

CAADS Web Listing Form

LICENSED PROVIDERS



caads
CA Association for Adult Day Services
COMMUNITY | CONNECTION | CHOICE

Revised 2019-05-20

Only licensed adult day centers in membership with CAADS are eligible for a listing on CAADS Web Site.

TO UPDATE EXISTING LISTING: Print listing from CAADS Web Site, mark changes, sign, date and **FAX TO: (866) 725-3123**. Listings appear alphabetically by center name, within each county, under the *Find a Center* tab at www.caads.org.

TO SUBMIT NEW LISTING: Complete this form and send to CAADS along with **photocopy of Center license**. For multiple centers, complete a separate form for each one – you may photocopy this form. **FAX TO: (866) 725-3123**

QUESTIONS: Contact Danielle Hanlon, Director of Membership & Communications: (916) 552-7400 or Danielle@caads.org

COMPLETED BY: _____
(Print Name and Title) (Date) (Initial Here)

Center

Center/DBA: _____

Site Address: _____ City: _____ State: _____ Zip+4: _____

Site County: _____ Site Tel: (_____) _____

Site Email: _____ Website: _____

CENTER MAILING ADDRESS (if different than above):

Mail Address: _____ City: _____ State: _____ Zip+4: _____

Licensee

Licensee: _____ Year Center Opened: _____

Licensee is: For-Profit Governmental Non-Profit

Adult Day Services center state license is current and valid: Yes No

Program/s

Program Type/s (check **all** that apply):

- ADHC** – Adult Day Health Care (Medical) **CBAS** – Community Based Adult Services **ADCRC** – Alzheimer’s Day Care Resource Center
 ADP – Adult Day Program (Non medical) **FQHC** – Federally Qualified Health Center **PACE** – Program of All-Inclusive Care for the Elderly
 ADVP – Adult Day Vendorized Program (exclusively serving Regional Center clients)

Describe the Center’s target population, philosophy of care and other distinguishing features. Limit 100 words, typed or neatly written.
(CAADS reserves the right to edit descriptions exceeding word limit, without notice.)

Languages Spoken

Languages spoken by Center staff (check all that apply):

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Armenian | <input type="checkbox"/> Cambodian | <input type="checkbox"/> Chinese – Cantonese |
| <input type="checkbox"/> Chinese – Mandarin | <input type="checkbox"/> Chinese – Other | <input type="checkbox"/> Chinese – Unknown | <input type="checkbox"/> English |
| <input type="checkbox"/> Farsi | <input type="checkbox"/> French | <input type="checkbox"/> German | <input type="checkbox"/> Hebrew |
| <input type="checkbox"/> Hindi | <input type="checkbox"/> Hmong | <input type="checkbox"/> Ilocano | <input type="checkbox"/> Indo-Eur./Other |
| <input type="checkbox"/> Italian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean | <input type="checkbox"/> Laotian |
| <input type="checkbox"/> Mien | <input type="checkbox"/> Polish | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Samoan | <input type="checkbox"/> Sign – American | <input type="checkbox"/> Sign – Other | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Tagalog | <input type="checkbox"/> Thai | <input type="checkbox"/> Turkish | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Inquire <input type="checkbox"/> Other/s: _____ | | | |

Accessing Services / Intake Process

Intake Tel: (_____) _____ Intake Email: _____

Reply Time – how soon someone can expect to hear back after inquiring about program space availability and/or services (check one only):

- Next Business Day 2 Business Days 3 Business Days 1 Week

Describe your intake process – limit to 30 words: (CAADS reserves the right to edit descriptions exceeding word limit, without notice.)

Hours, Capacity and Attendance

ADHC / CBAS (Medical Model) Hours & Attendance

<u>Program Days</u>	<u>Hours of Operation</u>
Monday	_____ to _____
Tuesday	_____ to _____
Wednesday	_____ to _____
Thursday	_____ to _____
Friday	_____ to _____
Saturday	_____ to _____
Sunday	_____ to _____

Average Daily Attendance: _____
(per most recent MSSR filed with the state)

ADHC Licensed Capacity: _____
(per CA Department of Public Health)

ADP (Non-Medical Model) Hours & Attendance

<u>Program Days</u>	<u>Hours of Operation</u>
Monday	_____ to _____
Tuesday	_____ to _____
Wednesday	_____ to _____
Thursday	_____ to _____
Friday	_____ to _____
Saturday	_____ to _____
Sunday	_____ to _____

