

COMPLIANCE FORM FOR DEPARTMENT APPROVED PROVIDER

INITIAL APPLICATION DATE: _____

RENEWAL DATE: _____

Name of Provider _____

Telephone Number _____

Address _____

TYPE OF CARE

<input type="checkbox"/> In-Home Day Care	<input type="checkbox"/> Chore	<input type="checkbox"/> Companion	<input type="checkbox"/> Homemaker
<input type="checkbox"/> Adoptive Parent	<input type="checkbox"/> Child Foster Parent	<input type="checkbox"/> Family Day Care	<input type="checkbox"/> Adult Foster/Family Care
<input type="checkbox"/> Adult Day Care			

CRIMINAL RECORDS SEARCH (Section 2.1B) Requested _____ (date requested) Not Requested

1. _____ Name _____ Date Verif. Rec'd _____	3. _____ Name _____ Date Verif. Rec'd _____
2. _____ Name _____ Date Verif. Rec'd _____	4. _____ Name _____ Date Verif. Rec'd _____

OTHER SOURCES OF INFORMATION

References (Section 2.1D)	<input type="checkbox"/> Requested: Date Completed _____	<input type="checkbox"/> Not Needed
Employment History (Section 2.1D)	<input type="checkbox"/> Requested: Date Completed _____	<input type="checkbox"/> Not Needed
Medical: Tuberculosis (Section 2.1F)	<input type="checkbox"/> Requested: Date Completed _____	<input type="checkbox"/> Not Needed
Medical: Other Examination (Section 2.1F)	<input type="checkbox"/> Requested: Date Completed _____	<input type="checkbox"/> Not Needed
Fire Inspection (Section 2.3B)	<input type="checkbox"/> Requested: Date Completed _____	<input type="checkbox"/> Not Needed
Sanitation Inspection (Section 2.3C)	<input type="checkbox"/> Requested: Date Completed _____	<input type="checkbox"/> Not Needed

INTERVIEW(S) DATES, LOCATION, AND WITH WHOM

VARIANCE None Variance Requested _____ Date Requested _____
 Granted Denied _____ Date Requested _____

Standards(s) on which Granted _____

ACTION

Initial: Full Approval Emergency Approval Denied: reason _____

Renewal: Full Approval Provisional Approval Suspension Revocation: reason _____

Approval Period _____ to _____ Capacity _____

Signature of Worker

Date

Signature of Supervisor

Date

Secondary Action: Full Approval Provisional Approval Suspension Revocation: reason _____

Secondary Approval Period _____ to _____ Capacity _____

Signature of Worker

Date

Signature of Supervisor

Date

MONITORING VISITS

1. _____
Date _____ Comments _____

Worker

2. _____
Date _____ Comments _____

Worker

3. _____
Date _____ Comments _____

Worker

4. _____
Date _____ Comments _____

Worker

COMPLIANCE CHECKLIST
PART A: ALL PROVIDERS

Code Responses Y=Yes, N= No, N/A= Not Applicable
 "Yes" Means Compliance, Except Where * Appears, No Means Compliance

STANDARDS	CODE	NOTES/COMMENTS
2.1 Standards For Providers And Other Persons		
A. Age		
Chore or Companion provider is at least 16		
Other provider is at least 18		
Assistant <input type="checkbox"/> No <input type="checkbox"/> Yes _____ is at least 16		
Criminal Record		
Has the provider been convicted of a felony or misdemeanor which jeopardizes safety or proper care of clients?	*	
OUT-OF-HOME: Has the assistant, spouse, or any adult household member who has contact with clients been convicted of a felony or misdemeanor which jeopardizes the safety or proper care of clients?	*	
C. Child Abuse/Neglect Records (Care For Children Only)		
Does the provider have a founded or unfounded/reason-to-suspect record in central registry?		
OUT-OF-HOME: Does the assistant, spouse, or any adult household member who has contact with clients a founded or unfounded record in central registry?		
D. Assessment (From Interview, Reference, and Employment History)		
Provider gave two references unrelated to the provider as follows (Initial application only)		Statement if oral: _____
1 _____ Name Date Verified		_____
2 _____ Name Date Verified		_____
Provider gave information on employment history as follows (Initial application only)		Statement if oral: _____
1 _____ Employer Date Verified		_____
2 _____ Employer Date Verified		_____
3 _____ Employer Date Verified		_____
4 _____ Employer Date Verified		_____
Provider is knowledgeable in providing necessary care to client.		
Provider is physically and mentally capable to provide necessary care to client.		
Provider is able to sustain positive and constructive relationships with client.		
Provider is able to relate to client with respect, courtesy and understanding.		
Provider is capable of handling emergencies with dependability and good judgment.		
Provider is able to communicate and follow instructions sufficiently to assure adequate care, safety and protection for client.		
<i>Adoption Only</i>		
Adoptive parent(s) demonstrate a capacity to love and nurture a child born to someone else.		
Adoptive parent(s) can accept the child for his/her own sake without expecting child to resolve family problems or fulfill family ambitions.		
Married couples show marital stability and mutual satisfaction with each other.		
Financial information \$ _____ \$ _____ Annual Income Property Value		
Savings/investment \$ _____ Debts \$ _____		
<i>Adult Foster Care And Foster Parent Only</i>		
Provider has sufficient income/resources to meet the basic needs of the provider's own family.		
\$ _____ Source of income Approximate annual amount		

