STONEY GLEN RESPITE APPLICATION

VILLAGE AT STONEY GLEN

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VILLAGE AT STONEY GLEN RESPITE APPLICATION 2021

Welcome to Village at Stoney Glen. We are pleased you are interested in applying for admission to Stoney Glen to provide your family member with residential/respite services. The application process allows the Admissions Committee to determine if we can meet the needs of the individual applying for admission.

In order to determine eligibility, we have established the following requirements to complete the admissions process:

1. Complete this application, along with the documents requested, with appropriate signatures, and submit to The Village Centers, 3819 Plum Valley Drive, Kingwood, Texas 77339; Attn: Admissions Manager; along with the $100.00 application fee. *(The application fee is necessary to cover costs of the initial paperwork, intake/assessment interview and other essential documentation review required to enroll a new client).* **Please complete the entire application, lack thereof will result in a delay of enrollment.**

   Submit the following documents:

   - Recent Photo
   - Copy of Driver's License or Photo ID
   - Copy of Social Security Card
   - Copy of Medicaid/Medicare/insurance card(s)
   - Proof of Guardianship (if applicable)
   - Vaccination record
   - Most recent ICAP score
   - Copy of SSI/SSDI annual award letter
   - Determination of Mental Retardation letter or other developmental disability (if applicable)
   - Most recent psychological assessment (if applicable)
   - Most recent psychiatric assessment (if applicable)
   - Copy of Behavior Management Plan (if applicable)
   - Copy of MRRC assessment (if applicable)
   - Most recent I.S.P/ I.E.P/ A.R.D (if applicable)
   - Current Physical & Doctors Orders

2. Interview and Initial Visit – If your application is approved for the second step in the Admissions process, you will be invited to tour our facilities and meet with the Admissions Committee. During this time, the specifics of the program will be outlined. The Villager and his/her family will have an opportunity to discuss any questions or concerns they may have.

3. Next, you will coordinate with the Village at Stoney Glen liaison to complete the admission agreement and review the facility policies and procedures. Following this, you will be asked to complete an In Person evaluation. During this time, the Villager will be at the facility for a minimum of 4 hours of respite care to allow staff to assess the Villager, followed by a 3 day stay (during the week), and followed by a weeklong stay (7 days).

4. Upon completion of the interview process, the Admissions Committee will notify you of acceptance or denial. Also, if government funds are required for payment, contract and approvals must be in place prior to the commencement of enrollment.

After enrollment there will be a 90 day probationary period during which time the Client will be further evaluated for appropriate placement.

THE VILLAGE CENTERS
Learn ★ Achieve ★ Connect

CLIENT INFORMATION

Person filling out application: □ Self □ Parent/Caregiver/Guardian

Contact Person: ______________________________ Relationship: ______________

Address: ____

City, State, Zip: ____

Home Phone: ____________________ Cell Phone: ______________________

Client Legal Full Name: ____
First Middle Last

Preferred Name: ____

Address: ____

City, State, Zip: ____

Client Home Phone: __________________ Client Cell Phone: __________________

Sex: M/F __________ DOB: ______________ Age (as of application date): __________

Social Security #: __________________ TX ID/Driver's License #: __________________

LON (Level of Need): ____1____2____3____4____5____ (HCS, TxHmL, CLASS) ______________

Ethnicity: ____ Caucasian ____ African American _____ Asian Other: ______________

Disability Diagnosis: ____
1st 2nd 3rd 4th

Guardianship:
Is the client their own legal guardian? □ Yes □ No

If **YES**, who do we have permission to talk to/consult with on your behalf?

(Please print name and relationship to client)______________________________

(Please print name and relationship to client)______________________________

(Please print name and relationship to client)______________________________

(Please print name and relationship to client)______________________________

If **NO**, who is the Legal Guardian? (Name): ______________________________

Legal Guardian's relationship to client: ______________________________

Who does he/she live with? (Check one): □ Parents □ Step Mother/Father □Mother

□ Father □ Group Home □ Other (please specify) ______________________

PARENT/GUARDIAN INFORMATION

1. Parent/Caregiver/Guardian Name: ____

Relation to Client: □ Parent □ Caregiver □ Guardian □ Sibling □ Other: _______________

Address: ____

City, State, Zip: ____

Employer: ____

Home Phone: ____________________________________ Cell Phone: ___________________________

Work Phone: ________________________ Email: ____
(Please list email address that we can send program updates and reminders to. This address will be used as a primary source of communication)

2. Parent/Caregiver/Guardian Name: ____

Relation to Client: □ Parent □ Caregiver □ Guardian □ Sibling □ Other: _______________

Address: ____

City, State, Zip: ____

Employer: ____

Home Phone: ____________________________________ Cell Phone: ___________________________

Work Phone: ________________________ Email: ____
(Please list email address that we can send program updates and reminders to. This address will be used as a primary source of communication)

EMERGENCY CONTACT: The emergency contact should be a person other than the above stated parent/caregiver/guardian(s). This contact can be that of an additional relative, neighbor, or friend who can be contacted in the event that the primary parent/caregiver/guardian(s) cannot be reached.

