DSHS
WASHINGTON STATE Department of Social and Health Services

| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER |
|---|---|
| PROVIDER / LICENSEE'S NAME | INSPECTION DATE |
| LICENSOR'S NAME | |

ATTACHMENT M

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ADULT FAMILY HOME (AFH)

# Administrative Records Review

**Instructions:** *Full* review sample should include one current caregiver hired since the last inspection and one of the following: Provider, Resident Manager, or Entity Rep. Conduct a *focused* review of background checks for all current staff. If the home does not have a specialty designation, mark "N/A" for that specialty and leave the line blank.

| STAFF | PROVIDER OR ENTITY REP | RESIDENT MANAGER | CAREGIVER | CAREGIVER | CAREGIVER |
|---|---|---|---|---|---|
| NAME | | | | | |
| DATE OF HIRE | | | | | |
| HOME ORIENTATION | | | | | |
| DATE OF BIRTH | | | | | |
| CONTACT INFO ON FILE | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| BGI EXPIRE DATE* | ☐ NR ☐ RR ☐ DQ | ☐ NR ☐ RR ☐ DQ | ☐ NR ☐ RR ☐ DQ | ☐ NR ☐ RR ☐ DQ | ☐ NR ☐ RR ☐ DQ |
| FINGERPRINT CHECK DATE (CHECK N/A IF NOT REQUIRED) | ☐ PENDING ☐ N/A | ☐ PENDING ☐ N/A | ☐ PENDING ☐ N/A | ☐ PENDING ☐ N/A | ☐ PENDING ☐ N/A |
| CCS EVALUATION* | ☐ N/A | ☐ N/A | ☐ N/A | ☐ N/A | ☐ N/A |
| TB TESTING MET | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| ORIENTATION AND SAFETY (5 HOURS) | | | | | |
| 70 HOUR BASIC **OR** | | | | | |
| FUNDAMENTALS OF CAREGIVING (WORKED PRIOR TO 01/01/202012) | ☐ ATTESTATION | ☐ ATTESTATION | ☐ ATTESTATION | ☐ ATTESTATION | ☐ ATTESTATION |
| CPR EXP. DATE | | | | | |
| FIRST AID EXP. DATE | | | | | |
| ND* TRAINING | | | | | |
| ND DIABETES FOCUS | | | | | |
| FOOD HANDLER EXP. | | | | | |
| **OR** FOOD SAFETY CE | | | | | |
| DOH LICENSE **TYPE**: | | | | | |
| DOH LICENSE **EXP**. | | | | | |
| NUMBER OF CE HOURS (N/A, IF NOT REQUIRED) | ☐ N/A | ☐ N/A | ☐ N/A | ☐ N/A | ☐ N/A |
| **SPECIALTY TRAINING** | | | | | |
| DEMENTIA ☐ N/A | | | | | |
| MENTAL HEALTH ☐ N/A | | | | | |
| DDA ☐ N/A | | | | | |

* BGI - Background Inquiry; NR - No Record; RR - Review Required; DQ - Disqualifying, CCS - Character, Competency, and Suitability; ND - Nurse Delegation; CE - Continuing Education

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ATTACHMENT M

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ADULT FAMILY HOME (AFH)

# Administrative Records Review

**TB Testing – Optional Worksheet**

This section can be used to assist in determining compliance with TB Testing requirements.
Once determined, indicate compliance status on Page 1.

| STAFF | PROVIDER OR ENTITY REP | RESIDENT MANAGER | CAREGIVER | CAREGIVER | CAREGIVER |
|---|---|---|---|---|---|
| DATE ADMINISTERED | | | | | |
| STEP 1 READ | | | | | |
| RESULT | ☐ Positive ☐ Negative | ☐ Positive ☐ Negative | ☐ Positive ☐ Negative | ☐ Positive ☐ Negative | ☐ Positive ☐ Negative |
| DATE ADMINISTERED | | | | | |
| STEP 2 READ | | | | | |
| RESULT | ☐ Positive ☐ Negative | ☐ Positive ☐ Negative | ☐ Positive ☐ Negative | ☐ Positive ☐ Negative | ☐ Positive ☐ Negative |
| 1 ADDITIONAL TEST DATE ADMINISTERED | | | | | |
| 1 ADDITIONAL TEST DATE READ | | | | | |
| RESULT | ☐ Positive ☐ Negative | ☐ Positive ☐ Negative | ☐ Positive ☐ Negative | ☐ Positive ☐ Negative | ☐ Positive ☐ Negative |
| BLOOD TEST | | | | | |
| RESULT | ☐ Positive ☐ Negative | ☐ Positive ☐ Negative | ☐ Positive ☐ Negative | ☐ Positive ☐ Negative | ☐ Positive ☐ Negative |
| X-RAY | | | | | |
| RESULT | ☐ Positive ☐ Negative | ☐ Positive ☐ Negative | ☐ Positive ☐ Negative | ☐ Positive ☐ Negative | ☐ Positive ☐ Negative |

NOTES