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|  | | Attachment G  **Assisted Living Facility Resident Interview** | | | | | |
| ASSISTED LIVING FACILITY NAME | | | | | | LICENSE NUMBER | |
| ENTRANCE DATE | | | LICENSOR NAME | | | | CD ID NUMBER |
|  | | | | | | | |
| RESIDENT NAME | | | | RESIDENT IDENTIFIER | | ROOM NUMBER | PAY STATUS  Private  State |
| REPRESENTATIVE NAME | | | | | | REPRESENTATIVE PHONE NUMBER | |
| Brief Review of Negotiated Service Agreement: | | | | | | | |
| Water Temperature (required for half of sampled residents):  Not reviewed for sample resident: Temperature:  Date:Time: AM /  PM | | | | | | | |
|  | | | | | | | |
| INTERVIEW TYPE  Resident Interview  Representative Interview Date:Time: AM /  PM | | | | | | | |
| **Instructions:** The interview must address each category (A through J) and include a documented response. Check “Y” if the answer is yes; check “N” if the answer is no and document interviewee response; or check “D” if the interviewee declined to answer the question. If the question does not apply to the resident, check N/A.  **HCBS questions are denoted with \*\* before each question**. For each HCBS question, that question is **REQUIRED** and **MUST** be asked as **written** during the interview. For categories with required \*\*HCBS questions, the additional example questions are optional.  If there is no \*\* HCBS question for that category, use one of the example questions or write your own question. **You must ask at least one question in each category.** Check the box next to the question asked and document the response or check no concerns.  If you are concerned about any response, please investigate further. | | | | | | | |
| 1. **Care and Service Needs (Required \*\*HCBS question in this section)** | | | | | | | |
| Y N D N/A | \*\* Can you make choices about the care and services you receive here at the facility? | | | | No Concerns | | |
| Y N D N/A | Who helps you with your medications? | | | | No Concerns | | |
| Y N D N/A | What do staff help you with? | | | | No Concerns | | |
| 1. **Response to Concerns Support of Personal Relationships (Required \*\*HCBS question in this section)** | | | | | | | |
| Y N D N/A | \*\* Do they pay attention to what you have to say? | | | | No Concerns | | |
| Y N D N/A | Who would you talk to if you had concerns about your care? | | | | No Concerns | | |
| Y N D N/A | Other: | | | | No Concerns | | |
| 1. **Support of Personal Relationships (Required \*\*HCBS question in this section)** | | | | | | | |
| Y N D N/A | \*\* Can you choose who visits you and when? | | | | No Concerns | | |
| Y N D N/A | Other: | | | | No Concerns | | |
| 1. **Meals / Snacks / Preferences (Required \*\*HCBS question in this section)** | | | | | | | |
| Y N D N/A | \*\* Do you have access to food anytime? | | | | No Concerns | | |
| Y N D N/A | Other: | | | | No Concerns | | |
| 1. **Respect of Individuality, Independence, Personal Choice, Dignity (Required \*\*HCBS question in this section)** | | | | | | | |
| Y N D N/A | \*\* If you have a roommate, were you informed you would have a roommate? Could you change roommates if you wanted to? | | | | No Concerns | | |
| Y N D N/A | \*\* Can you choose to lock your door? | | | | No Concerns | | |
| Y N D N/A | Are you allowed to make choices and, if yes, are staff respectful of your choices? | | | | No Concerns | | |
| Y N D N/A | Other: | | | | No Concerns | | |
| 1. **Activities (Required \*\*HCBS question in this section)** | | | | | | | |
| Y N D N/A | \*\* Do you have an opportunity to participate in community activities? | | | | No Concerns | | |
| Y N D N/A | \*\* Do you receive services in the community? | | | | No Concerns | | |
| Y N D N/A | | Do you participate in activities while in the facility? How often? | | | | No Concerns | | |
| Y N D N/A | | Other: | | | | No Concerns | | |
| 1. **Homelike Environment (Select the question asked by checking the box next to that question)** | | | | | | | |
| Y N D N/A | Tell me about your room. Did you help decorate it? | | | | No Concerns | | |
| Y N D N/A | Is the temperature comfortable to you? | | | | No Concerns | | |
| Y N D N/A | Other: | | | | No Concerns | | |
| 1. **Reasonable Facility Rules (Select the question asked by checking the box next to that question)** | | | | | | | |
| Y N D N/A | Are there any rules that prevent you from doing the things you like to do every day? | | | | No Concerns | | |
| Y N D N/A | Other: | | | | No Concerns | | |
| 1. **Sense of Well-Being and Safety (Select the question asked by checking the box next to that question)** | | | | | | | |
| Y N D N/A | Do you feel safe? | | | | No Concerns | | |
| Y N D N/A | Other: | | | | No Concerns | | |
| 1. **Medicaid Policy Notice (Select the question asked by checking the box next to that question)** | | | | | | | |
| Y N D N/A | What were you told about paying for your care here? | | | | No Concerns | | |
| Y N D N/A | Other: | | | | No Concerns | | |
| 1. **Notes** | | | | | | | |
|  | | | | | | | |
| Leave a contact number for the resident to be able to contact you / RCS staff in the future. | | | | | | | |