ALF CORE START-UP CONSULTING SERVICE

Further inclusions may exist depending on facility size and state requirements

Completion of AHCA Application and Follow-up with Agency
On-going consultation throughout license process
Two Visits to the facility (additional cost may incur, depending on location)

Policy & Procedures
Resident Binders
Staff Binders
Medication Binder
Facility Binder
Emergency Plan
Fire Plan

ALF In service training certificates
(no charge for Administrator with start-up consulting service, must attend trainings; additional cost for staff).

CPR & First Aid
AED (Automated External Defibrillation) **needed for 17 or greater**
HIV / AIDS (4 hrs. initial) One-time training
Water Safety **(if facility has a pool or lake)**
Bloodborne / Infection Control
Alzheimer's
Do Not Resuscitate
Assistance with Medication (6 hours of medication training effective July 1, 2015)- **NOT INCLUDED**
Safe Food Handling
Resident's Rights
Abuse, Neglect & Exploitation
Resident Behavior & Needs
Activities of Daily Living
Emergency and Elopement Training Procedures

Present during AHCA Initial Inspection (additional cost, pending location)

***Note**: The applicant is responsible for consulting with zoning, fire, health department and all other local government agencies regarding the structural requirements for the location. These local government agencies can need the signature of the applicant to sign off on documents for this reason Arrendell's cannot obtain these documents. If this is a home business, it is recommended to consult with your local government to satisfy their requirements related to a home business).*

Subject to change without notice

____**Initial** ____**Change of Ownership**

Facility Information: Answer where applicable and write legibly.

County: ___________________________
Name of Facility: ____ License #________
DBA: if applicable: ____
Full Address: ____
EIN: _________________________________ NPI: _________________________
Medicaid Number, if applicable: _____________________ / Medicaid waiver: ______________
Telephone: _____________________________Fax: ________________________
Email: _________________________________ Website: ______________________________
Capacity: _________ - ___OSS ___ Private Specialty License: __LNS __ECC __ LMH
Nurse On Site: ___ Full Time ___Part Time ___ Third Party ___ None

Management Company: _____ Yes _____ No?

Administrator: ____ Cell: ___________________
Full Address: ____
Email Address: ____
Administrator social security number: ____________________________ DOB: ____________
Education: ____ Highschool Diploma ____ GED
Are you administering to any other facilities: ____Yes ____No

Chief Financial Officer: _________________________________
Chief Financial Officer social security number: _______________________________

Who owns the property? _____ Business _____ You _____ Other: ___________
Name: ____________________________________ Phone __________________________
Full Address: ____

OWNERSHP

Owner #1: Full Name: ____ %: _________
Owner #2: Full Name: ____ %: _________
Owner #3: Full Name: ____ %: _________
Owner #4: Full Name: ____ %: _________

BOARD MEMBERS

BM #1: Full Name: ___________________________________ Telephone: _______________
BM #2: Full Name: ____________________________________ Telephone: _______________
BM #3: Full Name: ____________________________________ Telephone: _______________
BM #4: Full Name: ____________________________________ Telephone: _______________

1. Are you willing to hold a bed for a resident if, for example, they went to the hospital, rehab temporarily?
____ Yes ____ No
2. Are you affiliated with any religion / religious group? ____ Yes _____ No, if yes, please list here;
____
3. What forms of payment(s) do you accept? ____ Private Pay ____ Medicaid _____ SSI Other:
____
4. Will you provide day service to adults who will not residing on the premises? ________
5. Languages spoken at the facility by administrator and staff?
____