Average Daily Attendance: _____

ADP Licensed Capacity: _____
(per CA Department of Social Services)

Payments Accepted

Center accepts payment by (check all that apply):

- Medi-Cal Managed Care (CBAS) Contract/s with: _____
- Medi-Cal FFS/Regular Fee-for-Service Long Term Care Insurance Private Health Insurance Private Pay
- Regional Center Funding Veterans Administration Other: _____

Who We Serve

Center serves individuals ranging in age (check one only):

- 18 years or older (no upper limit) From age _____ to age _____ Average Client Age: _____

Other Eligibility Requirements: _____

Special Populations

We serve the following specialized populations (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Alzheimer's / Related Dementia | <input type="checkbox"/> Behavioral Health | <input type="checkbox"/> Cultural Focus: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Homeless <input type="checkbox"/> Intergenerational |
| <input type="checkbox"/> Lesbian, Gay, Bisexual, Transgender | <input type="checkbox"/> Persons with Developmental Disabilities | <input type="checkbox"/> Post-Stroke / Neurological |
| <input type="checkbox"/> Physical Disabilities | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Veterans |
| <input type="checkbox"/> Other: _____ | | |

Activities of Daily Living

We provide supervision and assistance with (check all that apply):

- Bathing Eating Toileting Transferring (Getting Up) Walking

Medical Devices

We provide supervision and assistance with (check all that apply):

- Catheter Colostomy Feeding Tube Oxygen Devices Wheelchair

Other

We provide supervision and assistance with (check all that apply):

- Behavioral Challenges Incontinence Training Injections Medications Monitoring Non-Ambulatory

Additional Offerings

ADHC / CBAS and ADP centers have separate state licensing requirements

ADHC: Must have licensed / credentialed staff to provide or arrange for the services marked [H] below.
(A home visit and assessment are required prior to ADHC enrollment.)

ADP: Must provide or arrange for the services marked [P] below:

Additional Offerings (check all that apply):

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Activity Program [H P] | <input type="checkbox"/> Adult Education | <input type="checkbox"/> Art Therapy | <input type="checkbox"/> Care Coordination [H] |
| <input type="checkbox"/> Care & Supervision [P] | <input type="checkbox"/> Community Outings | <input type="checkbox"/> Caregiver Support Groups | <input type="checkbox"/> CBHH Project Site |
| <input type="checkbox"/> Dietary Services [H] | <input type="checkbox"/> Gardening Therapy | <input type="checkbox"/> Health Check-Ups | <input type="checkbox"/> Meals [H P] |
| <input type="checkbox"/> Medication Administration [H] | <input type="checkbox"/> Medication Management [H] | <input type="checkbox"/> Money Management | <input type="checkbox"/> Music Therapy |
| <input type="checkbox"/> Occupational Therapy [H] | <input type="checkbox"/> Overnight Respite | <input type="checkbox"/> Pet Therapy | <input type="checkbox"/> Physical Therapy [H] |
| <input type="checkbox"/> Physician Services [H] | <input type="checkbox"/> Psychology / Psychiatry [H] | <input type="checkbox"/> Secured Perimeter | <input type="checkbox"/> Skilled Nursing [H] |
| <input type="checkbox"/> Social Worker Services [H] | <input type="checkbox"/> Speech Therapy [H] | <input type="checkbox"/> Transportation [H P] | <input type="checkbox"/> Vaccination Clinics |
| <input type="checkbox"/> Other: _____ | | | |

FUTURE PLANS

The following WILL NOT BE POSTED to the Web, nor disclosed without your permission.

To assist CAADS in identifying industry trends, please indicate your future plans (check all that apply):

- | | | | |
|---|---|---|---|
| <input type="radio"/> Additional Facility:
__ Build New OR __ Buy Existing | <input type="radio"/> Expand Current Facility Size | <input type="radio"/> Move Facility | <input type="radio"/> Sell Facility |
| | <input type="radio"/> Request Licensed Capacity Increase | <input type="radio"/> Change to Non-Profit | <input type="radio"/> Close Facility |
| <input type="radio"/> Other _____ | | | |

Services your organization provides, in addition to Adult Day Services (check all that apply):

- Board & Care CORF Home Health Hospice In-Home Care
 MSSP Nursing Facility/NF RCFE Regional Center Services Other _____

Thank You for providing this information to CAADS!