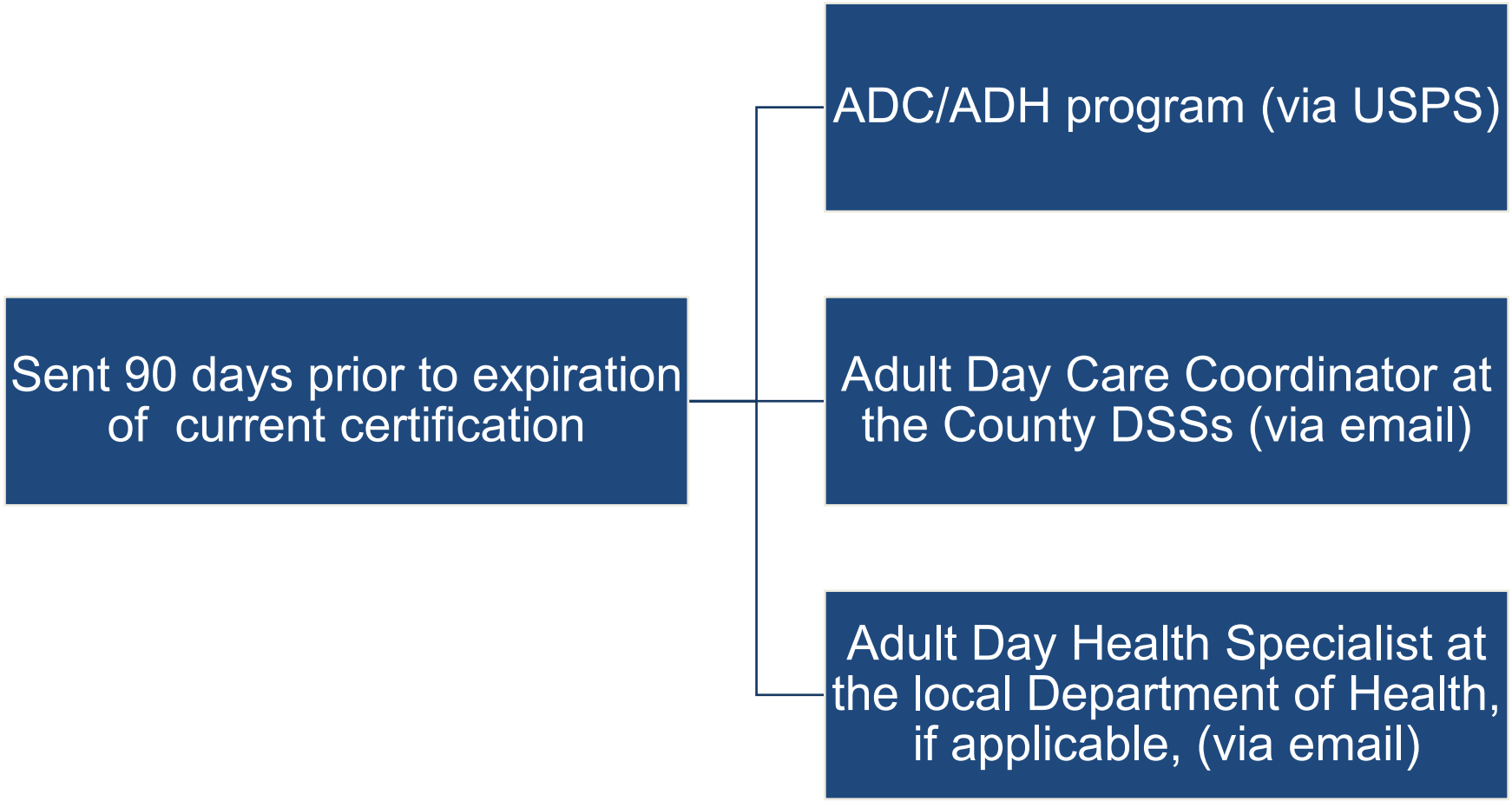
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Navigating the Adult Day Care Recertification Process

Terrie Deal
Adult Day Care Consultant

March 24, 2026

Certification Reminder Letter



TO: **Program Director Name**
FROM: **Terrie Deal**
DATE: **February 4, 2026**
RE: **Program Name**

This is to remind you that the current certification for Program Name expires on May 31, 2026. If the Division of Aging has not received the required recertification forms and materials prior to the expiration date, the certification will automatically terminate. Terrie Deal will be your staff liaison for recertification. Please note that the Adult Day Care team rotates responsibility for reviewing recertification materials, so this person may be different than who you worked with previously. Be sure to address your recertification package to the attention of the correct person.

The certification renewal process is the dual responsibility of the county department of social services' adult day care coordinator and the director of the adult day care program. It is suggested that the process be initiated at least 90 days in advance. The certification package, including the county's report and recommendation, DAAS 1500 must be received in the Division of Aging and Adult Services at least 30 days but not more than 60 days prior to the end of the certification period (see Standards for Certification, VI, B.4). While the coordinator shares in this process, it is the program director's responsibility to ensure that all additional materials required by standards are attached to the DAAS 1500 and are forwarded to the county department of social services within the established time frame. The required forms and materials are outlined in the North Carolina Adult Day Care and Day Health Services Standards

