DIVISION OF ASSISTED LIVING

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

ASSISTED LIVING/SHARED HOUSING INITIAL LICENSE APPLICATION

(Department Use Only)

Date Filed: _____

Max # of Residents: _____

 # Perm Units/Res: _____/_____

# of FL Units/Res: _____/_____

# of AZ's Units/Res: _____/_____

# of Ind Units/Res: _____/_____

Total # of Units to be Licensed: _____

Initial License #: _____

Issue / Expiration dates: _____/_____

Please address **ALL** questions and **TYPE** or **PRINT** your answers. If an item **DOES NOT** apply to your establishment, enter **N/A**. **This form (*and all required attachments)* must be completed, signed by the licensee, and sent to the address listed on page eight of this form.**

THE ENTIRE APPLICATION/LICENSURE PROCESS CANNOT BE LONGER THAN SIX (6) MONTHS. THE SIX (6) MONTH TIME FRAME BEGINS THE DAY THE DEPARTMENT RECEIVES YOUR APPLICATION. Questions may be directed to the Division of Assisted Living at 217-782-2448.

PART 1. GENERAL ESTABLISHMENT INFORMATION

Enter the Complete Name of the Establishment on the Lines Below: (Limit 30 Characters/Spaces):

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Address: _____

City, State ZIP: _____ **County:** _____

E-mail Address: _____

Phone: _____ **Fax:** _____

PART 2. LICENSEE INFORMATION

1. **Individual Responsible for Managing the Establishment***

   (e.g. Executive Director) _____

***IDPH MUST BE NOTIFIED OF CHANGES TO THIS DESIGNATION WITHIN 10 WORKING DAYS.**

IMPORTANT NOTICE: The state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under Public Act 91-0656. Disclosure of this information is mandatory.

PART 2. LICENSEE INFORMATION (Continued)

Contact Person for This Application:

Name: _____

Address: _____

City, State, ZIP: _____

E-mail Address: _____

Phone: _____ **Fax:** _____

2. Legal Entity Designation as the <u>LICENSEE*</u> is the Establishment's:

Owner _____ **OR** **Operator** _____

(YOU MUST CHECK ONE OF THE OPTIONS)

***<u>LICENSEE</u> Social Security Number:** _____

PART 3. OWNER INFORMATION

1. Type of LEGAL ENTITY Designated as the Owner: (Choose one)

	Federal
	State
	County
	Township
	City
	Hospital District
	Sanitary District
	Church Operated or Affiliated
	Non Profit – Other
	Independent Sole Proprietorship
	Limited Partnership
	For Profit Corporation
	For Profit Trust
	Non Profit – Corporation
	Non Profit – Trust
	Limited Liability Corporation
	General Partnership

PART 3. OWNER INFORMATION (Continued)

2. **Owner of Establishment:**

Name: _____

Address: _____

City, State, ZIP: _____

E-mail Address: _____

Phone: _____ **Fax:** _____

3. **Registered Agent for OWNER – Complete for corporate, limited partnership or limited liability company:**

Name: _____ **Number:** _____

Address: _____

City, State, ZIP: _____

4. **Ownership Disclosure Information – If applicable, provide name and mailing address of officers, directors, partners or members of a governing body who have financial interest of 5 percent or more of the legal entity designated as the OWNERSHIP/LICENSEE. If information is currently on file for any individual under operations, use the same format for listing the individual's name. If the OPERATOR/LICENSEE listed does not own 100 percent of the entity, do all others have less than 5 percent?**

Yes _____ **No*** _____ **N/A** _____

***IF NO EXPLAIN ON A SEPARATE SHEET.**

Name: _____

Address: _____

City, State, ZIP: _____

Name: _____

Address: _____

City, State, ZIP: _____

4. Ownership Disclosure Information (Continued)

List any additional individuals on a separate sheet.

Are more to be listed? _____Yes or _____ No

5. General Partnership – Complete for general partnership operations (if applicable). This information must be reflected on the partnership agreement.

List any additional partners on a separate sheet.

