

ADULT DAY CARE CENTER
Checklist for State Licensure

FACILITY NAME: _____

CITY: _____

CONTACT PERSON: _____

PHONE: _____ EMAIL: _____

Please mail or E-mail the following items to Healthcare Licensing and Surveys:

| CHECK OFF | ITEM |
|----------------------|--|
| | 1. A completed license application form and required fee. |
| | 2. Copy of organizational chart that reflects the administrative control and lines of authority for the delegation of responsibility from management down. |
| | 3. Copy of Admission policies. |
| | 4. Copy of Discharge policies. |
| | 5. Evidence of public liability insurance for bodily injury with a minimum limit of \$500,000 each occurrence/\$500,000 aggregate. |
| | 6. Policies regarding hiring of staff (including evidence of DFS central registry checks and State Board of Nursing registry check). |
| | 7. Policies regarding employee health, including tuberculosis screening. |
| | 8. Qualifications of the Program Director. |
| | 9. Policy regarding staffing (ratio of staff to participant). |

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| | 10. Policy on medication management. |
| | 11. Copy of participant rights. |
| | 12. List of mealtimes and/or snack time. |
| | 13. Emergency plans/procedures. |
| | 14. Written plan for internal evaluation of the program (formal evaluation to be completed annually). |
| | 15. Monthly schedule of activities. |
| | 16. Evidence at least one staff person with current CPR and first aid certification will be on premises at all times during hours of operation. |

FOR HEALTHCARE LICENSING AND SURVEYS USE ONLY

Date:

Surveyor Assigned to Review:

Surveyor Review Summary and Comments:

Healthcare Surveillance Branch Chief Comments:

Additional Information Needed: **Approved:** **Denied:**

Date: **Signature:**