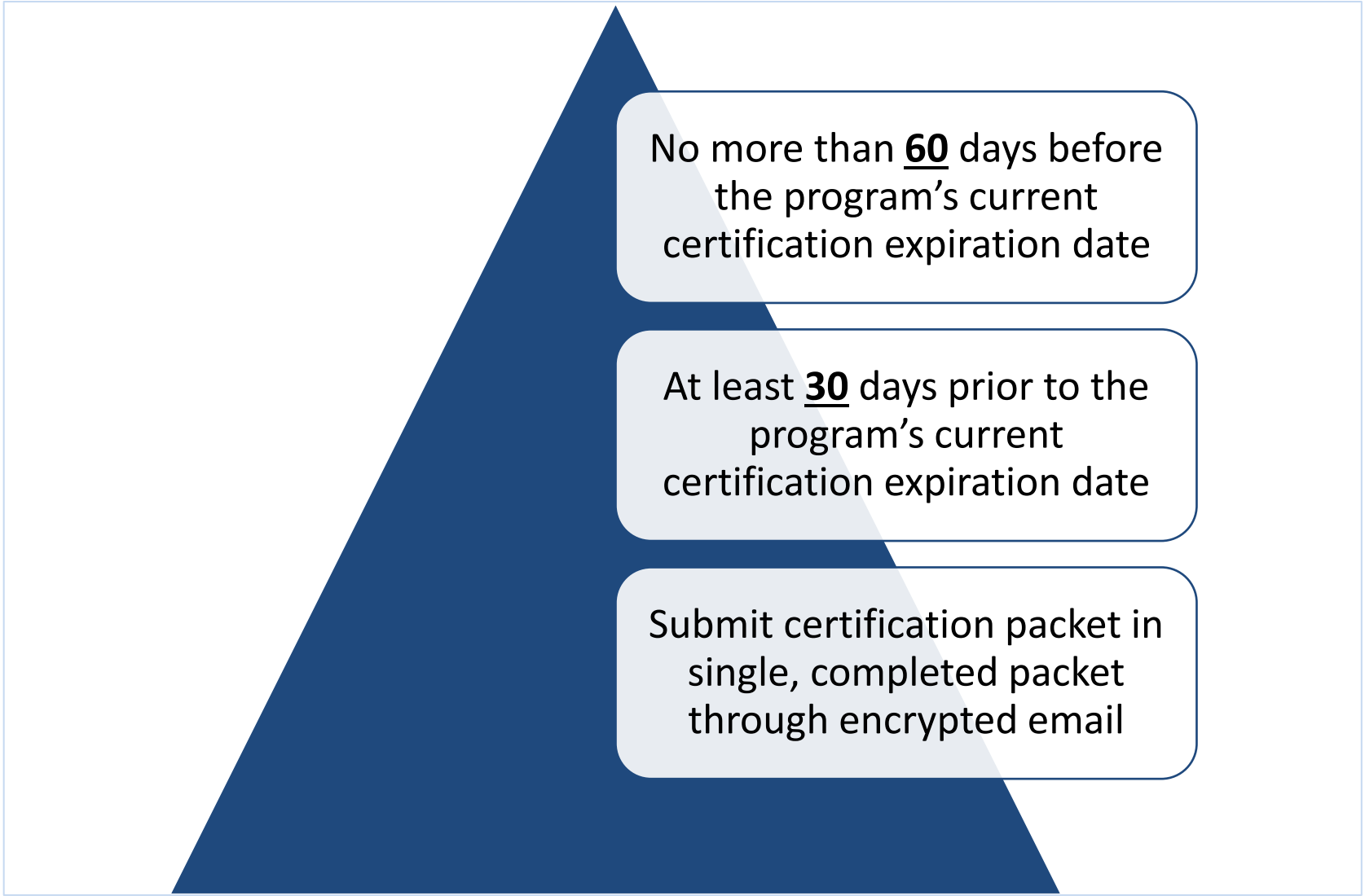
Initiating Recertification

90 days prior to current certification's expiration date

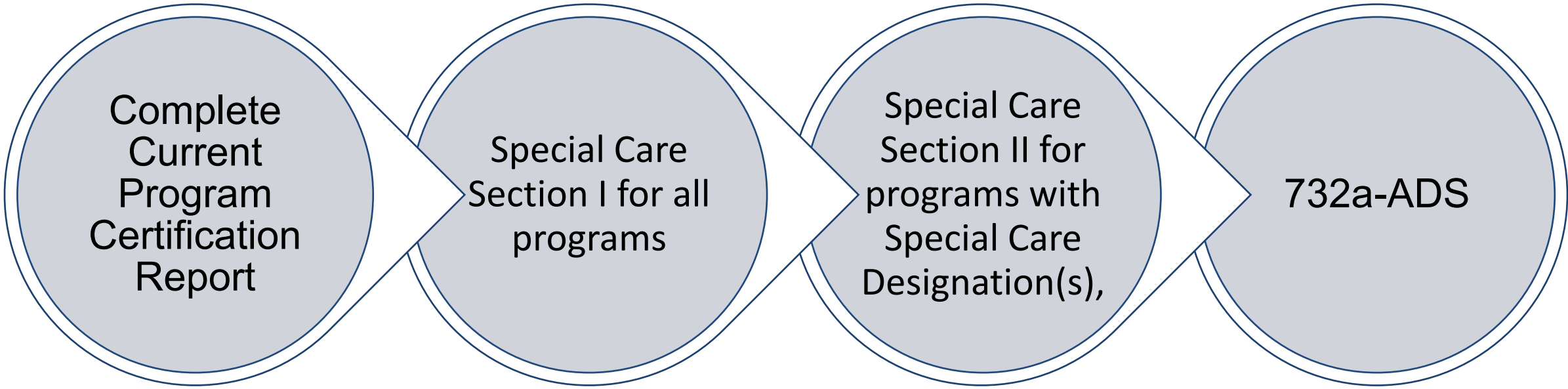
Review areas identified on Recertification Reports for Compliance

Gather required documentation

Deadline for Recertification Packet to Division of Aging



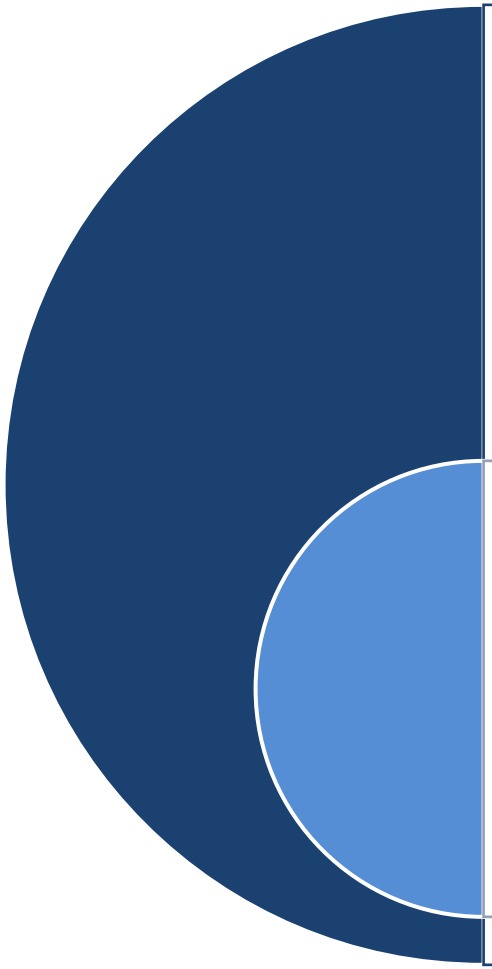
Basic Requirements



Basic Requirements (cont.)

