RA Mears CONSULTING
R A Mears, M.A.
Residential Services Consultant

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?

CPR	*I am an*
○ Yes ○ No	○ 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

Name	*Profession*
	Physician
	Dentist
	Psychiatrist
	Pharmacy
	Other (*specify*)
	Other (*specify*)

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.

_____
_____
_____
_____
_____
_____

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

RANdall, MA