COMPLIANCE CHECKLIST
PART A: ALL PROVIDERS

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STANDARDS	CODE	NOTES/COMMENTS
D. Assessment (Continued)		
<i>Homemaker Only:</i>		
Homemaker has appropriate knowledge, skills and ability in:		
a. Home management and household management		
b. Personal care of young children/ill/disabled/aged		
c. Child rearing		
d. Nutrition, meal planning and preparation/special diets		
e. Personal hygiene and consumer education		
E. Training		
Provider will attend orientation and training as follows: (Code N/A if not offered)		

F. Medical Requirements		
Provider is believed to be free from tuberculosis in a communicable form (initial application only unless a problem is suspected. Requirement does not apply to chore or other in-home provider if relative or friend of client.)		
1 _____ Name Date Verified		
2 _____ Name Date Verified		
Out-Of-Home: Assistant and adult household members who come in contact with clients are believed to be free from tuberculosis in a communicable form (initial application only)		
1 _____ Name Date Verified		
2 _____ Name Date Verified		
3 _____ Name Date Verified		
Provider submits results of physical/mental health exam when requested by the department. Adoptive parents submit physical exam.		
1 _____ Name Date Received		
2 _____ Name Date Received		
2.2 Standards for Care		
A. Non-Discrimination		
Does the provider discriminate against clients in care on the basis of race, color, sex, national origin, age, religion or handicap?	*	
B. Supervision (Excluding Chore, Companion and Homemaker Providers)		
Provider has a plan for seeking assistance from police, fire-fighters and medical professionals in an emergency.		
Provider has a responsible adult available to substitute in an emergency		
Name(s) of substitute: _____		
Provider understands that substitute arrangements must be approved by the department if extended absence of the provider is required		
Family Or In-Home Day Care Only:		
Provider understands that children must be supervised by an adult (18 and older) at all times.		
C. Food (Excluding Chore, Companion and Homemaker Providers)		
Clients will/do receive meals and snacks appropriate to the hours of care and daily nutritional needs of clients. Clients in residential care must receive three meals per day.		
Clients will/do receive special diets when prescribed by a physician or in accordance with religious, ethnic, or special needs.		
Drinking water is available at all times		

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PART A: ALL PROVIDERS

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STANDARDS	CODE	NOTES/COMMENTS
D. Transportation of Client		
Provider will/does transport clients. <input type="checkbox"/> yes <input type="checkbox"/> no (skip to next section)		
Provider has valid drivers license.		
Provider has automobile liability insurance.		
Vehicle has valid license.		
Vehicle has valid inspection sticker.		
Provider <input type="checkbox"/> does not <input type="checkbox"/> does transport children under age and weight requirements of Virginia law which requires child restraint devices. If yes, provider uses such devices properly.		
E. Medical Care (Excluding Chore Providers)		
Provider will have/has name, address, and phone number of each client's physician easily accessible.		
Provider has first aid supplies easily accessible.		
<i>Out-Of-Home:</i> Provider will/does keep medicine and drugs separate from food except those requiring refrigeration.		
<i>Family And In-Home Day Care Only:</i> Provider will/does only give prescription drugs with a prescription label or physicians order and with parent/guardians written consent.		
Provider will/does only give non-prescription drugs with parent/guardians written consent.		
Provider understands all major injuries, accidents and all head injuries must be reported to the parent/guardian immediately.		
Provider will have/has authorization for emergency medical care for each child.		
<i>Family Day Care Only:</i> Provider understands that he or she may refuse to accept a sick child.		
Provider will/does isolate a sick child and notify parent/guardian immediately.		
Provider will/does label all drugs with the child's name and return them to the parent/guardian when no longer needed.		
Provider will/does keep all drugs out of reach of children.		
F. Discipline Of Children		
Provider will/has established rules that encourage desired behavior and discouraged undesired behavior.		
Provider understands that he/she must not use corporal punishment.		
Provider understands that he/she must not humiliate or frighten any child in care.		
Provider understands that he/she must not withhold food, force naps or punish toileting accidents.		
G. Activities		
<i>Family or In-Home Day Care Only:</i> Provider will/does provide appropriate structured activities and unstructured experiences.		
Provider will/does provide opportunities for outdoor play as well as quiet activity daily.		
Provider will/does limit types of TV programs and does not use TV as a substitute for planned activity.		
<i>Adult Day Services Only:</i> Provider will/does provide recreational and other planned activities appropriate to the needs interests and abilities of adults in care.		
H. Abuse, Neglect Or Exploitation Responsibility Reporting		
Provider understands that he/she must immediately report any suspected abuse, neglect or exploitation of clients in care to the local department.		
I. Foster Parent Clothing Requirements		
Foster parent(s) will/does provide appropriate clothing for the age and size of each child in care.		
Foster parent(s) will/does launder or dry clean and alter or repair clothing of each child as needed.		