Employees hired since last year's program recertification who were not included in the personnel listing submitted with that recertification package

Current Program Certification Report



ADC (Social Model Only)

DAAS-1500

ADH (Health Model Only) and
ADC/ADH (Combination Model)

DAAS-6205 Part A
DAAS-6205 Part B

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF AGING AND ADULT SERVICES
ADULT DAY CARE SERVICES
PROGRAM CERTIFICATION REPORT
FACE SHEET

ACTION REQUESTED

(☐) Certification
(☐) Recertification
(☐) Denial or Revocation
(☐) Change in Program Director/Operator
(☐) Change of Capacity
(☐) Change of Program Location
(☐) Provisional

Type of Program: (☐) Public (☐) Profit (☐) Non-Profit (☐) Adult Day Care Home (☐) Adult Day Care Center

Program Offers Specialized Care for (☐) Alzheimer's/Dementia (☐) Developmental Disabilities (☐) OTHER: (☐) NONE

Date of Report:

Certification Period:
FROM: TO:

Name of Program:

Capacity:

Address (Street, City, Zip Code):

County:

Mailing Address (if Different from Above):

Program Telephone (Area Code and No.):

Name of Director/Operator:

Email Address/Web Address:

NOTE: Please check the appropriate blocks to indicate which materials are attached. Initial certification requires everything on this list. ***Recertification requires those items in bold and the other items only if changed since the program's last recertification.***

(☐) Program Policy Statement
(☐) Organizational Diagram for Centers
(☐) Job Descriptions
(☐) Personnel Policies
(☐) 732-a-ADS or Equivalent Annual Budget
(☐) Floor Plan (change of address, change of capacity, or when structural building modifications have been made)

(☐) 732-a-ADS or Equivalent Annual Budget
(☐) Floor Plan (change of address, change of capacity, or when structural building modifications have been made)
(☐) Fire Inspection Report, DOA-1498 or the equivalent
(☐) Building Inspection Report, DOA-1499 or the equivalent (change of address or when structural building modifications have been made)
(☐) Sanitation Evaluation Report, DENR-4054 or the equivalent
(☐) Articles of Incorporation, Bylaws, names and addresses of board members, if applicable
(☐) Current CPR and First Aid for Staff (front & back of card)
(☐) Current Medical Report on each paid staff (recertification: only for staff hired since last recertification)
(☐) Verification of Statewide Criminal History Check for the past 5 years for new Staff (recertification: only for employees hired since last recertification) by an agency approved by the North Carolina Administrative Offices of the Courts http://www.nccourts.org

Other Attachments, Please Specify
(☐) _____
(☐) _____

SEE REVERSE SIDE FOR INSTRUCTIONS

DAAS-1500 (8/2008)/ Program Operations

Prepare 2 copies: **Original to Adult Day Care Consultant at DAAS**, one copy to program and one copy for department of social services.

DAAS-1500 (12/2013)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF AGING AND ADULT SERVICES
ADULT DAY HEALTH SERVICES
PROGRAM CERTIFICATION REPORT
FACE SHEET

ACTION REQUESTED

( ) Certification
( ) Recertification
( ) Denial or Revocation
( ) Change in Program Director/Operator
( ) Change of Capacity
( ) Change of Address
( ) Provisional

Type of Program

( ) Public
( ) Profit
( ) Non-Profit

( ) Adult Day Health Center ( ) Adult Day Health Home
( ) Combination Program

Program Offers Specialized Care for ( ) Dementia/Alzheimer's
( ) Developmental Disabilities ( ) NONE ( ) OTHER:

Date of Report:

Certification Period:
FROM: TO:

Name of Program:

Capacity:

Address (Street, City, Zip Code):

County:

Mailing Address (if Different from Above):

Program Telephone (Area Code and No.):

Name of Director/Operator:

Email Address/Web Address:

NOTE: Please check the appropriate blocks to indicate which materials are included. Initial certification requires all items listed. ***Recertification requires those items in bold and the other items only if changed within the past year.***

( ) Program Policies

(☐) Organizational Diagram for Centers
(☐) Job Descriptions
(☐) Personnel Policies
(☐) **732-a-ADS or Equivalent Annual Budget**
(☐) Floor Plan (change of address, change of capacity, or when structural building modifications have been made)
(☐) **Fire Inspection Report, DOA-1498 or the equivalent**
(☐) Building Inspection Report, DOA-1499 or equivalent (change of address or when structural building modifications done)
(☐) **Sanitation Evaluation Report, DENR-4054 or the equivalent**
(☐) Articles of Incorporation, Bylaws, names and addresses of board members, if applicable
(☐)**Current CPR and First Aid for Staff (copy of front & back of cards)**

(☐) **Current Nursing License for Health Care Coordinator and Health Care Coordinator Substitute**
(☐) **Verification of Statewide Criminal History Record Check for last 5 years for new staff (recertification: only for employees hired since last recertification) by an agency approved by the North Carolina Administrative Offices of the Courts http://www.nccourts.org**
(☐) **Current Medical Report on each paid staff (recertification: only for staff hired since last recertification)**
(☐) **Department of Health Standards Review, DAAS-6205, Part B (recertification or change of address)**

Other Attachments, Please Specify
(☐) _____
(☐) _____

SEE REVERSE SIDE FOR INSTRUCTIONS

Prepare Three Copies: **Original to Adult Day Care/Day Health Consultant at DAAS,** 1 to program, 1 to county department of social services and 1 to local health department.