#1
Name: _____________________________________

Relationship to Client: ___________________________

Home Phone: ________________________________

Cell Phone: __________________________________

Work Phone: _________________________________

#2
Name: _____________________________________

Relationship to Client: ___________________________

Home Phone: ________________________________

Cell Phone: __________________________________

Work Phone: _________________________________

Special Instructions (if any – i.e. “Call Mom first, then Dad”):
____
____
____

CONSENT TO RELEASE INFORMATION

If the Villager is **his or her own legal guardian**, please have them complete the following information below.

I authorize The Village Centers, Inc. to disclose any information to the individual(s) listed below:

Name: ____ Relationship: _____________________

Name: ____ Relationship: _____________________

This authorization for release of information will remain in effect until such time as I no longer attend The Village Centers or inform The Village Centers of a new caregiver and sign a new form.

I understand that I have the right to revoke this authorization at any time.

Villager's First Name: _________________________ Villager's Last Name: ____________________________

Signature of Villager: ____

Printed Name of Parent/Guardian: ____

Relationship of Villager: ____

If the Villager is **NOT his or her own legal guardian**, The Village Centers will need a current copy of the Guardianship paperwork to place in their file. This will need to be submitted annually. Please send all guardianship paperwork to the attention of the Admissions Department. If you have any questions or concerns, please contact the Admissions Manager at 281-358-6172.

CONSENT TO RECEIVE SERVICES

___ YES ___ NO I give The Village Centers permission to contact my Medicaid Waiver Provider to obtain benefit information as it pertains to services provided by The Village Centers.

___ YES ___ NO I give consent to receive day habilitation and social/recreational services provided by The Village Centers, with the exception of the following activities/services:

____
____
____

Villager or Guardian Signature: ____ Date: ________________

FUNCTIONAL SKILLS INVENTORY

Communication:

□ Verbal (Talk/Speak) □ Non-Verbal
If non-verbal, what method of communication does he/she use:
□ Sign Language □ Symbols □ Other: ______________________________
□ Communication Device (Dynavox, iPad, etc. Liability Release required)
Please describe the device: ____

Ambulatory:

□ Is the client ambulatory? □ Yes □ No
Does the client require adaptive equipment? (i.e. walker, wheelchair, crutches) □ Yes □ No

If **YES**, please explain: ____
Does the client requires special assistance for long distances or if attending outings? □ Yes □ No

If **YES**, please explain: ____

Toileting:

□ Requires **no** assistance with toileting (can wipe, pull pants up, etc. independently)
□ Requires **minimal** assistance (needs verbal reminder to wipe, wash hands, etc.)
□ Requires **total** assistance (needs help with wiping, changing diaper/pad, etc.)
□ Wears adult diapers
□ Other: ____

Menses:

□ Requires **no** assistance, is able to self-manage during menstruation
□ Requires **minimal** assistance during menstruation (verbal reminder to check/change feminine products, etc.)
□ Requires **total** assistance during menstruation (take to bathroom, physically check/change feminine products, etc.)

Feeding:

□ Requires **no** assistance feeding themselves (can do independently)
□ Requires **minimal** assistance (help with warming up food, cutting up food, etc.)
□ Require **total** assistance (feeding tube, puree food, etc.)

Dressing:

□ Requires **no** assistance with dressing themselves (can do independently)
□ Requires **minimal** assistance with dressing themselves
□ Requires **total** assistance with dressing themselves
Please list what assistance is required: ____

FUNCTIONAL SKILLS INVENTORY (CONT'D)

Behaviors (please check all that apply)

___ Tantrums ___ Screams ___ Bites ___ Hits ___ Spits

___ Scratches ___ Pulls Hair ___ Kicks ___ Head Bangs ___ Slaps

___ Steals ___ Withdrawn ___ Moody ___ Self-Abusive ___ Destructive

___ Hyperactive ___ Runs Away ___ Pinches ___ Aggressive ___ Depressed

___ Fantasizes ___ Talks to Self ___ Uses Bad Language

Explanation of the above checked items: ____
____
____

Are there things that bother him/her (i.e. loud noises, change of routine, large crowds, etc.)?: ________________
____
____