Name: _____

Address: _____

City, State, ZIP: _____

Name: _____

Address: _____

City, State, ZIP: _____

6. Government Operated – Complete for unit of local government's chief executive officer (if applicable).

Name: _____

Address: _____

City, State, ZIP: _____

7. Trust or Endowment Operated – Complete for trustee (if applicable).

Name: _____

Address: _____

City, State, ZIP: _____

PART 4. OPERATOR INFORMATION

1. Type of LEGAL ENTITY Designated as the OPERATOR: (Choose one)

	Federal
	State
	County

	Township
	City
	Hospital District
	Sanitary District
	Church Operated or Affiliated
	Non Profit – Other
	Independent Sole Proprietorship
	Limited Partnership
	For Profit Corporation
	For Profit Trust
	Non Profit – Corporation
	Non Profit – Trust
	Limited Liability Corporation
	General Partnership

2. **OPERATOR OF ESTABLISHMENT (Complete <u>IF DIFFERENT</u> from Owner)**

   Name: _____

   Address: _____

   City, State, ZIP: _____

   E-mail Address: _____

   Phone #: _____ **Fax #:** _____

3. **Registered Agent for OPERATOR – Complete for corporate, limited partnership or limited liability company.**

   Name: _____ **Number:** _____

   Complete Address: _____

4. **Management Agreement – If applicable, provide a copy of the Management Agreement.**

5. **General Partnership* – Complete for general partnership operations (if applicable). This information must be reflected on the partnership agreement.**

Following, there is space enough to list two (2) partners. If there are additional partners, please list them on a separate sheet.

5. General Partnership (Continued)

Name: _____

Address: _____

City, State, ZIP: _____

Name: _____

Address: _____

City, State, ZIP: _____

Are there more partners? _____YES or _____ NO

6. Government Operated – Complete for unit of local government's chief executive officer (if applicable).

Name: _____

Complete Address: _____

City, State, ZIP: _____

7. Trust – OR – Endowment – Operated for Trustee (if applicable).

Name: _____

Complete Address: _____

City, State, ZIP: _____

PART 5. LICENSED UNIT INFORMATION-*ASSISTED LIVING LICENSE RESIDENT CAPACITY IS 17 or more. SHARED HOUSING CAPACITY IS THREE TO A MAXIMUM OF 16 RESIDENTS.*

1. What is the TOTAL NUMBER of ALL RESIDENTS your ESTABLISHMENT can accommodate? _____

2. What is the TOTAL NUMBER of ALL UNITS in your establishment? _____ With a Resident Capacity of _____

Number of *Permanent (NOT Floating/NOT AZ's)* Assisted Living Units: _____ With a Resident Capacity of _____

Number of *Floating* Assisted Living Units: _____ With a Resident Capacity of _____

Number of *Alzheimer's* Units: _____ With a Resident Capacity of _____

Number of *Shared Housing* Units: _____ With a Resident Capacity of _____

Number of *Independent* Units: _____ With a Resident Capacity of _____

3. What is the TOTAL NUMBER of Assisted Living or Shared Housing *UNITS* you are seeking to license? _____

PART 6. FINANCIAL INFORMATION

SUBMIT <u>ONE (1)</u> FORM OF FINANCIAL INFORMATION LISTED BELOW:

1) a surety bond in an amount equal to at least three months operating expenses *(see Appendix A for a sample surety bond)*

2) an independent certified public accountant's report expressing an opinion on the financial status of the establishment

3) an audited financial report certifying the financial status of the applicant

4) the entity's most recent bond rating (less than two years old) from Fitch's, Moody's or Standard and Poor's rating agency

5) if licensed under the Assisted Living and Shared Housing Act or the Nursing Home Care Act, submit evidence of operation for at least two years

PART 7. ESTABLISHMENT DOCUMENTS

SUBMIT <u>ALL</u> OF THE FOLLOWING DOCUMENTS:

1) copy of standard contract with the residents titled "Assisted Living Establishment Contract" or "Shared Housing Establishment Contract" which includes the description and **COST** of **MANDATORY SERVICES** ***<u>(AL/SH Admin Code 295.4020)</u>*** and the description and **COST** of any **OPTIONAL SERVICES** to be provided ***<u>(AL/SH Admin Code Section 295.2030 Establishment Contracts)</u>***.

