|  | | AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ENHANCED SERVICES FACILTY (ESF)  **ESF Resident Interview** | | | | | Attachment E | |
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| ENHANCED SERVICES FACILITY NAME | | | LICENSE NUMBER | ENTRANCE DATE | | LICENSOR’S NAME | | |
|  | | | | | | | | |
| RESIDENT’S NAME | | | | | | RESIDENT NUMBER | | ROOM NUMBER |
| REPRESENTATIVE’S NAME | | | | | | RESIDENT PHONE NUMBER | | |
| BRIEF REVIEW OF PERSON-CENTERED SERVICE PLAN | | | | | | | | |
| WATER TEMPERATURE (check for all resident bathrooms)  None Temperature: oF 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 | | | |
| **Respect of Individuality, Independence, Personal Choice, Dignity (Required \*\* HCBS question in this section)** | | | | | | | | |
| 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 so, are staff respectful of your choices? | | | | No Concerns | | | |
| Y N D N/A | Other: | | | | No Concerns | | | |
| 1. **Activities (Two 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 corresponding box)** | | | | | | | | |
| 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 corresponding box)** | | | | | | | | |
| Y N D N/A | Does anyone tell you that you cannot do the things you want to do? | | | | No Concerns | | | |
| Y N D N/A | Other: | | | | No Concerns | | | |
| 1. **Sense of Well-Being and Safety (Select the question asked by checking the corresponding box)** | | | | | | | | |
| Y N D N/A | Do you feel safe here? | | | | No Concerns | | | |
| 1. **Notice (Select the question asked by checking the corresponding box)** | | | | | | | | |
| Y N D N/A | Does anyone tell you how you can spend your money? | | | | No Concerns | | | |
| Y N D N/A | Other: | | | | No Concerns | | | |
| 1. **Notes** | | | | | | | | |
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