How would you describe his/her day-to-day behavior (i.e. quiet, hyperactive, social, aggressive, etc.)?: ________
____
____

Please include any other vital information about him/her that would be helpful to us: ________________________
____
____

PERSONAL INFORMATION:

Is the Client currently on a Behavior Plan?: □ Yes □ No

Reading (Please check all that apply):

□ Cannot Read □ He/She can read simple words □ Read independently

Writing (Please check all that apply):

□ Cannot write □ He/She can write simple words □ Write independently

Check any/all extracurricular activities that he/she enjoys doing:

___ Board Games ___ Crafts ___ Art ___ Sports ___ Reading ___ Computer

___ Drama ___ Fitness ___ Cooking ___ Music ___ Video Games

Other:
____
____
____

GETTING TO KNOW YOUR VILLAGER

We would like to get to know your Villager better, so please answer the following questions. Please print legibly.

What is his/her favorite activity, game, or hobby?

____

____

What is his/her favorite thing to talk about?

____

____

What are his/her favorite foods?

____

____

What are his/her least favorite foods?

____

____

Who are his/her favorite people?

____

____

When is he/she most cooperative?

____

____

When is he/she least cooperative?

____

____

What frightens him/her?

____

____

What calms him/her?

____

____

What personal goals would you like to have him/her work on?

1. ____
2. ____
3. ____

REFERENCES

Please list all that apply:

Personal

Name: ____ Relation: _________________________________

Phone #: ________________________________ Email: ____

School

Name: ____ Relation: _________________________________

Phone #: ________________________________ Email: ____

Job Site

Name: ____ Relation: _________________________________

Phone #: ________________________________ Email: ____

Social/Therapeutic Activities

Name: ____ Relation: _________________________________

Phone #: ________________________________ Email: ____

Special Olympics

Name: ____ Relation: _________________________________

Phone #: ________________________________ Email: ____

I hereby give permission for The Village Centers Admissions Committee to contact any and/or all of the above references.

Printed Name: ____

Signature: ____ Date: ______________________

PERSONAL DATA QUESTIONNAIRE

A. Medical/Behavioral History (Please check relevant items.)

____ Seizures ____ Depression ____ Substance Abuse ____ Head Trauma

____ Aggressive Behaviors ____ Self-inflicted Injury ____ Hallucinations ____ Delusions

Other ____

B. Speech/Language and Communications Skills

Please indicate which of the following apply to the Villager's speech/language and communication skills.

(Please check relevant items.)

____ Uses Speech Spontaneously ____ Understands Lengthy Dialogue

____ Uses Speech to Communicate Basic Needs ____ Understands Short Direct Commands

____ Uses Complete Sentences ____ Communicates by Writing

____ Uses Telegraphic Speech ____ Uses Sign Language

____ Uses Idiosyncratic Gestures ____ Uses Gestures Effectively

____ Uses Sentences Effectively

____ Makes Little or No Attempt to Communicate Verbally or With Gestures

____ Comprehends Written Statements ____ Has Sight Vocabulary for Specific Words

C. Functional Academic Skills (Math and Reading)

Please indicate which of the following tasks the Villager has mastered effectively.

(Please check relevant items.)

____ Identifies Coins/Bills ____ Counts Money ____ Makes Change

____ Handles Personal Finances ____ Reads Prices ____ Pays for Items Purchased

____ Reads for Pleasure ____ Reads the Newspaper – Sometimes

____ Tells Time ____ Writes Name, Address, Phone Number

____ Reads Road Signals ____ Reads Public Building Signs

PERSONAL DATA QUESTIONNAIRE (CONT'D)

Please describe which of these tasks would be a goal for the Villager to work on, and list any other relevant goals in this area:

____
____
____

D. Motor Skills

Please rate the Villager's ability in the following areas by giving the appropriate number response.

____ Large Muscle Control	1. Exhibits great difficulty.
____ Fine Motor Coordination	2. Needs additional training.
____ Balance When Walking	3. Is moderately capable.
____ Balance When Running	4. Exhibits no difficulty.

What sport or recreational activities does the Villager enjoy?

____
____
____

What motor activities do you wish for the Villager to develop or improve as part of his/her daily program?

____
____
____

E. Self-Help Skills – Eating

Use the ratings scale to rate the Villager's performance.