2) sample resident service plan ***<u>(AL/SH Admin Code Section 295.4010 Service Plan)</u>***

3) description of the establishment's quality improvement process, including a narrative identifying how the establishment benchmarks performance, is customer centered, data driven, and focuses on resident satisfaction ***<u>(AL/SH Admin Code Section 295.2060 Quality Improvement Program)</u>***

4) current documentation of liability insurance (make sure **<u>your establishment's address</u>** is **<u>on</u>** the documentation)

5) a scaled drawing of the ENTIRE establishment identifying <u>ALL UNITS</u> w/ the codes below: "**P"** for **PERMANENT Units** (**NOT** Floating/**NOT** Alzheimer's /**NOT** Independent)
"**F"** for **FLOATING Units**
"**A"** for **ALZHEIMER'S Units**
"**I"** for **INDEPENDENT Units**

<u>SPECIAL NOTE</u>: The documentation and information listed below MUST be submitted to IDPH PRIOR TO THE PHYSICAL PLANT ON-SITE SURVEY.

6) Air Balance Report, Matrix 4F (applicable for large facilities, more than 16 bed/8 units)

7) Sprinkler Contractor's Material and Test Certificate for Aboveground Piping (include a water flow test within 12 months of the dates on which the hydraulics were run);

8) Floor plan, if not previously submitted, which shows any and all magnetic or special locks

9) Certificate of Occupancy from the city**.**

10) Completed, stamped and notarized "Certification of Compliance" form which provides evidence of compliance with applicable residential standards ***(AL/SH Admin Code Section 295.500 12) Application for License)*** *(See Appendix C)*

PART 8. ALZHEIMER'S SPECIAL CARE DISCLOSURE

Does this establishment currently offer, advertise or market to provide care for persons with Alzheimer's disease through an Alzheimer's Special Care Program?

_____ YES OR _____ NO (Check One)

IF THIS TYPE OF CARE IS OFFERED, THE DOCUMENTATION AND INFORMATION IN *APPENDIX B* MUST BE SUBMITTED WITH THIS APPLICATION.

PART 9. LICENSEE FEE (EFFECTIVE SEPTEMBER 1, 2015)

<u>$2,000.00</u> FOR AN ASSISTED LIVING ESTABLISHMENT <u>PLUS $20.00 PER LICENSED UNIT</u>

OR

<u>$1,000.0</u>0 FOR A SHARED HOUSING ESTABLISHMENT.

After using the above information to calculate the license fee, make your check or money order (no cash) payable to the ILLINOIS DEPARTMENT OF PUBLIC HEALTH. Send it and ONE original signed application <u>AND ALL REQUIRED ATTACHMENTS</u>:

Illinois Department of Public Health
Division of Assisted Living
525 W. Jefferson St., Fifth Floor
Springfield, IL 62761

PART 10. DECLARATIONS/SIGNATURES

I, the undersigned authorized representative, hereby certify, to the best of my knowledge and belief, the information supplied is true, accurate and complete.

The applicant is expected to provide in writing to the Department any subsequent changes to information contained in this application. By submitting and signing this application, the applicant agrees to comply with the provisions of the Assisted Living and Shared Housing Establishment Code (77 Ill Administrative Code 295).