DAAS-6205 Part A (12/2013)

LOCAL DEPARTMENT OF HEALTH

STANDARDS REVIEW
(PART B)

Name of Program: _____ County: _____

Name of Health Care Coordinator _____

Date of Report: _____

II. PERSONNEL
E. Health Care Coordinator

YES	NO		
☐	☐	1.	Health Care Coordinator on Site a Minimum of 4 Hours Per Day and Additional Hours as Specified in Standards.
☐	☐	2.	Health Care Coordinator Responsibilities, Consistent with the Nursing Practice Act, Include But Are Not Limited To:
☐	☐		a. Completing Preadmission Health Assessment for Initial Acceptance Into Program, Including Problem-Identification and Care Planning;
☐	☐		b. Implementing the Health Care Components of the Established Service Plan;
☐	☐		c. Monitoring Participant's Response to Medical Treatment Plan and Nursing Interventions and Revising Plan of Care as Necessary;
☐	☐		d. Reporting and Recording Results of the Nursing Assessment, Care Rendered and Participant's Response to Care;
☐	☐		e. Collaborating With Other Health Care Professionals and Caregivers Regarding Provision of Participant's Health Care;
☐	☐		f. Educating Other Staff Members to Emergency Procedures and Providing Information to Staff and Caregivers About Health Concerns and Conditions of Participants;
☐	☐		g. Providing First Aid Treatment as Needed.
☐	☐		h. Making Certain Health and Personal Care Services Are Provided (Standards, Pg. 19.
☐	☐	3.	Health Care Coordinator Meets the Following Minimum Qualifications:
☐	☐		a. Either a Registered Nurse or a Licensed Practical Nurse Currently Licensed to Practice in North Carolina.
☐	☐		b. If the Health Care Coordinator is a Licensed Practical Nurse: If N/A, check (☐)

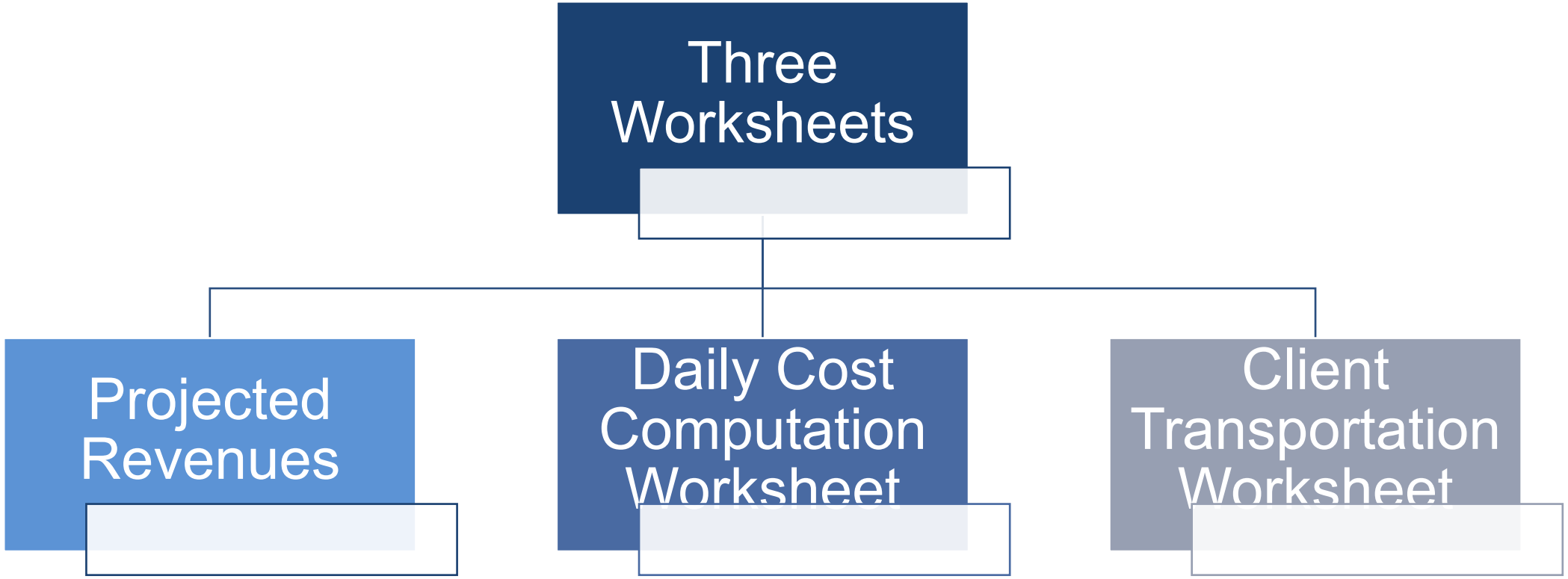
2. Health Care Coordinator Responsibilities, Consistent with the Nursing Practice Act, Include But Are Not Limited To:

- a. Completing Preadmission Health Assessment for Initial Acceptance Into Program, Including Problem-Identification and Care Planning;
- b. Implementing the Health Care Components of the Established Service Plan;
- c. Monitoring Participant's Response to Medical Treatment Plan and Nursing Interventions and Revising Plan of Care as Necessary;
- d. Reporting and Recording Results of the Nursing Assessment, Care Rendered and Participant's Response to Care;
- e. Collaborating With Other Health Care Professionals and Caregivers Regarding Provision of Participant's Health Care;
- f. Educating Other Staff Members to Emergency Procedures and Providing Information to Staff and Caregivers About Health Concerns and Conditions of Participants;
- g. Providing First Aid Treatment as Needed.
- h. Making Certain Health and Personal Care Services Are Provided (Standards, Pg. 19.