____ Handles Eating Utensils	1. Exhibits great difficulty.
____ Swallows Properly	2. Needs additional training.
____ Has Appropriate Table Manners	3. Is moderately capable.
____ Chews Food Properly	4. Needs minimal support.
____ Eats Meals Independently	5. Exhibits no difficulty.

PERSONAL DATA QUESTIONNAIRE (CONT'D)

Describe the Villager's food preferences or dislikes:

____
____
____

List any food allergies, special dietary needs, or any dietary concerns that you would like us to be aware of:

____
____
____

Do you have any goals in reference to the Villager's eating patterns or skills?

____
____
____

F. Self-Help Skills – Dressing

Use the rating scale to rate Villager's performance:

____ Selects Appropriate Clothing	1. Exhibits great difficulty.
____ Dresses Independently	2. Needs additional training.
____ Ties Shoes	3. Is moderately capable.
____ Manages Buttons	4. Needs minimal support.
____ Manages Zippers	5. Exhibits no difficulty.

Describe any concerns, considerations, or goals that you would like the staff to be aware of or to become a part of:

____
____
____

PERSONAL DATA QUESTIONNAIRE (CONT'D)

G. Household Responsibilities

Describe chores or responsibilities the Villager engages in at home and to what degree these can be done independently or with supervision:

____
____
____

What types of household responsibilities need to be monitored or could be designed as a goal for the Villager?

____
____
____

H. Leisure Activities

How does the Villager spend leisure time at home?

Television (i.e. favorite show): ____

Stays in Room (i.e. alone activities): ____

Reads (what does he/she like to read): ____

Hobbies: ____

Listens to Music (i.e. genre): ____

Has Friends Over to Visit: ____

Needs Help Initiating Leisure Activities: ____

Other: ____

Please list indoor games and activities the Villager enjoys (i.e. cards, checkers, computers, etc):

____
____
____

Outdoor Activities: ____

Describe other activities important to the Villager:

____
____
____

PERSONAL DATA QUESTIONNAIRE (CONT'D)

Task	Does	Does Not	With Help	Comments
Wash/Dry/Puts Away Dishes				
Operate Dishwasher				
Clean Sink				
Clean Stove				
Clean Refrigerator				
Set Table				
Clean Off Table				
Plan Grocery List				
Go Shopping				
Put Groceries Away				
Prepare Food				
Operate Microwave				
Operate Garbage Disposal				
Operate Electric Stove/Oven				
Prepares Juice				
Make a Sandwich				
Heats Up Food				
Follows Simple Recipe				
Uses Measuring Cup/Spoon				
Uses Sharp Knives Correctly				
Uses Hand Mixer				
Uses Coffee Pot				
Uses Blender				
Uses Electric Knife				
Uses Popcorn Popper				
Uses Crock Pot				
Uses Toaster				
Cleans Bathtub				
Cleans Toilet				
Cleans Bathroom Sink				
Changes Toilet Paper				
Knows Cleaning Products				
Collects Laundry				
Operates Washing Machines				
Hang Clothing On Line				
Folds Laundry				

PERSONAL DATA QUESTIONNAIRE (CONT'D)

Task	Does	Does Not	With Help	Comments
Irons Clothing				
Puts Away Clothing				
Clothing Repair				
Vacuum				
Scrubs Floors				
Waxes Floors				
Dry Mops Floors				
Shakes Rugs				
Dusts Furniture				
Washes Car				
Washes Windows				
Makes Bed				
Changes Light Bulbs				
Changes Linens				
Takes Out Trash				
Cuts Grass				
Trims and Edges Lawn				
Trims Hedges				
Rakes Leaves				
Washes Face				
Washes Hands				
Bathes/Showers				
Toileting				
Manages Menstrual Period				
Brushes Teeth				
Washes Hair				
Combs/Brushes Hair				
Cuts Fingernails				
Cuts Toenails				
Uses Deodorant				
Nasal Hygiene				
Ear Hygiene				
Shaves Correctly				
Uses Make-up				
Uses Perfume/Cologne				
Uses Hair Dryer				

TEXAS
Health and Human Services

Form 3647
November 2016-E

Assisted Living Disclosure Statement

The purpose of this Disclosure Statement is to empower individuals by describing a facility's policies and services in a uniform manner. This format gives prospective residents and their families consistent categories of information from which they can compare facilities and services. By requiring the Disclosure Statement, the department is not mandating that all services listed should be provided, but provides a format to describe the services that are provided.
The Disclosure Statement is not intended to take the place of visiting the facility, talking with residents, or meeting one-on-one with facility staff. Rather, it serves as additional information for making an informed decision about the care provided in each facility.