Print or type name whose signature appears below:

_____

Authorized signature: _____ **Date:** _____

<u>FOR ESTABLISHMENTS OPERATED BY AN INDIVIDUAL (SOLE PROPRIETORSHIP) ONLY</u>

PURSUANT TO SECTION 16 OF THE ILLINOIS ADMINISTRATIVE PROCEDURES ACT, THE LICENSEE IS REQUIRED TO ANSWER THE FOLLOWING QUESTIONS:

_____ **I certify under penalty that I am not more than 30 days delinquent in complying with a child support order. Failure to certify, may result in a denial of this license. Making a false statement may subject the licensee to contempt of court.**

_____ **I am more than 30 days delinquent in complying with a child support order.**

Print or type name whose signature appears below:

_____

Authorized signature: _____ **Date:** _____

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P. O. #467061 50 5/07

Illinois Department of Public Health
Division of Assisted Living
525 W. Jefferson St., Fifth Floor
Springfield, IL 62761

SURETY BOND

ASSISTED LIVING AND SHARED HOUSING ACT

Surety Company Bond No. _____

1. KNOW ALL MEN BY THESE PRESENTS, THAT the undersigned _____

_____

of _____as Principal, now or about to be licensed by the Illinois Department of Public Health to establish, operate, maintain or offer an establishment as an assisted living or shared housing establishment, as defined in the Assisted Living and Shared Housing Act, known as _____ located in the city of _____, in the county of _____ in the State of Illinois, and _____as Surety, a company duly authorized to transact surety business in the State of Illinois, are hereby held and firmly bound unto the People of the State of Illinois, in the penal sum of _____dollars ($_____) for the payment of which sum, we hereby jointly and severally bind ourselves, our heirs, administrators, executors, successors, and assigns.

2. WHEREAS, the Principal is now engaged or about to be engaged in the business of establishing, operating, maintaining or offering an establishment as a licensed assisted living establishment or shared housing establishment, in accordance with the requirements of the Assisted Living and Shared Housing Act, and must provide the Illinois Department of Public Health, prior to licensure, with financial information establishing that the project is financially feasible, as evidenced by several types of information, including a surety bond in an amount equal to at least three months operating expenses.

3. THE CONDITION OF THE ABOVE OBLIGATION IS SUCH, that whereas, the above-named principal filed with the Illinois Department of Public Health, Office of Health Care Regulation, an application seeking licensure as an assisted living or shared housing establishment, under the terms and provisions of the Assisted Living and Shared Housing Act, effective, January 1, 2001, and the Assisted Living and Shared Housing Establishment Code, effective December 1, 2001.

Now if the said Principal shall faithfully perform all requirements of the Assisted Living and Shared Housing Act and comply with all rules of the Department made in accordance with the provisions of this Act, within the State of Illinois, then this obligation shall be null and void; otherwise it shall remain in full force and effect.

_____
(Principal)

Date _____ By _____

_____
(Official Position)

Date _____ By _____
(Surety)

_____

Where one signs by virtue of Power of Attorney for a surety company, such Power of Attorney must be filed with the bond.

This bond may be released by the Department upon not less than 90 days advance written notice served by Certified Mail by the surety to the Department, and at the same time furnishing the Department, by the party desiring to cancel this bond, proof satisfactory to the Department that the principal or surety has fully complied with the terms and conditions of this bond for area obligated under the bond prior to the date of release request. This bond may be released in part or in its entirety. The surety company shall be notified at the following

Address: _____

APPENDIX B

ALZHEIMER'S DISEASE SPECIAL CARE DISCLOSURE FORM – PART A

ESTABLISHMENT IDENTIFICATION

Name of Establishment: _____

Complete Address: _____

If you answered YES in "Part 8 Alzheimer's Special Care Disclosure" of the application, you must submit ALL of the documentation and information below:

1) The form of care or treatment that distinguishes the establishment as suitable for persons with Alzheimer's disease.

2) The philosophy of the establishment concerning the care or treatment of persons with Alzheimer's disease.

3) A copy of the establishment's pre-admission, admission, and residency termination procedures.

4) A copy of the establishment's assessment, care planning, and implementation **guidelines** in the care and treatment of persons with Alzheimer's disease. Include information whether individuals are or are not monitored about eating, drinking, and personal hygiene; whether individuals will be monitored for potentially dangerous behavior while in the rooms; and whether a resident representative will be contacted with concerns that might require a change in the service plan.

5) A statement of the minimum and maximum staffing ratios, specifying the general licensed health care provider to client ratio and the trainee health care provider to client ratio for persons with Alzheimer's disease during the day, evening and night.