3. Health Care Coordinator Meets the Following Minimum Qualifications:

- a. Either a Registered Nurse or a Licensed Practical Nurse Currently Licensed to Practice in North Carolina.
- b. If the Health Care Coordinator is a Licensed Practical Nurse: If N/A, check (☐)
  - (1) Supervision Is Provided by a Registered Nurse Consistent With The Nursing Practice Act G.S. 90-171 and 21 and 21 NCAC 36 .0224 - .0225
  - (2) On-Site Supervision By The Registered Nurse Occurs No Less Frequently Than Every Two Weeks;
- c. Knowledgeable and Understanding of The Physical and Emotional Aspects of Aging, the Resultant Diseases and Infirmities and Related Medications and Rehabilitative Measures;
- d. At Least 18 Years of Age;
- e. Medical Report Dated Within Prior 12 Months Presented Prior to Employment;

Budget: 732a-ADS



1	**North Carolina Division of Aging and Adult Services Adult Day Services Projected Revenues**			
2				
3	Adult Day Services Program:_____			
4	County:			
5	Budget Period: through			
6				
7				
8				
9				Adult Day
10		Grand	Adult	Health
11	**Projected Revenues**	Total	Day Care	Care
12	**A. Fed/State Funding From the Division of Aging and Adult Services**	//////////////	//////////////	//////////////
13	Home and Community Care Block Grant (HCCBG)	0		
14	State Adult Day Care Fund (SADCF)	0		
15	Family Caregiver Support	0		
16	**Total Fed/State Funding Through Division of Aging and Adult Services**	**0**	**0**	**0**
17	**B. Required Minimum Match (Cash or In-Kind) Paid by Center or County**	//////////////	//////////////	//////////////
18	1) HCCBG (10%)	0	0	0
19	2) SSBG (12.5%)	0	0	0
20	No local match required for Family Caregiver Support Program	//////////////	//////////////	//////////////
21	**Total Required Minimum Match**	**0**	**0**	**0**
22	**C. Total Fed/State Funding and Required Minimum Match**	**0**	**0**	**0**
23	**D. Local Cash, Non-Match**	//////////////	//////////////	//////////////
24	1) fundraising Events	0		
25	2) Donations, Memorials, Etc.	0		
26	3) Grants/Foundations	0		
27	4)	0		
28	5)	0		
29	**Total Local Cash, Non-Match**	**0**	**0**	**0**
30	**E. Other Revenues Non-Match**	//////////////	//////////////	//////////////
31	1) Private Pay Daily Care	0		
32	2) Private Pay Transportation	0		
33	3) Medicaid CAP-DA	0		
34	4) Medicaid CAP-DD	0		

	Grand Total	Adult Day Care	Health Care
Projected Revenues			
A. Fed/State Funding From the Division of Aging and Adult Services	////////////	////////////	////////////
Home and Community Care Block Grant (HCCBG)	0		
State Adult Day Care Fund (SADCF)	0		
Family Caregiver Support	0		
Total Fed/State Funding Through Division of Aging and Adult Services	**0**	**0**	**0**
B. Required Minimum Match (Cash or In-Kind) Paid by Center or County	////////////	////////////	////////////
1) HCCBG (10%)	0	0	0
2) SSBG (12.5%)	0	0	0
No local match required for Family Caregiver Support Program	////////////	////////////	////////////
Total Required Minimum Match	**0**	**0**	**0**
C. Total Fed/State Funding and Required Minimum Match	**0**	**0**	**0**
D. Local Cash, Non-Match	////////////	////////////	////////////
1) fundraising Events	0		
2) Donations, Memorials, Etc.	0		
3) Grants/Foundations	0		
4)	0		
5)	0		
Total Local Cash, Non-Match	**0**	**0**	**0**
E. Other Revenues Non-Match	////////////	////////////	////////////
1) Private Pay Daily Care	0		
2) Private Pay Transportation	0		
3) Medicaid CAP-DA	0		
4) Medicaid CAP-DD	0		
5) Other	0		
6) NC Sales Tax Refund	0		
7)	0		
8)			
Total Other Revenues Non-Match	**0**	**0**	**0**
F. Client Cost Sharing	**0**		
Total Projected Revenues	**0**	**0**	**0**
NOTE: Projected revenues should equal projected expenditures			

732a-ADS Revenue Sheet

1	**North Carolina Division of Aging and Adult Services**			
2	**Adult Day Services Daily Cost Computation Worksheet** C:732Aadsdailyrate.xls			
3	Provider:			
4	County:			
5	Current Budget Period: through			
6				
7	**Do not include any client transportation costs such as**			
8	**drivers, fuel, vehicle maintenance, etc.**			**Adult Day**
9		**Grand**	**Adult**	**Health**
10	**Projected Line Item Expense**	**Total**	**Day Care**	**Care**
11	Staff Salary	//////////////	//////////////	//////////////
12				
13		0		
14		0		
15		0		
16		0		
17	**A. Subtotal, Staff Salary**	0	**0**	**0**
18	Fringe Benefits	//////////////	//////////////	//////////////
19	1) FICA	0		
20	2) Health Ins.	0		
21	3) Retirement	0		
22	4) Unemployment Insurance	0		
23	5) Worker's Compensation	0		
24	6) Long Term Disability	0		
25	7) Dental Insurance	0		
26	8) Life Insurance	0		
27	9) Other	0		
28	**B. Subtotal, Fringe Benefits**	0	**0**	**0**
29	Staff Travel	//////////////	//////////////	//////////////
30	1) Lodging and Meals	0		
31	2) Mileage Reimbursement	0		
32	3) Commercial Transportation	0		
33	4) Other Travel Cost:	0		
34	**C. Subtotal, Staff Travel**	0	**0**	**0**
35	Other Operating Expenses	//////////////	//////////////	//////////////
36	1) Rent	0		
37	2) Telephone	0		