Instructions to the Facility

1. Complete the Disclosure Statement according to the care and services that your facility provides. You may not amend the statement, but you may attach an addendum to expand on your answers.
2. Provide copies of and explain this Disclosure Statement to anyone who requests information about your facility.

Facility Name	License No.	Average No. Residents	Telephone No.
Village at Stoney Glen	101470	12/13	(281)358-4589

Address (Street, City, State, ZIP code)
2225 Stoney Glen Drive, Kingwood, TX, 77339

Manager	Date Disclosure Statement Completed
Vince Comeaux	08/26/2021

Completed By:	Title
Vince Comeaux	Manager

The Assisted Living Licensure Standards are available for review at all assisted living facilities (ALFs).
A copy of the most recent survey report may be obtained from facility management.:

To register a complaint about an assisted living facility, contact:
Texas Health and Human Services Commission at 1-800-458-9858

This facility is certified under Texas Administrative Code Title 40, Part 1, Chapter 92, Licensing Standards for Assisted Living Facilities, §92.51 to provide personal care services to residents with Alzheimer's disease or related disorders. ☐ Yes ☑ No

A. Indicate services which are not offered by your facility:

- ☐ **Assistance in transferring to and from a wheelchair**
- ☐ **Bladder incontinence care**
- ☐ **Bowel incontinence care**
- ☐ **Medication injections**
- ☑ **Feeding residents**
- ☑ **Intravenous (IV) therapy**
- ☑ **Oxygen administration**
- ☑ **Special diets**
- ☐ **Behavior management for verbal aggression**
- ☐ **Behavior management for physical aggression**
- ☑ **Other:**

Special diets are offered per doctors orders. For a limited time, the facility as a whole follows a heart healthy diet.

B. What is involved in the pre-admission process?

- ☑ **Facility Tour**
- ☑ **Family interview**
- ☑ **Medical records assessment**
- ☑ **Application**
- ☐ **Home assessment**
- ☑ **Other:**

3 days of respite (2 hours, 4 hours overnight)

C. What services and/or amenities are included in the base rate:

- ☑ **Meals (** 3 per day. **)**
- ☑ **Housekeeping (** 7 days per week. **)**
- ☐ **Activities program (** ____ days per week. **)**
- ☐ **Incontinence care**

- [x] **Temporary use of wheelchair/walker**
- [x] **Barber/beauty shop**
- [ ] **Special diet**
- [ ] **Select menus**
- [x] **Injections**
- [x] **Personal laundry**
- [x] **Licensed nurse** (______ hours per day.)
- [x] **Transportation (specify):**
- [ ] **Other:**

D. What additional services can be purchased?

- [ ] **Beauty/barber services**
- [ ] **Incontinence products**
- [ ] **Companion**
- [x] **Minor nursing services provided by facility staff**
- [ ] **Other:**
- [x] **Incontinence care**
- [ ] **Injections**
- [ ] **Transportation to doctor visits**
- [ ] **Home health services**

E. Do you charge more for different levels of care?........ [x] **Yes** [ ] **No**

II. Admission Process

A. Does the facility have a written contract for services? .... [x] **Yes** [ ] **No**

B. Is there a deposit in addition to rent?........ [x] **Yes** [ ] **No**

If yes, is it refundable? .... [x] **Yes** [ ] **No**

If yes, when? $1,000 move in (non-refundable); $1,000 security deposit (refundable after move out minus repairs)

C. Do you have a refund policy if the resident does not remain for the entire prepaid period? .... [x] **Yes** [ ] **No**

If yes, explain? Resident must give a 30 day written notice

D. What is the admission process for new residents?

- [x] **Doctors' orders**
- [x] **Residency agreement**
- [x] **History and physical**
- [x] **Deposit/payment**
- [x] **Other:**

Admissions Agreement, Interview with Family, Respite Stays, Tour of DayHab, Stay at DayHab

E. Does the facility have provisions for special resident communication needs?

- [x] **Staff who can sign for the deaf**
- [ ] **Services for persons who are blind**
- [ ] **Other:**

F. Is there a trial period for new residents?........ [x] **Yes** [ ] **No**

If yes, how long? New residents are evaluated every 30, 60, and 90 days

III. Discharge/Transfer

A. What could cause temporary transfer from specialized care?

- [x] **Medical condition requiring 24–hour nursing care**
- [x] **Unacceptable physical or verbal behavior**
- [x] **Drug stabilization**
- [x] **Resident requires services the facility does not provide**
- [x] **Other:** Psychiatric Individuals

