

DEPARTMENT OF HEALTH - DIVISION OF DRUG AND ALCOHOL PROGRAM LICENSURE
STAFFING REQUIREMENTS FACILITY SUMMARY REPORT

HD1028F

Facility Name _____
 Facility Address _____

 Facility # _____

Date (s) of Licensing Inspection _____
 Date Report Completed By Facility _____
 SCA _____

	DATE OF HIRE		ACCREDITED EDUCATION	Years of Experience In Human Service Agency Which included supervision, direct service and program planning	
	PROJECT	CURRENT POSITION	HIGHEST DEGREE: COLLEGE, UNIVERSITY YEAR, MAJOR	NO.OF YEARS	MAJOR DUTIES
Project Director Name: _____ Facility Job Title: _____					
Facility Director Name: _____ Facility Job Title: _____					

Attach copies of current CPR and First Aid cards to demonstrate coverage for all hours of operation.

For Inpatient Non-Hospital Residential Rehabilitation facilities (except transitional living facilities):

Position(s) providing 24-hour coverage, 7 days per week: _____

Attach work schedules for past 4 weeks

For Inpatient Non-Hospital detoxification only:

Name of physician(s) on call 24 hours/day: _____ **DEA#:** _____ **PA License #** _____

I attest to the accuracy, veracity and authenticity of this information.

Project/Facility Director Signature

Date

PROJECT DIRECTOR/FACILITY DIRECTOR
TRAINING REPORT

	GENERAL TRAINING DATE, PROVIDER AND NUMBER OF HOURS OF DEPARTMENT APPROVED CURRICULUM			ANNUAL TRAINING REQUIREMENT PRIOR TRAINING YEAR			
	HIV/AIDS	TB/STD/OTHER HEALTH ISSUES	DATE INDIVIDUAL TRAINING PLAN DEVELOPED	DATE	SUBJECT AREA	PROVIDER	NUMBER OF HOURS COMPLETED
PROJECT DIRECTOR							
FACILITY DIRECTOR							

Facility training year: _____ to _____

Date overall assessment of staff training needs completed: _____

CLINICAL SUPERVISOR, COUNSELOR AND COUNSELOR ASSISTANT QUALIFICATIONS*

(Include contracted staff/consultants who function in these positions)

CIRCLE CURRENT POSITION	DATE OF HIRE		EDUCATION	FULL CAC CERTIFICATION NUMBER AND EXPIRATION DATE	YEARS OF EXPERIENCE				
	ORIGINAL HIRE DATE AT FACILITY **	DATE OF CURRENT POSITION ***	DEGREE/YEAR/MAJOR INSTITUTION DATE OF ISSUE		TOTAL YEARS	DRUG AND ALCOHOL DIRECT SERVICE	NON- DRUG AND ALCOHOL CLINICAL	PRACTICUM	SUPERVISION
CLINICAL SUPERVISOR/LEAD COUNSELOR NAME _____ TITLE _____									
COUNSELOR OR COUNSELOR ASSISTANT NAME _____ TITLE _____									
COUNSELOR OR COUNSELOR ASSISTANT NAME _____ TITLE _____									
COUNSELOR OR COUNSELOR ASSISTANT NAME _____ TITLE _____									
COUNSELOR OR COUNSELOR ASSISTANT NAME _____ TITLE _____									
COUNSELOR OR COUNSELOR ASSISTANT NAME _____ TITLE _____									
COUNSELOR OR COUNSELOR ASSISTANT NAME _____ TITLE _____									
COUNSELOR OR COUNSELOR ASSISTANT NAME _____ TITLE _____									
COUNSELOR OR COUNSELOR ASSISTANT NAME _____ TITLE _____									

* Not all positions will meet the definitions of these classifications. List only those that match the definitions of these positions. All other employees are to be listed on page 7.

** Actual date continuous employment began with this facility.

*** Actual date continually employed in current position.

CLINICAL SUPERVISOR/COUNSELOR/COUNSELOR ASSISTANT TRAINING REPORT

(Include contracted staff/consultants who function in these positions)

CIRCLE CURRENT POSITION	GENERAL TRAINING		DATE AND PROVIDER OF SUPERVISION CORE CURRICULUM, IF REQUIRED	DATE INDIVIDUAL TRAINING PLAN DEVELOPED	NUMBER OF HOURS REQUIRED	ANNUAL TRAINING REQUIREMENTS PRIOR TRAINING YEAR	
	Date, Number of Hours, and Provider (Department approved curriculum)					NUMBER OF HOURS COMPLETED	
	HIV/AIDS	TB/STD/Other Health Issues				PROVIDED BY FACILITY STAFF	PROVIDED BY OUTSIDE TRAINER
CLINICAL SUPERVISOR/LEAD COUNSELOR NAME _____ TITLE _____							
COUNSELOR/COUNSELOR ASSISTANT NAME _____ TITLE _____							
COUNSELOR/COUNSELOR ASSISTANT NAME _____ TITLE _____							
COUNSELOR/COUNSELOR ASSISTANT NAME _____ TITLE _____							
COUNSELOR/COUNSELOR ASSISTANT NAME _____ TITLE _____							
COUNSELOR/COUNSELOR ASSISTANT NAME _____ TITLE _____							
COUNSELOR/COUNSELOR ASSISTANT NAME _____ TITLE _____							
COUNSELOR/COUNSELOR ASSISTANT NAME _____ TITLE _____							

HOURS PER WEEK AND CASELOAD COUNT ARE TO BE THE ACTUAL NUMBERS AS OF THE DATE OF THE SITE INSPECTION.