25	7) Dental Insurance	0		
26	8) Life Insurance	0		
27	9) Other	0		
28	**B. Subtotal, Fringe Benefits**	0	**0**	**0**
29	Staff Travel	////////////	////////////	////////////
30	1) Lodging and Meals	0		
31	2) Mileage Reimbursement	0		
32	3) Commercial Transportation	0		
33	4) Other Travel Cost:	0		
34	**C. Subtotal, Staff Travel**	0	**0**	**0**
35	Other Operating Expenses	////////////	////////////	////////////
36	1) Rent	0		
37	2) Telephone	0		
38	3) Postage/Shipping	0		
39	4) Printing/Publications	0		
40	5) Copying	0		
41	6) Equipment Rental	0		
42	7) Equipment Purchase/Depreciation	0		
43	8) Equipment Maintenance	0		
44	9) Contracted Labor	0		
45	10) Activity/Program Supplies	0		
46	11) Office Supplies	0		
47	12) Conference Registration	0		
48	13) Auto Liability Insurance	0		
49	14) Client Meals	0		
50	15) Advertising	0		
51	16) Employee Recruitment	0		
52	17) Other:	0		
53	18) Other:	0		
54	**D. Subtotal, Other Operating Expenses**	**0**	**0**	**0**
55	**E. Grand Total, Expenses**	**0**	**0**	**0**
56	**F. Total Projected Service Days**	////////////		
57	**G. Projected Average Daily Participation**	////////////		
58	**H. Daily Cost Per Client (E divided by F, divided by G)**	////////////	**#DIV/0!**	**#DIV/0!**
59				

52	17) Other:	0		
53	18) Other:	0		
54	**D. Subtotal, Other Operating Expenses**	**0**	**0**	**0**
55	**E. Grand Total, Expenses**	**0**	**0**	**0**
56	**F. Total Projected Service Days**	////////////////		
57	**G. Projected Average Daily Participation**	////////////////		
58	**H. Daily Cost Per Client (E divided by F, divided by G)**	////////////////	**#DIV/0!**	**#DIV/0!**
59				
60				
61				
62				
63				
64				
65	**North Carolina Division of Aging and Adult Services**			
66	**Adult Day Services Client Transportation Worksheet** C:732Aadsdailyrate.xls			
67	Provider:			
68	County:			
69	Current Budget Period through			
70				
71				**Adult Day**
72		**Grand**	**Adult**	**Health**
73		**Total**	**Day Care**	**Care**
74	**A. Total Projected Client Transportation Costs**			
75	**B. Total Projected Service Days**	////////////////		
76	**C. Average Daily Participation Utilizing Transportation**	////////////////		
77	**D. Average Daily Cost of Round Trip Per Client***	////////////////	**#DIV/0!**	**#DIV/0!**
78	* **A divided by B, divided by C**			
79				
80				
81	**Grand Total: Daily Care Expenses + Projected Client**			
82	**Transportation Costs**	**0.00**	**0.00**	**0.00**
83				
84				
85	**Total Projected Revenues**			
86	**732a-ADS Daily Rate Sheet**			

Current, Approved Inspection Reports

Fire Inspection

- DOA 1498
- DCD-0303 or equivalent

Sanitation

- DENR-4054 or equivalent

ADULT DAY CARE & CHILD CARE FIRE INSPECTION REPORT

COUNTY_____ DATE OF INSPECTION_____Provider #_____

Please complete all items below. If not applicable, check N/A in the box with a written explanation attached.

Name of Center or Home_____ Adult ____ Child ____
Address _____ Phone_____
City _____ Zip _____ Responsible Party_____

GENERAL PRECAUTIONS:	YES	NO	N/A
1. Attic/basement/closets/garage/furnace room & heaters clear of trash & combustible materials.			
2. Clearance from ignition sources & combustible materials maintained.			

EMERGENCY PLANNING:	YES	NO	N/A
3. Approved evacuation plan posted.			
4. Evidence of monthly fire drills posted.			
5. Record of employee training in fire prevention/evacuation & annual fire safety training on site.			

FIRE SERVICE FEATURES:	YES	NO	N/A
6. Street Number posted. (Contrasting color to building & height 4" or more.)			
7. Unobstructed fire apparatus road. (Width of 20' & vertical clearance of not less than 13'6").			
8. Hydrants/Fire Department connections/control valves clear of obstructions by 3'.			

BUILDING SERVICES AND SYSTEMS:	YES	NO	N/A
9. Approved heating system, listed. (No fuel burning space heaters or portable electric space heaters)			
10. Emergency lighting/exit lights in good operating order.			
11. Electrical panels clear of storage. (Minimum 30")			
12. Wiring/fixtures in good condition. (Extension cords not suitable for permanent wiring.)			
13. Type I hood system over all domestic cooking appliances that produce grease laden vapors.			

FIRE RESISTANCE RATED CONSTRUCTION:	YES	NO	N/A
14. Required fire resistant rating maintained. (Walls, partitions, floors)			
15. Door-hold open devices/automatic door closures operating properly.			

FIRE RESISTANCE RATED CONSTRUCTION:	YES	NO	N/A
14. Required fire resistant rating maintained. (Walls, partitions, floors)			
15. Door-hold open devices/automatic door closures operating properly.			

INTERIOR DECORATIONS & FURNISHINGS:	YES	NO	N/A
16. No storage of clothing/personal effects in corridors & lobbies.			
17. Maximum 10% of decorative materials covering walls. Does not apply to artwork & teaching material in classroom. Nothing suspended from ceiling			
18. 20% maximum coverage for artwork & teaching material located on corridor walls.			
19. Exits free of obstructions.			

FIRE PROTECTION:	YES	NO	N/A
20. Sprinkler system maintained with annual test reports provided.			
21. Smoke detector/fire alarm system maintained with annual test reports provided.			
22. Approved extinguishers mounted properly & in good working order.			
23. Cooking suppression systems & hood exhaust properly maintained.			
24. Protective guards(such as screens) on fuel burning furnaces or fireplaces provided.			

MEANS OF EGRESS:	YES	NO	N/A
25. All exits & their access (i.e. Aisles & Corridors) free of obstructions.			
26. All locking devices on exit doors are of an approved type.			
27. Yards & fencing to allow unobstructed exit to exterior of site.			

At the time of this inspection, the fire safety conditions in this facility were found to be:

satisfactory _____ **unsatisfactory**

Inspector _____ **Phone** _____

Prepare form in triplicate—one copy retained by local fire authority, one copy to facility director, and one copy to the County Department of Social Services.