B. The need for the following services could cause permanent discharge:

- [x] **24–hour nursing care**
- [ ] **Sitters**
- [ ] **Medication Injections**
- [ ] **Assistance in transferring to and from wheelchair**
- [x] **Bowel incontinence care**
- [x] **Feeding by staff**
- [ ] **Behavior management for physical aggression**
- [ ] **Bladder incontinence care**
- [x] **Oxygen administration**
- [ ] **Behavior management for verbal aggression**
- [x] **Intravenous (IV) therapy**
- [x] **Special diets**
- [ ] **Other:**

C. Who would make this discharge decision?

- [x] **Facility manager**
- [x] **Other:** Nurse

D. Do families have input into these discharge decisions?.. [x] **Yes** [ ] **No**

E. Is there an avenue to appeal these decisions? .... [x] **Yes** [ ] **No**

F. Do you assist families in making discharge plans? .... [ ] **Yes** [x] **No**

IV. Planning and Implementation of Care (check all that apply)

A. Who is involved in the service plan process?

- [ ] **Resident**
- [x] **Family member**
- [ ] **Activity director**
- [ ] **Attendants**
- [x] **Manager**
- [x] **Licensed nurses**
- [ ] **Social worker**
- [ ] **Dietary**
- [x] **Physician**
- [ ] **Other:**

B. Does the service plan address the following?

- [x] **Medical needs**
- [x] **Nursing needs**
- [x] **Activities of daily living**
- [x] **Psychosocial status**
- [x] **Nutritional status**
- [ ] **Dental Services**
- [ ] **Other:**

C. How often is the service plan assessed?

- [ ] **Monthly**
- [ ] **Quarterly**
- [x] **Annually**
- [ ] **As Needed**
- [ ] **Other:**

D. How many hours of structured activities are scheduled per day?

- [ ] **1–2 Hours**
- [ ] **2–4 Hours**
- [ ] **4–6 Hours**
- [x] **6–8 Hours**
- [ ] **8+ Hours**

E. What types of programs are scheduled?

- [x] **Music program**
- [x] **Arts program**
- [x] **Crafts**
- [x] **Exercise**
- [ ] **Cooking**
- [ ] **Other:**

F. Who assists/administers medications?

- [x] **RN**
- [x] **LVN**
- [x] **Medication aide**
- [ ] **Attendant**
- [ ] **Other:**

V. Aging in Place

Rules

An inappropriately placed resident is a resident who was appropriate when admitted to the ALF, but whose condition has changed. All residents must be appropriate for the ALF licensure type when admitted to the facility. After admission, if the resident's condition changes, the resident may no longer be appropriate for the facility's license. An ALF is not required to keep a resident who is no longer appropriate for the facility's license.

An inappropriately placed resident may be identified by the ALF or by HHSC.

There are two situations which a resident may be determined to be inappropriate:

- Resident experiences a change in condition, needs additional services and meets evacuation criteria.
- Resident experiences a change in condition and does not meet evacuation criteria.

What are the ALF's policies and procedures for aging in place?

☐ **Resident experiences a change in condition and meets evacuation criteria. Documentation is submitted to HHSC.**
☑ **Resident experiences a change in condition and does not meet evacuation criteria. Waiver request submitted to HHSC.**
☐ **No documentation submitted to HHSC. Resident is discharged.**

An ALF is not required to keep a resident who is no longer appropriate for the facility's license. A facility will determine its ability to accommodate a resident and decide if it will apply for a waiver request on a case by case basis. HHSC rules about inappropriately placed residents may be found in the Licensing Standards for Assisted Living Facilities at 40 Texas Administrative Code Chapter 92, Subchapter 92.41(f). The following link will direct you to the Licensing Standards for Assisted Living Facilities:

https://hhs.texas.gov/laws-regulations/handbooks/licensing-standards-assisted-living-facilities-handbook

VI. Change In Condition Issues

What special provisions do you allow aging in place?