6) A description of the establishment's activities available to persons with Alzheimer's disease.

7) A description of the role of family members in the care of persons with Alzheimer's disease.

8) A copy of the establishment's fee schedule containing the costs of care and treatment under the program.

9) A copy of the establishment's documentation/information concerning the physical environment including whether or not doors are monitored. Please include a drawing of the establishment's floor plan.

PLEASE SEE THE REVERSE OF THIS FORM FOR INSTRUCTIONS

ALZHEIMER'S DISEASE SPECIAL CARE DISCLOSURE FORM INSTRUCTIONS FOR COMPLETION - PART B

PLEASE PRINT OR TYPE THE DOCUMENTATION AND INFORMATION

SPECIAL NOTE: The items in Part B are required by state law for establishments that offer care for persons with Alzheimer's disease.

Item 3 The documentation/information for this item requires the **procedures** for pre-admission, admission and discharge for the program. This is **not** the establishment's policies or criteria, but the **process** followed for the program.

Item 4 The documentation information for this item requires the establishment's **guidelines** for assessment, care planning and implementation for the program. (It is not necessary to submit copies of assessment, care planning and implementation forms.)

Item 5 The staffing documentation/information needs to be in the form of **ratios** (provider: residents) for the establishment's program.

Item 7 The **written documentation/information** for this item explains the role of the family members in the care given to the residents in the establishment's program.

Item 9 The **floor plan** needs to be submitted with this form.

Please return this form, **with all applicable** documentation/information described in **Part B**, to:

Illinois Department of Public Health
Division of Assisted Living
525 W. Jefferson St., Fifth Floor
Springfield, IL 62761

APPENDIX C

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF ASSISTED LIVING

CODE CERTIFICATION OF COMPLIANCE

Establishment Name _____

Establishment Contact Person _____

Establishment Address _____

City _____ State Illinois ZIP Code _____

Date of Inspection _____ Number of Units _____

I have (check applicable box or boxes)

☐ inspected the establishment

☐ prepared or directly supervised the preparation of the architectural/engineering drawings and specifications for the above mentioned establishment

I duly certify, to the best of my professional knowledge, that the above establishment meets the following:

- requirements of the Assisted Living and Shared Housing Establishment Code (77 Ill. Admin. Code 295), as may be amended from time to time;

- requirements specified in the Illinois Accessibility Code (71 Ill. Admin. Code 400), as may be amended from time to time, or, if constructed prior to January 1, 1997, the accessibility requirements which applied at the time of construction, provided, however, if the building has undergone alterations, additions, historic preservation, restoration or reconstruction in whole or in part after January 1, 1997, then the alteration, addition, historic preservation, restoration or reconstruction must meet the requirements specified in the Illinois Accessibility Code, as may be amended from time to time; and

- accessibility guidelines specified in the Americans with Disabilities Act of 1990 (42 USC 12101 et. seq.) and the regulations thereunder, as may be amended from time to time, or, if constructed prior to January 26, 1992, the accessibility requirements in place at the time of construction, provided; however, if the building has undergone alterations in whole or in part after January 26, 1992, then the alteration must meet the requirements specified in the Americans with Disabilities Act of 1990 and the regulations there under, as may be amended from time to time.

APPENDIX C

For purposes of determining compliance with Life Safety Code requirements, the building meets the standard set forth below (check applicable box):

☐ Residential Board and Care Occupancies Chapter of the National Fire Protection Association's (NFPA) Life Safety Code 101, Chapter 32, (New Residential Board & Care Occupancies), 2000 Edition **or**

☐ Health Care Occupancies Chapter of the NFPA Life Safety Code 101, 2000 Edition Chapter 18, **or**

☐ Life Safety Code 101A, Chapters 6 (Evaluating Evacuation Capability) and 7 (Board and Care Occupancies), 2001 Edition.