DCD –0303
Rev. 7/21

ADULT DAY CARE & CHILD CARE FIRE INSPECTION REPORT

COUNTY _____ DATE OF INSPECTION _____ Facility ID #_____

Please complete all items below. If not applicable, check N/A in the box with a written explanation attached.

Name of Facility _____ Adult ____ Child ____
Address _____ Phone _____
City _____ Zip _____ Responsible Party _____

GENERAL PRECAUTIONS:	YES	NO	N/A
1. Attic/basement/closets/garage/furnace room & heaters clear of trash & combustible materials.			
2. Clearance from ignition sources & combustible materials maintained.			

EMERGENCY PLANNING:	YES	NO	N/A
3. Approved evacuation plan posted.			
4. Evidence of monthly fire drills posted.			
5. Record of employee training in fire prevention/evacuation & annual fire safety training on site.			

FIRE SERVICE FEATURES:	YES	NO	N/A
6. Street Number posted. (Contrasting color to building & height 4" or more.)			
7. Unobstructed fire apparatus road. (Width of 20' & vertical clearance of not less than 13'6").			
8. Hydrants/Fire Department connections/control valves clear of obstructions by 3'.			

BUILDING SERVICES AND SYSTEMS:	YES	NO	N/A
9. Approved heating system, listed. (No fuel burning or portable electric space heaters.)			
10. Emergency lighting/exit lights in good operating order.			
11. Electrical panels clear of storage. (Minimum 30")			
12. Wiring/fixtures in good condition. (Extension cords not suitable for permanent wiring.)			
13. Type I hood system over all domestic cooking appliances that produce grease laden vapors.			

FIRE RESISTANCE RATED CONSTRUCTION:	YES	NO	N/A
14. Required fire resistant rating maintained. (Walls, partitions, floors)			
15. Door-hold open devices/automatic door closures operating properly.			

INTERIOR DECORATIONS & FURNISHINGS:	YES	NO	N/A
16. No storage of clothing/personal effects in corridors & lobbies.			
17. Maximum 50% of decorative materials covering walls. Nothing suspended from ceiling			
18. 20% maximum coverage for artwork & teaching material located on corridor walls			

4. Evidence of monthly fire drills posted.			
5. Record of employee training in fire prevention/evacuation & annual fire safety training on site.			

FIRE SERVICE FEATURES:	YES	NO	N/A
6. Street Number posted. (Contrasting color to building & height 4" or more.)			
7. Unobstructed fire apparatus road. (Width of 20' & vertical clearance of not less than 13'6").			
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BUILDING SERVICES AND SYSTEMS:	YES	NO	N/A
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FIRE RESISTANCE RATED CONSTRUCTION:	YES	NO	N/A
14. Required fire resistant rating maintained. (Walls, partitions, floors)			
15. Door-hold open devices/automatic door closures operating properly.			

INTERIOR DECORATIONS & FURNISHINGS:	YES	NO	N/A
16. No storage of clothing/personal effects in corridors & lobbies.			
17. Maximum 50% of decorative materials covering walls. Nothing suspended from ceiling			
18. 20% maximum coverage for artwork & teaching material located on corridor walls.			
19. Exits free of obstructions.			

FIRE PROTECTION:	YES	NO	N/A
20. Sprinkler system maintained with annual test reports provided.			
21. Smoke detector/fire alarm system maintained with annual test reports provided.			
22. Approved extinguishers mounted properly & in good working order.			
23. Cooking suppression systems & hood exhaust properly maintained.			
24. Protective guards(such as screens) on fuel burning furnaces or fireplaces provided.			

MEANS OF EGRESS:	YES	NO	N/A
25. All exits & their access (i.e. Aisles & Corridors) free of obstructions.			
26. All locking devices on exit doors are of an approved type.			
27. Yards & fencing to allow unobstructed exit to exterior of site.			

☐ **Approved for day time care only** ☐ **Approved for day time and night care**

At the time of this inspection, the fire safety conditions in this facility were: ☐ **Satisfactory** ☐ **Unsatisfactory**

Inspector _____ Phone _____

N.C. Department of Environment and Natural Resources
Division of Environmental Health

INSPECTION OF ADULT DAY SERVICE FACILITY

Score: _____ _____
Date of Insp/Chg _____
Status Code: _____

Health Department _____
Current ID Number _ _ _ _ _ _ _ _ _ _
Old ID Number _ _ _ _ _ _ _ _ _ _

Classification: ☐ **Superior** ☐ **Approved** ☐ **Provisional** ☐ **Disapproved**

Water Supply: [1] Community [2] Transient Non-Community [3] Non-Transient Non-Community [4] Non-Public Water Supply

Wastewater System: [1] Community [2] On-Site System

Water sample taken today? ☐ Yes ☐ No

[1] Inspection ☐ Name Change
[2] Re-Inspection ☐ Verification of Closure

Health Department: _____ Facility ID No.: _____ Maximum Capacity: _____

Name of Facility: _____ Operator: _____

Address (City, Zip Code): _____

FOOD: (.3304, .3305, .3306, .3307, .3308, .3310) — **Demerits**

***1. From approved sources, free from spoilage and adulteration**	**6**	
2. Potentially hazardous food temperatures	5	
3. Properly prepared, handled, packaged, and identified	4	
4. Not re-served	4	
5. Protected at all times according to these rules	4	
6. Refrigerators with thermometers, product thermometers provided	3	

FOOD SERVICE EQUIPMENT AND UTENSILS: (.3304, .3306, .3307, .3309, .3310, .3311, .3312, .3313, .3314, .3316)

***7. Meets specifications for refrigeration, sinks, and dishwashing equipment according to type of service**	**6**	
8. Meets requirements for handwash lavatories	5	
9. Meets specifications for other equipment and utensils, approved material and construction, in good repair	4	
***10. Food contact surfaces, including multi-use utensils, properly washed, rinsed and sanitized**	**6**	
***11. Single-service articles not reused**	**6**	
12. Single-use articles not reused	2	
13. Non-food contact surfaces clean	4	
14. Equipment and utensils, including single-service articles, protected from contamination	4	
15. Approved testing equipment for sanitizers, sanitizing solution provided	3	