☑ **Sitters** ☐ **Additional services agreements** ☐ **Hospice** ☑ **Home health** -If so, is it affiliated with your facility? ☐ **Yes** ☑ **No**
☐ **Other:** ______

VII. Staff Training

A. What training do new employees receive?

☑ **Orientation:** 4 **hours** ☐ **Review of resident service plan** ☑ **On–the–job training with another employee:** ~20 **hours**
☐ **Other:** ______

B. Is staff trained in CPR? .... ☑ **Yes** ☐ **No**

If no, please explain why you do not require CPR training:

C. How much ongoing training is provided and how often? (Example: 30 minutes monthly): (A.N.E.) (Safety Care B.C.B.A.) (CPR)

D. Who gives the training and what are their qualifications?

Medication Administration RN; Abuse Neglect Exploitation Online by the State; Safety Cares B.C.B.A; P.P.E. LVN; CPR Certified Trainer

E. What type of training do volunteers receive?

☑ **Orientation:** 8 **hours** ☑ **On–the–job training**
☑ **Other:**

Background Checks

F. In what type of endeavors are volunteers engaged?

☑ **Activities** ☑ **Meals** ☐ **Religious services** ☑ **Entertainment** ☑ **Visitation**
☐ **Other:** ______

G. List volunteer groups involved with the family?

Young Mens Service League	First Baptist / Sunday School	
National Charity League	First Presbyterian / Bible Study	

VIII. Physical Environment

- [x] **Emergency call systems**
- [x] **Sprinkler system**
- [x] **Fire alarm system**
- [ ] **Wander Guard or similar system**
- [x] **Built according to NFPA Life Safety Code, Chapter 12, Health Care**
- [x] **Built according to NFPA Life Safety Code, Chapter 21, Board and Care**
- [ ] **Other:**

B. Does the facility's environment include the following?

- [x] **Plants**
- [ ] **Pets**
- [x] **Vegetable/flower gardens for use by residents**
- [ ] **Other:**

C. Are the residents allowed to have:

- [x] **Plant's**
- [ ] **Pets** -If so, is a deposit required?.......... [ ] **No** [x] **Yes** How much?............2 deposits of $1,000 each

IX. Staffing Patterns

A. What are the qualifications of the manager?

Assisted Living Standards (License); Texas Assisted Living Manager (License); Abuse Neglect Exploitation Training (Certificate); Training in Residents Morals (Certificate); COVID-19 Response Planning (Certificate); Infection Control in Assisted Living Facilities (Certificate)

B. Please list the facility's normal 24-hour staffing pattern on:

1. the attached chart; or
2. a separate attachment which explains your facility's unique staffing policies and patterns.

X. Residents's Rights

A. Do you have a Resident's Council? .... [ ] **Yes** [x] **No**

How often does it meet?

B. Do you have a Family Council?.......... [x] **Yes** [ ] **No**

How often does it meet? monthly

C. Does the facility have a formal procedure for responding to resident grievances and suggestions for improvement? .... [x] **Yes** [ ] **No**

Is there a Grievance Committee? .... [ ] **Yes** [x] **No**

Is there a suggestion box? .... [ ] **Yes** [x] **No**

D. How can the company that owns the facility be contacted?

All phone numbers and Facility Administrators's phone numbers are posted in the entry to the building.

Shift Times and Staffing Patterns at the Facility

Full-Time Personnel

Shifts (Enter the hours of each of your facility's shifts.)	Number of Staff Per Shift						
	R.N.s	L.V.N.s	Attendants	Medication Aides	Activity Workers	Universal Workers	Other Workers
On Call 24/7	yes				Saturdays		Volunteers
M-F 9am-5pm		yes			1pm-4pm		every other
M-S 3p-11pm,11pm-9am			yes	yes	Tuesdays		Friday
Weekends 9am-3pm			yes	yes	5pm-7pm		6pm-8pm

Part-Time Personnel

Shifts (Enter the hours of each of your facility's shifts.)	Number of Staff Per Shift						
	R.N.s	L.V.N.s	Attendants	Medication Aides	Activity Workers	Universal Workers	Other Workers
Weekends 9am-3pm			yes	yes			Volunteers
Weekends 3pm-11pm			yes	yes			every other
Saturdays 1pm-4pm					yes		Friday
Tuesdays 5pm-7pm					yes		6pm-8pm

ASSISTED LIVING DISCLOSURE STATEMENT AGREEMENT

I have received the Assisted Living Disclosure Statement for Village at Stoney Glen.

Resident's Name ____

Responsible Party Signature ____

Date ___________________________

TEXAS Health and Human Services

Day Activity and Health Services (DAHS)

Physician's Orders

Day Activity and Health Services (DAHS) is a licensed day care program for adults with chronic medical conditions administered by the Texas Health and Human Services Commission or STAR+PLUS manged care organizations (MCOs). The program provider must have services available for eligible individuals/members at least 10 hours per day, Monday through Friday, except holidays. Services include licensed nursing care, planned activities, hot lunch and mid-morning/afternoon snacks, personal care assistance, transportation to and from the facility, and related services.

