

- 1) Attach the PAPP
- 2) Attach your current AFC Program Plan:
- 3) Have any problems occurred in the past year regarding consumers and their medications? If so, briefly describe the problem and what actions were taken to correct the situation.
- 4) Describe any changes which have been made over the last year regarding how medications are purchased, stored, administered, disposed, or charted.
- 5) Describe evening and weekend activities – detailing leisure time and recreational events which are part of the program at this site.
- 7) Goals for your program in the next year:
 - 1.
 - 2.
 - 3.

IV. Staffing Patterns/Training:

- 1) Current Staffing patterns. If there have been changes in the last year, please note the differences. (Can attach a copy of staffing patterns)

- 2) New positions added or eliminated in the house since last year? **Attach/send in any new or changed Job descriptions.**

- 3) Staff training attended by all staff over last year (non 245-D):

V. Resident Information:

1) Current Residents: (Can attach resident fact/information sheets)

Consumer Name	DOB	Admission Date	Case Manager/County

If the case manager is **not** from Carver County, please provide the contact information of the case manager.

- 1) Are there any dietary restrictions for any of the residents? If so, who and what are the restrictions? (Diabetic, limited calorie intake, lactose intolerant)

- 2) What is the supervision for each resident? Unsupervised time? When? How long?

- 3) Briefly outline the programming used to teach self-help and/or independent living skills to consumers. On a scale of 1-5 (5 being excellent, 1 being no success), how would you rate the success of this programming? If not a 5, what would need to happen for it to move in that direction?

2) Individualized Service Plans or CSSP for each resident:

Consumer Initials	Service Plan Date	Risk Management Plan Date	Date:	Request Letter To:

VI. Placements:

- 1) Positive attributes of resident grouping:

- 2) Negative attributes of resident grouping:

- 3) Staff interactions with residents:

- 4) Relationship with consumer families:

Provider Signature date

Licenser date