Additionally, I certify that the establishment meets the following standard for determining the level of evacuation capability, as defined in Section A.3.3.56 of the NFPA Life Safety Code 101, 2000 Edition (check applicable box):

☐ **PROMPT** **or** ☐ **SLOW** **or** ☐ **IMPRACTICAL**

I, _____ architect/engineer, understand and acknowledge that this certification will be relied upon by the Illinois Department of Public Health and other regulatory bodies in determining the establishment's compliance with the above-mentioned life safety and physical plant requirements.

Date _____ Illinois Registration Number _____

Architect/Engineer Signature _____

(Architect/Engineer Seal)

Subscribed and sworn to before me by _____this _____day of _____, 200__.

_____

Notary Public

(Notary Seal)

My commission expires:_____

ILLINOIS DEPARTMENT OF PUBLIC HEALTH DOCUMENTS, ESTABLISHMENT CONTRACT AND PUBLIC ACT INFORMATION

The **"ASSISTED LIVING AND SHARED HOUSING INCIDENT AND ACCIDENT REPORT"** form (attached) was developed by the Illinois Department of Public Health (IDPH) to assist establishments in complying with Section 295.2050 (Incident and Accident Reporting) of the Assisted Living and Shared Housing Establishment Code (Code). Please begin using this form upon submission of your application.

****

The "**PHYSICIAN CERTIFICATION"** form (attached) was developed as a result of language contained in Section 295.4000 of the Code, entitled "Physicians Assessment." (An earlier draft of this form was contained in the published rule as "Appendix A".) The purpose of this form is to assist Department survey staff in ensuring that all residents receive a comprehensive assessment by their physician no more than 120 days prior to admission to the establishment, at least annually thereafter, and upon identification of a significant change in the resident's condition. The completed Physician Certification form should be maintained as part of the resident's record, per the requirements of Section 295.7000 b) 6) of the Code, which states that "an establishment shall maintain a resident's record that contains…documentation of assessments and evaluations conducted pursuant to Section 295.4000."

****

Section 295.2030 a) 20) of the Code, entitled "Establishment Contracts," requires that the following paragraph (exactly as written) must be in your establishment/resident's contract:

The Illinois Department of Public Health shall conduct an annual, unannounced on-site review of the establishment to determine compliance with applicable licensure requirements and standards. Additional unannounced on-site reviews may be conducted without prior notice to the establishment. During an on-site review, IDPH staff may tour any area of the establishment; observe residents and staff; communicate privately with residents upon their consent; inspect a resident's clinical and administrative records with the resident's written consent; and enter the apartment of a resident who grants permission and entry.

****

Public Acts 093-1003; 094-0429; 094-0256 revised the Assisted Living and Shared Housing Act, among the statutory changes were:

expansion of the definition of shared housing establishment to allow up to 16 persons (PA 093-1003

language allowing IDPH to deny a license application if the applicant has not provided all required information within six months of submitting the initial application (PA 093-1003)

language requiring AL/SH establishments that provide medication administration as an optional service, to administer or arrange for administration of an influenza and pneumococcal vaccination for all residents age 65 or older, IF it is medically contraindicated or refused by the resident. (PA 093-1003 and PA 094-0429)

language allowing licensed health professionals employed by an establishment to administer sliding scale insulin (PA 094-0256)

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IDPH

ASSISTED LIVING AND SHARED HOUSING INCIDENT AND ACIDENT REPORT PLEASE PRINT/WRITE LEGIBLY!!!

INSTRUCTIONS: This form should be completed and faxed to the Illinois Department of Public Health, Division of Assisted Living at 217-557-2432 WITHIN 24 HOURS OF THE INCIDENT OR ACCIDENT WHERE RESIDENT IS SENT OUT FOR UNPLANNED MEDICAL CARE

Name of Establishment _____

Full Establishment Address _____

ESTABLISHMENT E-MAIL ADDRESS _____

Contact/Title Name _____ **Ph#:** _____ **Fax #:** _____

Incident/Accident Date _____ **Accident/Incident Time** _____

Resident Name _____ **Age:** _____ **M**____ **F** ____

Location of Incident/Accident _____

Description of Incident/Accident, including impact on resident (use additional page, if necessary)

_____

_____

_____

Description of Action Taken by Establishment as Result of Incident/Accident (use additional page, if necessary)

_____

_____

_____

DID RESIDENT GO TO THE HOSPITAL? YES ___ NO ___ (If NO, do NOT submit this form to IDPH, UNLESS there has been a significant issue such as an elopement, abuse, medication error/omission, Norovirus outbreak, electrical outages, flooding, etc).