Section I. Individual/Member Information

Individual/Member Name (Last, First, Middle Initial)	Date of Birth	Individual/Member Medicaid No.
DAHS Facility Name	DAHS Nurse	DAHS Area Code and Telephone No.
DAHS Facility Address (Street, City, State and ZIP Code)		

Section II. Chronic Medical Diagnosis(es) from the Last 24 Months	Corresponding ICD-10 Code(s)

Section III. Functional Limitations Related to Medical Diagnoses

☐ Behavior/Emotional Problems	☐ Dizziness	☐ Difficulty Swallowing	☐ Limited Range of Motion
☐ Contractors	☐ Hearing Impairment	☐ Limited Dexterity	☐ Uses Ambulation Device
☐ Incontinence	☐ Nausea	☐ Hearing Impairment	☐ Paralysis
☐ Spasticity	☐ Shortness of Breath	☐ Tremors	☐ Numbness
☐ Pain	☐ Vision Impairment	☐ Unable to Stand for Long	☐ General Weakness
☐ Blackouts	☐ Falls Easily	☐ Cognitive Impairment	

☐ Other: ____________________

Section IV. Special Diet

Instructions/Notes/Comments:

Section V. Medications and Treatments

To provide better emergency care, list all known medications taken; not only those prescribed by this office, such as Prescribed/PRN/OTC.

Medications							
				Location of Medication Administration			
Medication	Dosage	Route	Frequency	Home	DAHS	Initial	Date
				☐	◯ Self-Admin ☐ with Supervision ◯ Licensed Nurse		
				☐	◯ Self-Admin ☐ with Supervision ◯ Licensed Nurse		
				☐	◯ Self-Admin ☐ with Supervision ◯ Licensed Nurse		
				☐	◯ Self-Admin ☐ with Supervision ◯ Licensed Nurse		
				☐	◯ Self-Admin ☐ with Supervision ◯ Licensed Nurse		
				☐	◯ Self-Admin ☐ with Supervision ◯ Licensed Nurse		
				☐	◯ Self-Admin ☐ with Supervision ◯ Licensed Nurse		
				☐	◯ Self-Admin ☐ with Supervision ◯ Licensed Nurse		
				☐	◯ Self-Admin ☐ with Supervision ◯ Licensed Nurse		
				☐	◯ Self-Admin ☐ with Supervision ◯ Licensed Nurse		
				☐	◯ Self-Admin ☐ with Supervision ◯ Licensed Nurse		
				☐	◯ Self-Admin ☐ with Supervision ◯ Licensed Nurse		

Therapies or treatments performed at DAHS, including monitoring tasks, specific interventions or procedures.		
Ordered Treatments/Monitoring/Intervention	**Frequency**	**Notes/Comments**

+ –

Section VI. Physician's Certification

I certify this individual/member has a chronic medical diagnosis and a functional limitation and will benefit therapeutically from DAHS. I hereby order the above care, monitoring or intervention by a licensed nurse to be performed at the DAHS facility.

I also certify that I am not a significant owner, partner or member of the service provider requesting this order for DAHS.

☐ Check this box to certify the individual/member had no significant change in care plan from the previous assessment and sign below.

Signature – Physician	Today's Date	Effective Date	End Date (if order is time limited)

Physician's Name (Type or Print)	MD ☐	DO ☐	License No./NPI	State	Military or VA ☐ Yes ☐ No
Physician's Address (Street, City, State, and ZIP Code)				Area Code and Telephone No.	

Print Form   Reset Form

VILLAGE AT STONEY GLEN

ADMISSION PHYSICAL EXAMINATION

** THIS FORM MUST BE COMPLETED BY A PHYSICIAN **

NAME: ____ DATE: _________________

PHYSICIAN: ____PHYSICIAN NUMBER: _______________

PHYSICIAN ADDRESS: ____

PHYSICAL EXAM:

HEIGHT: ________ WEIGHT: ________ TEMP: ________ RESP: ________ B/P:_________ PULSE: _________

ALLERGIES: ____

CURRENT DIAGNOSIS: ____

____

VACCINATIONS (please list or attach vaccinations record)

DATE	VACCINE	DATE	VACCINE

RESTRICTIONS/RECOMMENDATIONS FOR OVER THE COUNTER MEDICATIONS:

____

____

DESCRIBE HOSPITALIZATIONS, MAJOR ILLNESSES, AND SURGERIES:

____

____

DESCRIBE ANY PSYCHOLOGICAL OR PSYCHIATRIC TREATMENTS:

____

____

***Please use the attached form (DAHS form 3055) for current physician's orders

____ _________________________

PHYSICIAN'S SIGNATURE DATE