COMPLIANCE CHECKLIST

PART B: OUT-OF-HOME PROVIDERS (Use ONLY with Part A)

Name of Provider:		Date Completed:
STANDARDS	CODE	NOTES/COMMENTS
2.3 Standards For The Home A. Physical Accommodations		
Home has sufficient, appropriate space and furnishings for each client in care.		
Home has space to keep client's clothing and personal belongings.		
Home has accessible basin and toilet facilities.		
<i>Residential Care Only:</i> Home has at least one toilet, one basin, and one tub or shower for every 8 persons in the household.		
Home has comfortable sleeping/napping furnishings.		
Home has sleeping space on first floor for clients (other than small children) unable to use stairs (Code yes if space is available. Code N/A if space is not available and no clients are present who would require it; note this limitation on certificate. Code no if space is not available and clients who require it are present.)		
Home has space for recreational activities.		
Home has sufficient space and equipment for food preparation, service, and proper storage.		
All rooms used by clients are heated in winter, dry and well ventilated.		
All doors and windows used for ventilation are screened.		
Rooms used by clients are adequately lit for activities and the comfort of clients.		
Home has access to a working phone. If yes, location is: <input type="checkbox"/> in home <input type="checkbox"/> outside home; specify location		
Home is in compliance with the following local ordinances (specify applicable ordinances): _____ _____ _____ _____		
<i>Adult Foster Care Only:</i>		
Maximum number of adults sharing a room is two.		
If a room is shared, it is shared only by adults of the same sex or those who are married or related to each other who consent.		
Privacy is available outside of sleeping rooms to entertain or talk.		
<i>Foster Parent Only:</i>		
Maximum number of children sharing a room is four.		
There is at least 70 feet of space in a room occupied by one child.		
There is at least 50 square feet of space per child in a shared room.		
If a bed is shared, it is only by children of the same sex.		
B. Home Safety		
Home and grounds are free from litter and debris and present no safety hazard.		
Home is free from fire hazards (check one): <input type="checkbox"/> observation by worker <input type="checkbox"/> inspection by fire officials Date requested _____ Date completed _____		
Provider has written evacuation plan.		
Plan will be/is rehearsed twice a year.		
Plan will be/is reviewed with each new client other than an infant entering the home.		
All sleeping areas have an operable smoke detector.		

COMPLIANCE CHECKLIST

PART B: OUT-OF-HOME PROVIDERS

Code Responses Y=Yes, N= No,

N/A= Not Applicable: "Yes" Means Compliance, Except Where * Appears, No Means Compliance

STANDARDS	CODE	NOTES/COMMENTS
B. Home Safety (Continued)		
Attic or basement used by clients has two fire exit.		
Provider stores firearms and ammunition in a locked cabinet or inaccessible area.		
The provider will/does protect clients from household pets.		
C. Sanitation		
Water source: <input type="checkbox"/> public <input type="checkbox"/> private		
Sanitation: <input type="checkbox"/> public <input type="checkbox"/> private		
Inspection of private system(s) <input type="checkbox"/> not requested <input type="checkbox"/> requested; date		
Date inspection completed: _____ <input type="checkbox"/> approved <input type="checkbox"/> not approved (Code yes if private system requested. Code no if private system was inspected and not approved.)		
Home and grounds are free of garbage and debris.		
2.4 Capacity		
Clients currently receiving care (describe in relation to capacity limits for particular care): _____ _____ _____ _____ _____		
Other individuals requiring special attention (describe): _____		
Provider will not/does not exceed the capacity specified by the department.		
2.4 Client Record Requirements		
Provider will/does maintain written information on each client in care including: identifying information on the client.		
Name, address and home and work telephone numbers of responsible persons.		
Name and telephone number of another person in case of emergency when responsible person cannot be reached.		
Name of persons not authorized to call or visit the client.		
Date of admission and withdrawal.		
Medical information pertinent to the health care of the client.		
Correspondence related to the client and other written client information provided by the department.		
<i>Adult Foster, Family Day Care, Foster Parents:</i> Placement agreement.		
<i>Adult and Family Day Care Only:</i> Daily attendance record.		
<i>Family Day Care Only:</i> Authorization for classes, clubs, or other activities and individual authorization for each field or out-of-town trip.		
Provider understands that client records are confidential and cannot be shared without client approval except department representatives have to all records.		