**Agency Survey Addendum: ELDER AND DISABLED ADULT LIVING**

**Agency Name:**

To get a clear picture of the services you provide and the populations that you serve, please complete this form in addition to the Agency Survey form. Please read all the categories, and indicate all that apply to your organization regularly? This completed form will help us to make only the most proper referrals to your organization. *Please provide a copy of your DHR license/certification and any other official documentation.*

Please specify program type(s) offered (check all that apply):

<table>
<thead>
<tr>
<th>Type of Program</th>
<th>Program Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Residential Care Homes</td>
<td>Group Residencies for Adults with Disabilities</td>
</tr>
<tr>
<td>Hospice Facility</td>
<td>Continuing Care Retirement Communities</td>
</tr>
<tr>
<td>Assisted Living Facility</td>
<td>Adult Day Program Center</td>
</tr>
<tr>
<td>Subacute Care Nursing Facilities</td>
<td>Semi-independent Living Residences for Adults with Disabilities</td>
</tr>
<tr>
<td>Congregate Living Facility</td>
<td></td>
</tr>
<tr>
<td>Independent Living Community/Complexes for Older Adults</td>
<td></td>
</tr>
</tbody>
</table>

**Please list specific fees:**

- [ ] No Fee
- [ ] Straight Fee; please specify:
- [ ] Sliding Fee Scale; specify range:

**Please indicate if you accept:**

- [ ] Medicaid
- [ ] Medicare
- [ ] Social Security
- [ ] Private Insurance
- [ ] Other:

**Location of Services:**

- [ ] Center-based
- [ ] Out of client’s home
- [ ] Other:

Do you offer transportation to/from doctor appointments?

- [ ] Yes
- [ ] No

If yes, is there an additional fee? (Specify)

- [ ] Yes, the transportation costs are included
- [ ] Yes, there is an additional fee
- [ ] No

Is transportation:

- [ ] bus
- [ ] car
- [ ] van

**Do you administer prescribed medications?**

- [ ] Yes
- [ ] No

If yes, who administers the medication?

- [ ] Nurse Practitioner
- [ ] MD
- [ ] Other staff (specify):

**Meals provided:**

- [ ] Breakfast
- [ ] Lunch
- [ ] Dinner
- [ ] Snack

Do you have a dietician on staff?

- [ ] Yes
- [ ] No

**Do you provide meals for individuals with special needs** (i.e., low sodium, puree meals for those who cannot chew)?

- [ ] Yes
- [ ] No

If yes, please specify types of special meals:

**Activities provided:**

- [ ] Outdoor Trips
- [ ] Outdoor Activities
- [ ] Game Room
- [ ] Movie time
- [ ] Computer Access
- [ ] Music/Dance time
- [ ] Fitness Center
- [ ] Others (specify):