



FINANCE  
245 LEPHILLIP COURT, NE  
CONCORD, NC 28025

## PBH Finance Communication Bulletin

FY-0708-FN-75

To: PBH Community of Network Providers – Providers of Residential Services for DD and DDMRMI Consumers  
From: Renee Snipes – Finance Director  
Date: April 11, 2008  
RE: Residential Survey

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Dear Provider:

PBH has worked with the Provider Network Council to develop a Residential Survey to assist in developing appropriate residential services for DD and DDMRMI consumers. The survey will also be used to determine appropriate rates for the residential services.

Attached please find the “Residential Survey (DD and DD/MR/MI) Form and Instruction Sheet (two tabs in workbook)

Please complete a survey for each of your consumers who receive DD and DD/MR/MI Residential Services funded through PBH.

Please return the forms (one for each consumer) to Sarah Chesley, Accounting Manager at PBH, 245 LePhillip Court, Concord, NC 28025 no later than April 30<sup>th</sup>.

If you have any questions, please feel free to contact Sarah via email [sarahe@pamh.com](mailto:sarahe@pamh.com), or by phone at 704-721-7002.

Thank you for your help and support.

Attachment: Residential Survey

cc: Network Department  
Sarah Chesley, Accounting Manager  
Lisa Harkey, Executive Assistant to the Area Director

## Instructions for Residential Survey Form

### SECTION A: General Information

This section is to gather general information about the Agency, the site and consumer  
Please enter a Contact Name and Phone Number in case we have any questions or need clarification

Number of beds in the facility - please enter the total number of beds available in the facility

Is this a licensed facility - please check yes or no

Other payment sources: If the consumer receives any funding from a source other than PBH,  
please indicate if it is from the Department of Social Services (DSS), self pay, HUD or other.

### SECTION B: PBH Funded residential Service Type

For Group Living Low, Group Living Moderate, Group Living High and Alternative Family  
Living, please check all boxes that apply

For Supported Living please enter which level applies to this consumer if any

For Supervised Living please enter which level applies to this consumer if any

For Residential Supports please enter which level applies to this consumer if any

### SECTION C: Staffing Pattern

Total Direct Care Staffing - please enter the total "full time equivalency" staff employed by the agency

For Shift Staffing: please enter the total number of full time equivalency staff for a 24 hour period

Total weekday FTE: please enter the total number of "full time equivalency" staff for a weekday

1st shift: enter the number of staff employed during the 1st shift on a weekday

2nd shift: enter the number of staff employed during the 2nd shift on a weekday

3rd shift: enter the number of staff employed during the 3rd shift on a weekday

\* 1st, 2nd, and 3rd shifts should equal Total weekday staff.

Total weekend FTE: please enter the total number of "full time equivalency" staff for a weekend

1st shift: enter the number of staff employed during the 1st shift on a weekend

2nd shift: enter the number of staff employed during the 2nd shift on a weekend

3rd shift: enter the number of staff employed during the 3rd shift on a weekend

\* 1st, 2nd, and 3rd shifts should equal Total weekend staff.

### SECTION D: Enhanced Support Service

Does the consumer have a "Behavior Support Plan" please check yes or no

crisis Services: Please enter the number of times during the year this consumer was in jail,  
in a hospital, and/or referred for crisis/emergency assessment

Psychiatric Inpatient services: please check the applicable box for the number of times this  
consumer received psychiatric inpatient services during the last year, 1, 1 to 2 or 2+ (more than two)

### SECTION E: Medical Needs

Please check the yes box for any of the medical needs listed that apply to this consumer.

### SECTION F: Miscellaneous

Does the consumer require night time awake staff - please check yes or no

Has the Medical Necessity for awake staff been determined by an MD or Psychiatrist - please check yes or no

Does the consumer require Occasional Situational Support at night - please check the box  
for the number of times per month 0, 0-2 or 2+(more than two)

How many hours of one on one staffing is required per day for this consumer (beyond routine staffing of the facility)  
please check the box for the number of hours per day, none, 1, 2 to 4, 5 to 8, or 9+

Annual number of days a residential bed was held while this consumer was on leave from the  
facility - please enter a number

Do you enhance your weekend staffing to promote individual outings with Residential funding - please  
check yes or no.



RESIDENTIAL SURVEY (DD and DD/MR/MI)

Please fill out one form for each consumer receiving DD and DD/MR/MI Residential Services funded through PBH

**A** Agency Name: \_\_\_\_\_ Consumer Name: \_\_\_\_\_  
 County (where facility/site is located): \_\_\_\_\_ Facility (Site) Name: \_\_\_\_\_  
 Contact Name and Phone No. of person completing this form: \_\_\_\_\_

Number of beds in this facility : \_\_\_\_\_  
 Is this a licensed facility?: yes  no

Does your current payment for residential services funded through PBH, for this consumer, include room and board: yes  no

Other payment sources: HUD  DSS  Self pay  Other

**B PBH Funded Residential Service Type:**

Group Living Low  Group Living Moderate   
 Group Living High  Alternative Family Living   
 Supported Living (Enter Level 1-4) \_\_\_\_\_  
 Supervised Living (Enter Level 1-6) \_\_\_\_\_  
 Residential Supports (Enter Level 1-4) \_\_\_\_\_

**C Staffing Pattern FTE (Full Time Equivalency): (number of staff for Residential only)**

Total Direct Care Staffing: \_\_\_\_\_  
 May include FTE% of Group Home Manager's Direct Care Time

Shift Staffing: Total weekday FTE \_\_\_\_\_ 1st shift \_\_\_\_\_ 2nd shift \_\_\_\_\_ 3rd shift \_\_\_\_\_  
 Total weekend FTE \_\_\_\_\_ 1st shift \_\_\_\_\_ 2nd shift \_\_\_\_\_ 3rd shift \_\_\_\_\_

*Note: 1st, 2nd and 3rd shift should equal Total FTE*

**D Enhanced Support Service:**

Behavior Support Plan yes  no   
 Crisis Services:  
 Number of times during year this consumer was: in jail \_\_\_\_\_ in hospital \_\_\_\_\_ referred for crisis/emerg assessment \_\_\_\_\_  
 Number of days this consumers received Psychiatric Inpatient services during last year: 0  1-2  2+

**E Medical Needs:**

Med administration yes  no  G - tube yes  no   
 On-site nursing procedure yes  no  PRN medication yes  no   
 Chronic Medical Intervention yes  no  Seizure management yes  no

**F** Consumer Requires Night Time Awake Staff (full time) yes  no   
 Medical Necessity for awake staff has been determined by MD or Psychiatrist yes  no   
 Consumer Requires Occasional Situational Support at night: frequency/month 0  0-2  2+   
 Does staff for this consumer require specialized training (beyond typical training) based on Habilitation Plan: yes  no   
 How many hours of one on one staffing is required for this consumer (beyond routine staffing of the facility) : none  1  2 to 4  5 to 8  9 +   
 Annual Number of Days consumer Residential Bed was held while consumer was on leave from facility: \_\_\_\_\_  
 Do you enhance your weekend staffing to promote individual outings with Residential funding: yes  no

*Note: if enhanced weekend staffing relates to a service other than residential (e.g. Community Networking), do not include here*

Thank you for taking the time to complete this form in order to help PBH set rates that support individual needs.