STANDARD WORK WEEK MUST BE ONE OF THE THREE: 40 HOURS 37.5 HOURS 35 HOURS

COMPLETE ONE FORM PER ACTIVITY: RESIDENTIAL REHABILITATION; AND PARTIAL HOSPITALIZATION

*****DO NOT COMPLETE IN ADVANCE OF THE SITE INSPECTION*****

CHECK THE APPROPRIATE ACTIVITY

Residential Treatment and Rehabilitation (Hospital)

Partial Hospitalization

Residential Treatment and Rehabilitation (Non-Hospital)

FACILITY PRIMARY CARE HOURS <input type="text"/> TO <input type="text"/> NAME	Project Director	Facility Director	Clinical Supervisor	Counselor	Counselor Assistant	TOTAL HOURS WORKED PER WEEK AT THIS FACILITY	NUMBER OF HOURS PER WEEK PER ACTIVITY				NUMBER OF CLIENTS ON CASELOAD AS OF THE DATE OF THE LICENSING INSPECTION			
							ACTIVE D/A CLIENTS		NON-DA CLIENTS	OTHER	TOTAL NUMBER OF CURRENT CLIENTS	ACTIVE D/A CLIENTS		NON-DA CLIENTS
							ADULTS	ADOLESCENTS				ADULTS	ADOLESCENTS	
TOTALS							0	0	0	0	0	0	0	0

NUMBER OF HOURS / WORK WEEK = FTE

NUMBER OF CLIENTS / FTE = RATIO

HOURS PER WEEK AND CASELOAD COUNT ARE TO BE THE ACTUAL NUMBERS AS OF THE DATE OF THE SITE INSPECTION.

STANDARD WORK WEEK MUST BE ONE OF THE THREE: 40 HOURS _____ 37.5 HOURS _____ 35 HOURS _____

OUTPATIENT CASELOAD COMPUTATION SHEET

STAFF NAMES	Project Director	Facility Director	Clinical Supervisor	Counselor	Counselor Assistant	TOTAL HOURS PER WEEK AT THIS FACILITY	NUMBER OF CLINICAL HOURS PER WEEK PER COUNSELOR			NUMBER OF CLIENTS ON CASELOAD AS OF THE DATE OF THE LICENSING INSPECTION			
							HOURS PER WEEK FOR DRUG AND ALCOHOL CLIENTS	NON DA CLIENTS	OTHER	TOTAL NUMBER OF CLIENTS	DRUG AND ALCOHOL CLIENTS ON EACH CASELOAD AND CASELOAD COMPUTATION	NON DA CLIENTS	
TOTALS							0	0	0	0	0	0	0

NUMBER OF HOURS / WORK WEEK = FTE

NUMBER OF CLIENTS / FTE = RATIO

CHECK THE APPROPRIATE ACTIVITY:

_____ Hospital
 _____ Non-Hospital

ACTIVITY - DETOXIFICATION

FACILITY PRIMARY CARE HOURS:

_____ TO _____

NAME

NAME	Clinical Supervisor	Counselor	Physician	Physician Assistant	Psychologist	Registered Nurse	Licensed Practical Nurse	Other *	TOTAL HOUR WORKED PER WEEK AT THIS FACILITY	NUMBER OF HOURS PER WEEK			NUMBER OF CLIENTS ON CASELOAD AS OF THE DATE OF THE LICENSING VISIT					
										ACTIVE D/A CLIENTS		NON-DA CLIENTS	OTHER	TOTAL # CURRENT CLIENTS	ACTIVE D/A CLIENTS		NON-DA CLIENTS	DOH USE ONLY
										ADULTS	ADOLESCENTS				ADULTS	ADOLESCENTS		
TOTALS										0	0	0	0	0	0	0	0	0

* Specify positions: _____

Primary Care Hours: The primary hours of operation during which primary care services are provided as established by the facility and approved by the Department.
 Primary Care Staff: The group of individuals, including clinical supervisors, counselors, physicians, physician's assistants, psychologists, registered nurses and licensed practical nurses who provide primary care services and those individuals who are responsible for developing and implementing the treatment plan.

DETOXIFICATION ACTIVITY

ACTUAL PRIMARY CARE STAFF¹ SCHEDULE FOR THE WEEK OF _____

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
12:00 AM							
1:00 AM							
2:00 AM							
3:00 AM							
4:00 AM							
5:00 AM							
6:00 AM							
7:00 AM							
8:00 AM							
9:00 AM							
10:00 AM							
11:00 AM							
12:00 PM							
1:00 PM							
2:00 PM							
3:00 PM							
4:00 PM							
5:00 PM							
6:00 PM							
7:00 PM							
8:00 PM							
9:00 PM							
10:00 PM							
11:00 PM							
CENSUS							

¹Primary care staff:

- The group of individuals, including clinical supervisors, counselors, physicians, physician's assistants, psychologists, registered nurses and licensed practical nurses who provide primary care services and those individuals who are responsible for developing and implementing the treatment plan.
- Include actual hours primary care staff (assigned exclusively to the detoxification unit) work each day. If initials are used, please list the individual's full name and position on the reverse side.