



Uniform Disclosure Statement Assisted Living/Residential Care Facility

The purpose of this Uniform Disclosure Statement is to provide you with information to assist you in comparing Assisted Living and Residential Care facilities and services. Oregon Department of Human Services requires all Assisted Living and Residential Care facilities to provide you with this Disclosure Statement. There is also a Consumer Guide booklet available that can assist you in making a decision about the care setting that is most appropriate for you or your loved one.

The Disclosure Statement is not intended to take the place of visiting the facility, talking with residents, or meeting one-on-one with facility staff. Please carefully review each facility's residency agreement/contract before making a decision.

Facility Type: **Assisted Living Facility** **Residential Care Facility**

Facility Name: _____

Address: _____

Telephone Number: _____ Number of Apts/Units: _____

Administrator: _____ Hire Date: _____

Facility Owner: _____ Facility Operator: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

Telephone: _____ Telephone: _____

Does this facility accept Medicaid as a payment source? Yes No

Does this facility require you to disclose personal financial information? Yes No

Does this facility allow smoking? Yes No

Does this facility allow pets? Yes No

Does this facility allow alcohol consumption? Yes No

Date this Disclosure Statement was completed/revised: _____

I. Services

What services and/or amenities are available? (See residency agreement for all services)

- CODE:** **I** = Included in the base rate
 \$ = Available at extra cost
 A = Arranged with an outside provider
 N = Not available

NOTE: Cost will generally increase as your personal care needs, services or preferences increase. Please thoroughly review and understand this facility's method for determining rates and rate changes.

I \$ A N

Meals (3 per day) _____

Snacks/beverages between meals _____

Physician-ordered diets (types) _____

Dietary preferences (e.g. vegetarian) _____

Facility transportation _____

Arrange transportation (e.g. cab, senior transports, volunteers, etc.) _____

Assistance with medications _____

Arrange/coordinate outside health services (e.g. physician appt., hospice, home health, etc.) _____

Oversight and monitoring of health status _____

Assistance for cognitively impaired residents (e.g. redirecting, cuing, intervention, etc.) _____

Assistance with bathing _____

Assistance with dressing _____

Assistance with eating _____

Assistance with toileting _____

Assistance with incontinence _____

Assistance with transfers from bed to wheelchair, etc. _____

Housekeeping (____ days per week) _____

Personal laundry _____

Linen laundry _____

(continued on next page)

I. Services *(continued from previous page)*

CODE: **I** = Included in the base rate
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I \$ A N

- Linens/towels _____
- Health care supplies _____
- Personal toiletries (e.g. toilet paper, soap, shampoo) _____
- Apt/Unit furniture provided _____
- Personal phone _____
- Cable TV _____
- Internet access _____

II. Deposits/Fees

What deposits and/or fees are charged in addition to rent?

- | | <u>Refundable?</u> | | | <u>Refundable?</u> | |
|---|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| <input type="checkbox"/> Security/Damage | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Application | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Cleaning | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Smoking | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Pet | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Keys | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Other _____ | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

NOTE: If a deposit or fee is refundable, it is typically refunded only if specified criteria are met.

III. Medication Administration

A. Who on the staff routinely administers medications?

B. Describe the orientation/training staff receive before administering medications?

C. Who is responsible for the training and supervision of safe medication administration practices?

(continued on next page)

III. Medication Administration *(continued from previous page)*

D. Although the resident retains the right to use a pharmacy of his/her choice, if the resident requires medication administration, the facility's policy for ordering and packaging medications is:

1. Is there an additional charge for *not* using the facility pharmacy? Yes No

2. If so, what is the cost? _____

IV. Staffing Patterns

Assisted Living and Class II Residential Care facilities are required to have a Registered Nurse on staff or on contract. A nurse in these facilities typically does not provide hands-on personal/nursing care. The nurse is usually available to provide consultation with facility staff regarding resident health concerns and coordination with community health care providers.

NOTE: Assisted Living and Residential Care facilities in Oregon are not required to employ Certified Nursing Assistants (CNA) or Certified Medication Aides (CMA) as resident care staff.

A. How is the facility Registered Nurse employed? On Staff On Contract

Average number of hours per week a nurse is on-site in the facility: _____

B. Please check all applicable duties of the facility Registered Nurse:

Upon admission, assess the health condition and health care needs of all residents.

Participate in the development of all resident service plans.

Monitor resident health status and initiate actions in response to changing needs.

Monitor all medications and prescriptions.

Other (specify): _____

C. Typical staffing patterns for full-time personnel.

Shifts (Enter the hours for each of your facility's shifts.)	Number of Staff per Shift				
	Direct Care Staff	Medication Aide	Universal Worker	Activity Worker	Other Worker
Days: (___ a.m. to ___ p.m.)					
Evenings: (___ p.m. to ___ p.m.)					
Nights: (_____ to _____)					

IV. Staffing Patterns *(continued from previous page)*

Direct Care Staff: Staff whose primary responsibility is to provide personal care services to residents (e.g. bathing, dressing, toileting, answering call lights).

Medication Aide: Staff whose primary responsibility is medication administration and performing non-complex nursing tasks delegated/assigned by a registered nurse (e.g., blood sugar testing, blood pressure checks).

Universal Worker: Staff assigned to provide duties of Resident Care Staff and/or Medication Aide as well as housekeeping and food service duties.

Activity Worker: Staff whose primary responsibility it is to organize and initiate resident activities, both group and individual.

Other Worker: (Please specify job title and primary responsibilities): _____

Additional comments regarding staffing patterns: _____

V. Discharge/Transfer

Licensed community-based care facilities may only ask a resident to move for reasons specified in applicable Oregon Administrative Rule. Oregon rules do not require that a resident be moved out of a facility due to increased medical services; however, if a facility is unable to meet a resident's needs based on the criteria listed in the Oregon Administrative Rules, a resident may be given a written notice to move from the facility.

A person has the right to object to a move-out notice and can request an informal conference and hearing with the Department of Human Services. Information about these rights and who to contact will be included on the move-out notification.

You can access the **Assisted Living and Residential Care Facilities Consumer Guide** on the **Web at sdsd.hr.state.or.us**

For office use only:

Reviewed by: _____ Date: _____