|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Text  Description automatically generated | Residential Care Services (RCS)  **ALF / ESF / AFH Request for Records** | | | |
| Entity Name | | | | License Number |
| Visit Date | | Regulator Name | | Complaint Number |
| Please provide the following checked documentation for RCS review by . | | | | |
| **Resident Information** | | | | |
| **Resident Name:** | | | **Resident Name:** | |
| Face Sheet: | | | Face Sheet: | |
| Assessment: | | | Assessment: | |
| Care Plan: | | | Care Plan: | |
| Progress Notes: | | | Progress Notes: | |
| Physician Orders: | | | Physician Orders: | |
| MAR Months: | | | MAR Months: | |
| Incident Report / Investigation: | | | Incident Report / Investigation: | |
| Other: | | | Other: | |
| Other: | | | Other: | |
| **Resident Name:** | | | **Resident Name:** | |
| Face Sheet: | | | Face Sheet: | |
| Assessment: | | | Assessment: | |
| Care Plan: | | | Care Plan: | |
| Progress Notes: | | | Progress Notes: | |
| Physician Orders: | | | Physician Orders: | |
| MAR Months: | | | MAR Months: | |
| Incident Report / Investigation: | | | Incident Report / Investigation: | |
| Other: | | | Other: | |
| Other: | | | Other: | |
| **Resident Name:** | | | **Resident Name:** | |
| Face Sheet: | | | Face Sheet: | |
| Assessment: | | | Assessment: | |
| Care Plan: | | | Care Plan: | |
| Progress Notes: | | | Progress Notes: | |
| Physician Orders: | | | Physician Orders: | |
| MAR Months: | | | MAR Months: | |
| Incident Report / Investigation: | | | Incident Report / Investigation: | |
| Other: | | | Other: | |
| Other: | | | Other: | |
| **Resident Information Notes** | | | | |
|  | | | | |
| **Entity Information** | | | | |
| Characteristics Roster: | | | | |
| Staff Trainings or Inservice: | | | | |
| Policies: | | | | |
| Other: | | | | |
| **Staff Information** | | | | |
| **Staff Name:** | | | **Staff Name:** | |
| Background / Fingerprint Results: | | | Background / Fingerprint Results: | |
| TB Testing Information: | | | TB Testing Information: | |
| Continuing Education: | | | Continuing Education: | |
| Schedule: | | | Schedule: | |
| Other: | | | Other: | |
| Other: | | | Other: | |
| **Staff Name:** | | | **Staff Name:** | |
| Background / Fingerprint Results: | | | Background / Fingerprint Results: | |
| TB Testing Information: | | | TB Testing Information: | |
| Continuing Education: | | | Continuing Education: | |
| Schedule: | | | Schedule: | |
| Other: | | | Other: | |
| Other: | | | Other: | |
| **Staff Name:** | | | **Staff Name:** | |
| Background / Fingerprint Results: | | | Background / Fingerprint Results: | |
| TB Testing Information: | | | TB Testing Information: | |
| Continuing Education: | | | Continuing Education: | |
| Schedule: | | | Schedule: | |
| Other: | | | Other: | |
| Other: | | | Other: | |
| **Staff Information Notes** | | | | |
|  | | | | |