California Consumer Information Questionnaire for Skilled Nursing Facilities

Facility Name and Contact Information

Facility Name: _____

Address: _____

City: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____ TDD (if any): (____)_____

E-mail Address: _____ Web Address (URL): _____

Person Completing Questionnaire (*Required*)

Full Name: _____ Position: _____ Date: _____

E-mail Address: _____ Phone Number: _____

** Three Easy Options for Filling Out This Questionnaire:*

1. **Complete Online at http://www.NursingHomeGuide.org**
2. **Mail to:** California Consumer SNF Project, 650 Harrison Street, 2nd Floor, San Francisco, CA 94107
3. **Fax to:** (415) 777-2904

*** (please answer every question)**

Admissions: Types of Residents Accepted

Age 18-30	☐Yes	☐No	Residents needing Dialysis	☐Yes	☐No
(If so, what % in this age range) _____			Naso-Gastric/Gastro-Intestinal Tube	☐Yes	☐No
Age 30-60	☐Yes	☐No	Tracheotomy	☐Yes	☐No
(If so, what % in this age range) _____			Oxygen Therapy Dependent	☐Yes	☐No
ALS	☐Yes	☐No	Psychiatric [primary diagnosis]	☐Yes	☐No
HIV / AIDS	☐Yes	☐No	Respite	☐Yes	☐No
Huntington's	☐Yes	☐No	Ventilator	☐Yes	☐No
Multiple Sclerosis	☐Yes	☐No	Wanderers	☐Yes	☐No
Spinal Cord Injury	☐Yes	☐No	Sub-Acute/Medi-Cal Contract	☐Yes	☐No

Special requirements for admission (e.g., religious affiliation, gender, continuing care contract, etc.):

_____

Which of the following services does your facility offer?

Hospice Care	☐Yes	☐No	Secured Alzheimer's Unit	☐Yes	☐No
Dialysis	☐Yes	☐No	Other Alzheimer's Unit	☐Yes	☐No
Infectious Disease Care (Isolated)	☐Yes	☐No	Wanderer Alert System	☐Yes	☐No
24-Hour Security Guards/Systems	☐Yes	☐No	Air Conditioned Rooms	☐Yes	☐No
Locked Ward	☐Yes	☐No	Culture Change Initiative	☐Yes	☐No

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Which languages other than English are spoken by direct-care staff on a daily basis?

☐ Tagalog ☐ Cantonese ☐ Mandarin ☐ Japanese
☐ German ☐ Russian ☐ Spanish ☐ Yiddish
☐ Sign Language (ASL)

Other languages, not listed above (separate by commas):_____

Food:

Vegetarian Selections? ☐Yes ☐No Kosher Selections? ☐Yes ☐No Ethnic Selections? ☐Yes ☐No

Ethnic selections or other accomodations of food choices: _____

Bed Types

Is the facility a freestanding nursing facility?.....☐ Yes ☐ No

Does the facility accept Medi-Cal? .....☐ Yes ☐ No

Does the facility have a Medi-Cal Subacute contract?.....☐ Yes ☐ No If "Yes," # beds covered: ____

Are there RCFE (aka 'Assisted Living') beds on the same premises?.....☐ Yes ☐ No If "Yes," how many: _____

Is your facility a Continuing Care Contract (CCC) Facility? .....☐ Yes ☐ No

If a CCC Facility, does your nursing facility unit accept patients from outside your community? ..... ☐ Yes ☐ No

Certification Information

Has facility filed intent to withdraw from Medi-Cal program?.....☐ Yes ☐ No If "Yes," date filed:_____

Family Council

Is there a family council active at the facility? .....☐ Yes ☐ No

If "Yes," contact & phone number:_____

Staff

	Name	Since	E-Mail
Administrator:	_____	_____	_____
Medical Director:	_____	_____	_____
Director of Nursing:	_____	_____	_____

Business Info

Licensee: _____ License Number:_____

Principal Owner: _____ Since: _____

Parent Corporation: _____ Since: _____

Address: _____ City:_____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____ Web Address (URL):_____