1. **GENERAL POLICIES AND PROCEDURES**
	1. Describe your capability to provide temporary overnight shelter for elders, and as needed, other household members.
	2. Describe your intake procedure to provide emergency shelter during the day, evening, overnight, and weekend hours.
	3. Describe your procedure for complying with local building codes and Board of Health regulations. Attach copies of any current certifications.
	4. Describe your handicap accessibility capacity.
	5. Describe your capacity/procedure to respond to the following emergencies Fire

Loss of utilities (power/heat)

Hurricanes and snowstorms

Floods

Medical crisis

Child and Adult Protective Services

1. What is your proposed rate for Emergency Shelter? per

Describe any additional charges.

1. For the units which will be utilized by ASAP consumers, check all which apply: Elevator access

Individual controls for heating and AC

Wheelchair accessible (including consumer units) Food available

H. What supplies, if any, (e.g. soap, towels, etc.) are provided to ASAP consumers?

Employee who completed this form Date:

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| --- |
| EMPLOYEE Records Review |
| Provider Date Monitor |  |  |  |  |  |
| Start Date& Termination Date, if applicable |  |  |  |  |  |
| Number of reference checks |  |  |  |  |  |
| CORI Check |  |  |  |  |  |
| Job Description(s) |  |  |  |  |  |
| Annual Performance Appraisal: Date |  |  |  |  |  |
| Comments**Obtain Current copy of DPH License** |

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| CONSUMER Record Review |
| Provider Date Monitor |  |  |  |  |  |
| ASAP Authorization |  |  |  |  |  |
| ID Info – name; address; phone; DOB |  |  |  |  |  |
| Emergency Contact(s) name and phone |  |  |  |  |  |
| Name of current CM |  |  |  |  |  |
| Start Date& Termination Date, if applicable |  |  |  |  |  |
| Comments |
| NOTE: Shaded data elements are only required in the Consumer File if provider is not on Provider Direct.  |
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