



Independent Living/Assisted Living Facility Profile

Facility _____

Corporate Affiliation _____ How long owned? _____

Address _____

Phone _____ **Medical**

Director _____

Administrator _____ **Billing Person** _____

Admissions Director _____ **Nursing Director**

Total # of apts _____ Private _____ Semi _____

Current Occupancy _____ Wait list? _____ Approx. wait time _____

Cost per month _____ Entrance / application fee/sliding scale? _____

What meals are included in price? _____ Price per meal for guests _____

Refund / Cancellation Policy _____

Ability to progress to next level of care _____

Ratio of Nursing to residents _____ Credentials of Nursing _____

Transportation services available? _____

Church services available? _____ Reserved parking available? _____ Charge? _____

Visitor parking available? _____

Furnishings provided? _____

Family overnight visitation allowed? _____

Guest facilities available? _____

Activities? _____

Activities Director _____ Hours _____

Cooking facilities available in apartments? _____

Phone / TV hook ups in room? _____ Charges _____

Pets allowed? _____ Pet deposit? _____

Barber/ beautician services available? _____ Price? _____

Podiatrist visits? _____ Dentist visits? _____

Social Services? _____ Social Service Director _____

Psych services available? _____ Audiologist? _____

Optometrist? _____ Dietitian? _____

Wheelchair availability _____

How often are residents checked on, what's the system for doing so?

Types of Nursing services available: BP checks _____ Medication dispense _____

blood sugar checks _____ Wound care _____ Injections _____

Ostomy care _____

Types of personal care available: bathing _____ dressing _____ toileting _____

ambulation assist _____ transfers _____



Resident status requirements: Fully ambulatory without assistance _____
 Min. assist to ambulate _____ Independent with WC or scooter _____
 Able to climb at least one flight of stairs _____
 Independent with all ADLs _____ Min assist with ADLs _____
 Continent or able to manage changes _____

Therapy Services Available? PT OT ST Hours of Operation _____ M-
 F Sat?
 Sun? _____

In - House or Contract Company? _____

Who to contact? _____

Cost per hour _____ Availability of assistive devices _____

State Survey result? _____ Date of last Survey _____

Admission Procedure _____

Incident Procedure _____

Grievance Procedure _____

Date Completed _____ **Person Completing** _____

Information Provider Name _____

- Have the facility mail:
1. Brochure describing facility (with pictures preferred)
 2. Copy of admission packet
 3. Map of the area and the location of the facility
 4. List of key staff member names and phone extensions
 5. Sample of activity calendar