



## Regional Center Program Design Questionnaire

We recommend the following steps when completing this questionnaire.

- Copy the questionnaire to your hard drive.
- Ensure you have a current version of Adobe Reader installed on your laptop or desktop computer. When completing the questionnaire on a tablet device, we recommend you install the Adobe Reader app on that device. You will be able to save your work at any time.
- If you prefer, you can print the questionnaire and hand write your answers.
- Having trouble? Please let us know. We will schedule a phone call and complete the form for you via phone interview.

Please answer the following questions so that we can start your *Regional Center Program Design*. Let us know at any time if you have questions or need clarification on anything.

Once you have completed the questionnaire, email, fax, or mail it to us using the contact information in the footer of this form. We will call you to discuss your project shortly thereafter. Please provide the name and number of the person you want us to contact below.

Contact name

Contact phone number (    )

### *Questions*

1. At which Regional Center will submit your application?

[See the Regional Centers we write Program Designs for](#)

2. What type of facility will be vendored?

- GH  
Group Home  
(i.e., age 3-17)
- ARF  
Adult Residential Facility  
(i.e., age 18-59)
- RCFE  
Residential Care Facility  
for the Elderly (i.e., age 60 or †)

3. Is your license in the name of a sole proprietor, Partnership, Limited Liability Company, or corporation?

- Sole Proprietor     Partnership     Limited Liability Company     Corporation

3b. What is the exact name of that sole proprietorship, Partnership, Limited Liability Company, or corporation?

4. What is the name, address, and phone number of your facility?

Facility Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Phone Number \_\_\_\_\_

4b. Please provide a brief description of the house below, including the number of private and shared bedrooms, bathrooms, whether single story or multiple floors, if there is a facility vehicle, and any other features you'd like to include.

5. What is the name of the Administrator as you would like it to appear on the application?

5b. Please write a few lines below regarding the Administrator's background, education, etc. Administrator's must have a minimum amount of experience working with the DD population, as follows: Level 2 = 6-months; Level 3 = 9-months; and Level 4 = 12-months.

5c. Does the Administrator have a current GH, ARF or RCFE Administrator certificate?

- Yes       No       In the process  
of renewing

5d. For Group Homes, ARF's, and RCFE's does the Administrator have a current current First Aid certification? A LVN, RN, or higher license will satisfy this requirement.

- Yes     No     LVN     RN     Other (specify) \_\_\_\_\_

- 5e. For RCFE's, we recommend the Administrator have a current First Aid certification *and* CPR (or LVN, RN, or higher license)? If you are opening a RCFE, do you have CPR?

<i>CPR</i>	<i>I am an</i>
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> LVN, RN, or higher

- 5f. Regional Centers have a variety of other requirements that must be satisfied by the Licensee and/or Administrator, such as the RSS/RSO, training in applied behavioral analysis, etc. If you haven't contacted the person that vendors new facilities at your regional center, we recommend you do so right away. Please list any additional regional center requirements that you have satisfied, or need to satisfy, below.

6. If your facility will be Level 4, will your staff be trained in ProAct, CPI, or some other management of assaultive behavior system?

N/A     ProAct     CPI     Other (*specify*) \_\_\_\_\_

7. Would you like to incorporate your own House Rules, Grievance Procedure, program philosophy, or other information into your application or should we use samples? You can email, fax, or mail information you want us to use.

Use samples                       I will email, fax, or  
mail information to you

8. Do you want us to use a specific physician, dentist, psychiatrist, or pharmacy, or should we use samples in your area?

Use samples                       Use those indicated  
below

<i>Name</i>	<i>Profession</i>
	Physician
	Dentist
	Psychiatrist
	Pharmacy
	Other ( <i>specify</i> )
	Other ( <i>specify</i> )

9. Do you want us to use specific day programs, schools, employment, etc., or should we use samples from your area?

- Use samples
- Use those indicated below

*Name of School, Day Program, Employment, etc.*

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10. What capacity will you request?

- 1
- 2
- 3
- 4
- 5
- 6
- Other (*specify*) \_\_\_\_\_

11. Which gender(s) will you accept?

- Male
- Female
- Both

12. Which ambulatory status will you accept? How many of each?

- Ambulatory \_\_\_\_\_  
How many?
- Non-Ambulatory \_\_\_\_\_  
How many?
- Bedridden \_\_\_\_\_  
How many?

13. What level will you be vendored as?

- 2O
- 2S
- 3O
- 3S
- 4A
- 4B
- 4C
- 4D
- 4E
- 4F
- 4G
- 4H
- 4I

Note: O = Owner Operated and S = Staff Operated. Staff operated rates are slightly higher.

[See current Regional Center rates](#)

14. If your facility will be Level 4, will the needs of the residents be primarily behavioral or medical?

- Behavioral
- Medical
- Other (*specify*) \_\_\_\_\_

15. For Level 4 only. Indicate the behaviors you *will* and *will not* accept.

*Behaviors you will accept*

*Behaviors you will not accept*


16. For Level 4 only. Indicate the medical conditions you *will* and *will not* accept, or have been granted an exception/waiver for.

*Medical conditions you will accept*

*Medical conditions you will not accept*


17. Who will your behavior (or nurse, etc.) consultant be? Please note that you may need to attach to your Program Design a signed contract, license and résumé, and sample initial behavior (or nursing, etc.) assessment from that consultant.

Please write any comments or questions you have below.

Thank you

*RAMEAL, MA*