Was the Resident Hospitalized?

Yes_____ **Name of Hospital** _____ **Diagnosis** _____
No ____ **(If No, explain)** _____

Was the Resident's M.D. Notified? Yes __ **No** ___
Resident's Family/Representative Notified? Yes ____ **No** ____

FAX THIS REPORT TO 217-557-2432

PHYSICIAN CERTIFICATION

Resident Name: _____

Birth Date: _____

Telephone: _____

Street Address: _____

City/State/ZIP: _____

Resident Representative's Name (if applicable)

_____

Telephone: _____

Street Address: _____

City/State/ZIP: _____

Other Emergency Contact Person: _____

Complete Address: _____

Telephone Number: _____

Purpose of Assessment: ____**Prior to Admission** ____**Annual** ____**Significant Change in Condition**

Establishment Name_____

Complete Address_____**Phone**_____

The Assisted Living and Shared Housing Act requires every resident, prior to admission, annually and upon identification of significant change in their condition, to receive a comprehensive physician's assessment. The assessment must include an evaluation of the person's physical, cognitive, and psychosocial condition, and shall include documentation of the presence or absence of tuberculosis infection in accordance with the Control of Tuberculosis Code.

The Act prohibits persons having certain conditions or limitations and requiring certain types of care from residing in an establishment. A list of these conditions, limitations, and types of care appear in Part III of this form.

PART I – I CERTIFY THAT THE FOLLOWING HAVE BEEN COMPLETED:

_____**a physical, psychosocial and cognitive assessment;**

_____ **written instructions for any needed home health services, including periodic nutritional and skin integrity assessments;**

_____ **instructions, as appropriate, contained in Part II of this form; and**

_____ **an assessment documenting the presence or absence of tuberculosis infection.**

I further certify in my professional judgment the person for whom this certification is being completed meets the conditions, limitations, and care requirements specified in the Assisted Living and Shared Housing Act and outlined in Part III of this form.

Signature: _____**Date:** _____

Physician Name (Typed or Printed): _____ **Physician ID Number:** _____

PART II – PERSONAL SERVICES NEEDS: Based on my assessment, the resident's condition warrants assistance with the following personal services: (*Note any specific needs and instruction)*

REQUIRED SERVICES	YES	NO	EXPLANATION
Eating			
Dressing			
Toileting			
Transferring			
Bathing			
Personal Hygiene			
Evacuating in Case of Emergency			

OPTIONAL SERVICES	YES	NO	EXPLANATION
Does resident have any special dietary needs?			
Does resident require licensed personnel to administer medication?			
Does resident require supervision or reminders to take medication?			

PART III – RESIDENCY CONDITIONS, CARE AND LIMITATIONS

MUST
√ be an adult
√ pose no serious threat to anyone including self
√ be able to communicate needs
√ not have a severe mental illness

NOT NEED
√ total assistance with 2 or more Activities of Daily Living
√ assistance from more than 1 paid caregiver for any ACTIVITY OF DAILY LIVING*****
√ more than minimal assistance to move to safe area in case of emergency*****
√ five or more skilled nursing visits per week for conditions other than treatment of stage three or stage four decubitus ulcers (for a period not exceed three consecutive weeks)

NOT NEED (unless self-administered or administered by a qualified licensed health care professional)
√ intravenous and/or gastrostomy feeding therapies
√ insertion, sterile irrigation, and replacement of catheter, except for routine maintenance*****
√ sliding scale insulin administration and injections.
√ sterile wound care
√ treatment of stage three or stage four decubitus ulcers or exfoliate dermatitis

*Except for quadriplegic, paraplegic, or individuals with neuron-muscular disease

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