|  | ADULT FAMILY HOME’S (AFH) NAME | LICENSE NUMBER |
| --- | --- | --- |
| PROVIDER / LICENSEE’S NAME | INSPECTION DATE |
| LICENSOR’S NAME |
| ATTACHMENT M AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)ADULT FAMILY HOME (AFH)**Administrative Records Review** |
| **Instructions:** *Full* review sample should include one current caregiver hired since the last inspection and one of the following: Provider, Resident Manager, or Entity Rep. Conduct a *focused* review of background checks for all current staff. If the home does not have a specialty designation, mark “N/A” for that specialty and leave the line blank. |
| **STAFF** | **PROVIDER OR ENTITY REP** | **RESIDENT MANAGER** | **CAREGIVER** | **CAREGIVER** | **CAREGIVER** |
| NAME |  |  |  |  |  |
| DATE OF HIRE |  |  |  |  |  |
| HOME ORIENTATION |  |  |  |  |
| DATE OF BIRTH |  |  |  |  |  |
| CONTACT INFO ON FILE | [ ]  YES [ ]  NO | [ ]  YES [ ]  NO | [ ]  YES [ ]  NO | [ ]  YES [ ]  NO | [ ]  YES [ ]  NO |
| BGI EXPIRE DATE\* | [ ]  NR [ ]  RR [ ]  DQ | [ ]  NR [ ]  RR [ ]  DQ | [ ]  NR [ ]  RR [ ]  DQ | [ ]  NR [ ]  RR [ ]  DQ | [ ]  NR [ ]  RR [ ]  DQ |
| FINGERPRINT CHECK DATE (CHECK N/A IF NOT REQUIRED) | [ ]  PENDING[ ]  N/A | [ ]  PENDING[ ]  N/A | [ ]  PENDING[ ]  N/A | [ ]  PENDING[ ]  N/A | [ ]  PENDING[ ]  N/A |
| CCS EVALUATION\* | [ ]  N/A | [ ]  N/A | [ ]  N/A | [ ]  N/A | [ ]  N/A |
| TB TESTING MET | [ ]  YES [ ]  NO | [ ]  YES [ ]  NO | [ ]  YES [ ]  NO | [ ]  YES [ ]  NO | [ ]  YES [ ]  NO |
| ORIENTATION AND SAFETY (5 HOURS) |  |  |  |  |  |
| 70 HOUR BASIC **OR** |  |  |  |  |  |
| FUNDAMENTALS OF CAREGIVING (WORKED PRIOR TO 01/01/202012) | [ ]  ATTESTATION | [ ]  ATTESTATION | [ ]  ATTESTATION | [ ]  ATTESTATION | [ ]  ATTESTATION |
| CPR EXP. DATE |  |  |  |  |  |
| FIRST AID EXP. DATE |  |  |  |  |  |
| ND\* TRAINING |  |  |  |  |  |
|  ND DIABETES FOCUS |  |  |  |  |  |
| FOOD HANDLER EXP.  |  |  |  |  |  |
| **OR** FOOD SAFETY CE |  |  |  |  |  |
| DOH LICENSE **TYPE**: |  |  |  |  |  |
| DOH LICENSE **EXP**. |  |  |  |  |  |
| NUMBER OF CE HOURS (N/A, IF NOT REQUIRED) | [ ]  N/A | [ ]  N/A | [ ]  N/A | [ ]  N/A | [ ]  N/A |
| **SPECIALTY TRAINING** |
| DEMENTIA[ ]  N/A |  |  |  |  |  |
| MENTAL HEALTH[ ]  N/A |  |  |  |  |  |
| DDA[ ]  N/A |  |  |  |  |  |
| \* BGI - Background Inquiry; NR - No Record; RR - Review Required; DQ - Disqualifying, CCS - Character, Competency, and Suitability; ND - Nurse Delegation; CE - Continuing Education |
| **TB Testing – Optional Worksheet**This section can be used to assist in determining compliance with TB Testing requirements.Once determined, indicate compliance status on Page 1. |
| **STAFF** | **PROVIDER OR ENTITY REP** | **RESIDENT MANAGER** | **CAREGIVER** | **CAREGIVER** | **CAREGIVER** |
| DATE ADMINISTERED |  |  |  |  |  |
| STEP 1 READ |  |  |  |  |  |
| RESULT | [ ]  Positive[ ]  Negative | [ ]  Positive[ ]  Negative | [ ]  Positive[ ]  Negative | [ ]  Positive[ ]  Negative | [ ]  Positive[ ]  Negative |
| DATE ADMINISTERED |  |  |  |  |  |
| STEP 2 READ |  |  |  |  |  |
| RESULT | [ ]  Positive[ ]  Negative | [ ]  Positive[ ]  Negative | [ ]  Positive[ ]  Negative | [ ]  Positive[ ]  Negative | [ ]  Positive[ ]  Negative |
| 1 ADDITIONAL TEST DATE ADMINISTERED |  |  |  |  |  |
| 1 ADDITIONAL TEST DATE READ |  |  |  |  |  |
| RESULT | [ ]  Positive[ ]  Negative | [ ]  Positive[ ]  Negative | [ ]  Positive[ ]  Negative | [ ]  Positive[ ]  Negative | [ ]  Positive[ ]  Negative |
| BLOOD TEST |  |  |  |  |  |
| RESULT | [ ]  Positive[ ]  Negative | [ ]  Positive[ ]  Negative | [ ]  Positive[ ]  Negative | [ ]  Positive[ ]  Negative | [ ]  Positive[ ]  Negative |
| X-RAY |  |  |  |  |  |
| RESULT | [ ]  Positive[ ]  Negative | [ ]  Positive[ ]  Negative | [ ]  Positive[ ]  Negative | [ ]  Positive[ ]  Negative | [ ]  Positive[ ]  Negative |
| NOTES |