

ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT

Emergency Shelter

I. General Policies and Procedures

- A. Describe your capability to provide temporary overnight shelter for elders, and as needed, other household members.

- B. Describe your intake procedure to provide emergency shelter during the day, evening, overnight, and weekend hours.

- C. Describe your procedure for complying with local building codes and Board of Health regulations. Attach copies of any current certifications.

- D. Describe your handicap accessibility capacity.

- E. Describe your capacity/procedure to respond to the following emergencies:

Fire

Loss of utilities (power/heat)

Hurricanes and snowstorms

Floods

Medical crisis

Child or Adult Protective Services

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F. What is your proposed rate for Emergency Shelter? Describe any additional charges.

G. For the units which will be utilized by ASAP consumers, check all which apply:

| | YES | NO |
|--|--------------------------|--------------------------|
| Elevator access | <input type="checkbox"/> | <input type="checkbox"/> |
| Individual controls for heating and AC | <input type="checkbox"/> | <input type="checkbox"/> |
| Wheelchair accessible (including consumer units) | <input type="checkbox"/> | <input type="checkbox"/> |
| Food available | <input type="checkbox"/> | <input type="checkbox"/> |

H. What supplies, if any, (e.g. soap, towels, etc.) are provided to ASAP consumers?

Provider employee who completed this form

Name: _____

Date: _____

SERVICE SPECIFIC ON-SITE REVIEW

Emergency Shelter

Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On Site Evaluation

| CONSUMER Record Review | | | | | |
|---|--|--|--|--|--|
| Provider | | | | | |
| Date | | | | | |
| Monitor | | | | | |
| ASAP Authorization | | | | | |
| ID Info – name; address; phone; DOB | | | | | |
| Emergency Contact(s) name and phone | | | | | |
| Name of current CM | | | | | |
| Start Date & Termination Date, if applicable | | | | | |
| Comments | | | | | |
| NOTE: Shaded data elements are only required in the Consumer File if provider is not on Provider Direct. Otherwise the PD Demonstrator will be asked to illustrate “on screen”. | | | | | |
| Name and Position of Provider Direct Demonstrator | | | | | |

SERVICE SPECIFIC ON-SITE REVIEW

Emergency Shelter

Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On Site Evaluation.

| EMPLOYEE Records Review | | | | | |
|---|--|--|--|--|--|
| Provider | | | | | |
| Date | | | | | |
| Monitor | | | | | |
| Start Date & Termination Date, if applicable | | | | | |
| Number of reference checks | | | | | |
| CORI Check | | | | | |
| Job Description(s) | | | | | |
| Annual Performance Appraisal: Date | | | | | |
| Comments | | | | | |