

## DS-ABD RESIDENTIAL INFORMATION PACKET FOR CERTIFICATION

**Name of Program:**

**Certification Number:**

INDIVIDUAL NAME(S)	AREA AGENCY

- Please submit copies of completed criminal record checks, NH DMV record checks and BEAS Registry checks for all staff, providers, and household members over 18 years old.
- Self-reported deficiencies must be written, and in letter format prior to the certification. Self-reports must be given to the surveyor at the beginning of the inspection.
- Complete entire packet prior to certification. Incomplete packets with attachments in lieu of the completed packet will not be accepted.
- Submit copies of Fire Safety Risk Assessments for all initial reviews and for new individuals, and a current floor plan that indicates where the individual(s) bedroom is located. **Please ensure all drills are documented on the last page of this form in the grid provided.**
- When filling out the packet, please only use the original criminal record check and training dates from the date of hire/contract. Do not use updated training dates or more recent criminal record check dates. Attestation dates per Appendix K may be requested, if applicable.
- When filling out the insurance information, please list all home and auto insurance as applicable to the certified residence.

**IMPORTANT: I swear or affirm that the information provided is accurate to the best of my knowledge and belief. I understand that providing false information shall be grounds for denial, suspension or revocation of the certification.**

\_\_\_\_\_  
**Signature and title of agency representative verifying that all information provided is complete and accurate**

\_\_\_\_\_  
**Date**

**MEDICATION ADMINISTRATION INFORMATION**

<b>Certified Residence Name</b>	<b>Name:</b>
<b>Name and Title of Approved Nurse-Trainer</b>	<b>Name and Title:</b>
<b>Total Number of Individuals in the Program:</b>	<b>Number:</b>
<b>Number of Individuals Receiving Administered Medications:</b>	<b>Number:</b>
<b>Number of Individuals Who Self-Administer their Medication:</b>	<b>Number:</b>
<b>Date Of The Last Two Self-Administration Assessments For Individuals that Self-Administer Medications</b>	<b>Individual Initials: NT Approval Date: Guardian Approval Date: Individual Initials: NT Approval Date: Guardian Approval Date:</b>
<b>Initial Self-Administration Assessment Date for those Individuals that <u>Do Not Self-Administer Medications</u></b>	<b>Individual’s Initials and Dates: Individual’s Initials and Dates:</b>
<b>Medication Storage Location</b>	<b>Location:</b>
<b>If Medication Storage is Unlocked, Date of Nurse-Trainer Approval:</b>	<b>Date:</b>
<b>Name of Licensed Person Responsible for Quality Reviews:</b>	<b>Name:</b>
<b>Dates of Quality Reviews for the Past Twelve (12) Months:</b>	<b>Dates:</b>
<b>Frequency of Quality Reviews:</b>	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Every six (6) months  <input type="checkbox"/> Other (specify):

<b>Name(s) of Authorized Provider(s) per He-M 1201.06</b>	<b>Current Authorization Date Range</b>	<b>Previous Authorization Date Range</b>

**Signature of Nurse-Trainer verifying information:**

**Date:**

**Complete For All Individuals, Including Those Who Self-Administer Their Medications**

Individual's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name of Medication	Dosage	Frequency	Prescribing Practitioner	Order Date	Reviewer ✓

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Full name and signature of person completing this form \_\_\_\_\_

Date form completed \_\_\_\_\_





**Residence Information**

What is the manufacture date on each smoke alarm: (excludes licensed homes with a complete fire alarm panel that has been serviced annually)		Certified Bedroom #1: Certified Bedroom #2: Certified Bedroom #3: Living Room:	Provider Bedroom #1: Provider Bedroom #2: Basement Alarm : Other:
What dates were the batteries in the smoke alarms changed? He-M 1001.03(p)(3)		Date #1:	Date #2:
What was the date of last two (2) furnace cleanings? He-M 1001.03(p)(7)		Date #1:	Date #2:
What was the date of the last well water test? He-M 1001.03(u)(5)a.		Current Date:	Previous date (if applicable):
Have modifications been made to the residence that required a building permit or changed any means of egress? If so, what is the date of new life safety local approval? He-M 1001.12(c)(3)		Life Safety Code Date:	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are all doors, hallways and stairs clear, unobstructed and uncluttered? He-M 1001.03(p)(4)	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are portable heaters used and installed in accordance with manufacturer's recommendations and utilized correctly? Are portable heaters unplugged after being turned off?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the home free of frayed, cracked, or crimped electrical cords?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the home free of electrical extension cords (except for a temporary use)? Any extension cord must be rated for that particular use and amperage.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the home free of overloaded electrical outlets?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are multi-plug devices fused and attached to the wall	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do all electrical outlets and junction boxes have cover plates, and no exposed wiring?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are electrical outlets, which are located within 3' of a water source, GFCI, (ground fault interrupted) protected?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there at least one fire extinguisher in the basement at the top of the stairs, and one Fire extinguisher near the kitchen in the path of travel to the door?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is lighting sufficient at all means of egress?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do all bedroom doors close and latch? Additionally, do any required corridor doors close and latch?	
Please list the names and ages of all people over age eighteen (18) living in the household not receiving services in the box to the right.			

**Please complete the grid below with the fire drill dates for the past year, or dating back to the last certification inspection. All sleep hour drills must be between 10:00pm to 6:00am**

Date of Drill	Time drill began	AM/PM	Evacuation time in minutes and seconds	Names of Participants	Exits Used	Original Fire Safety Assessment dates