|  | 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 | | | | | | | |