WATER SUPPLY: DRINKING WATER FACILITIES: (.3315, .3316)

STORAGE: (.3317, .3320) — **Demerits**

***30. Medications and hazardous products properly stored and locked**	**6**	
31. Facilities provided for proper storage, kept clean	3	

BEDS, LINENS, FURNITURE AND EQUIPMENT: (.3321, .3322)

32. Beds, chairs, cots, or mats clean and in good repair, stored properly	5	
33. Mattress covers, individual linen provided	5	
34. Linen clean, in good repair; properly handled and stored	4	
35. Other furniture and equipment easily cleanable, good repair clean	4	

PERSONNEL: (.3323)

36. Approved hygienic practices, clean clothes, hair restraints where required	3	
37. Tobacco not used in food prep areas or areas occupied by non-smokers	5	
***38. Persons with communicable disease or a communicable condition excluded from situations in which transmission can reasonable be expected to occur, in accordance with 15A NCAC 19A.0200**	**6**	
***39. Wounds or lesions properly bandaged**	**6**	

FLOORS, WALLS & CEILINGS: (.3324, .3325)

40. Easily cleanable, durable, good repair, clean	4	

LIGHTING AND THERMAL ENVIRONMENT: (.3326)

41. Maintained as required	4	

6. Refrigerators with thermometers, product thermometers provided ..... 3 _____

FOOD SERVICE EQUIPMENT AND UTENSILS: (.3304, .3306, .3307, .3309, .3310, .3311, .3312, .3313, .3314, .3316)

***7. Meets specifications for refrigeration, sinks, and dishwashing equipment according to type of service ..... 6** _____

8. Meets requirements for handwash lavatories ..... 5 _____

9. Meets specifications for other equipment and utensils, approved material and construction, in good repair ..... 4 _____

***10. Food contact surfaces, including multi-use utensils, properly washed, rinsed and sanitized ..... 6** _____

***11. Single-service articles not reused ..... 6** _____

12. Single-use articles not reused ..... 2 _____

13. Non-food contact surfaces clean ..... 4 _____

14. Equipment and utensils, including single-service articles, protected from contamination ..... 4 _____

15. Approved testing equipment for sanitizers, sanitizing solution provided ..... 3 _____

WATER SUPPLY: DRINKING WATER FACILITIES: (.3315, .3316)

***16. Supply meets 15A NCAC 18A .1700 or 15A NCAC 18C ..... 6** _____

***17. Hot water supplied and maintained in accordance with this section. ..... 6** _____

18. No cross connections, backflow prevention devices provided ..... 4 _____

19. Drinking fountains or drinking utensils of approved type, regulated, clean ..... 4 _____

TOILET AND LAVATORY FACILITIES: (.3310, .3317, .3318, .3319)

20. Toilets and lavatories provided, properly located ..... 5 _____

21. Fixtures properly sized, cleaned, sanitized, cleaning and and sanitizing solutions provided, labeled ..... 4 _____

22. Potty chairs, bedpans, urinals properly located, cleaned and disinfected ..... 4 _____

23. Soap, disposable towels or approved hand-drying device; lavatories free of storage ..... 4 _____

24. Approved clothing changing facilities ..... 4 _____

25. Clothing change and bathing surfaces cleaned and sanitized after each use; cleaning and sanitizing solutions provided.. 4 _____

26. Approved clothing changing methods by caregivers ..... 5 _____

27. Test kits provided; sanitizer labeled ..... 3 _____

28. Clothing changing surfaces clean and free of storage ..... 2 _____

29. Handwashing signs posted ..... 2 _____

properly ..... 5 _____

33. Mattress covers, individual linen provided ..... 5 _____

34. Linen clean, in good repair; properly handled and stored .... 4 _____

35. Other furniture and equipment easily cleanable, good repair clean ..... 4 _____

PERSONNEL: (.3323)

36. Approved hygienic practices, clean clothes, hair restraints where required ..... 3 _____

37. Tobacco not used in food prep areas or areas occupied by non-smokers ..... 5 _____

***38. Persons with communicable disease or a communicable condition excluded from situations in which transmission can reasonable be expected to occur, in accordance with 15A NCAC 19A.0200 ..... 6** _____

***39. Wounds or lesions properly bandaged ..... 6** _____

FLOORS, WALLS & CEILINGS: (.3324, .3325)

40. Easily cleanable, durable, good repair, clean ..... 4 _____

LIGHTING AND THERMAL ENVIRONMENT: (.3326)

41. Maintained as required ..... 4 _____

42. Equipment clean and in good repair ..... 2 _____

COMMUNICABLE DISEASE CONTROL: (.3327)

43. Designated area for sick participants ..... 5 _____

44. Treatment room provided for day health facilities ..... 5 _____

HANDWASHING: (.3308, .3319, .3328)

45. Proper handwashing ..... 5 _____

WASTEWATER: (.3329)

***46. Wastewater disposed of by approved methods ..... 6** _____

SOLID WASTES: (.3330)

47. Solid waste properly handled ..... 2 _____

48. Can cleaning facilities adequate and containers kept clean.. 2 _____

ANIMAL & VERMIN CONTROL: PREMISES; OUTDOOR ACTIVITY AREA: (.3331, .3332)

***49. Approved pesticides, properly used ..... 6** _____

50. Effective control of rodents, insects, and other vermin ..... 4 _____

51. No animals in food prep areas and no unrestrained animals except as noted ..... 4 _____

52. Premises clean, drained, and free of hazards, vermin harborages and breeding areas ..... 4 _____

SWIMMING & WADING POOLS: (.3833)

***53. Designed, constructed, operated and maintained in accordance with 15A NCAC 18A .2500 ..... 6** _____

***Indicates critical item (6-point demerit).**

Signed _____ AGENT

Division of Environmental Health

DENR 4054 (August 1, 2002)
Environmental Health Services Section (Review 08/05)

Existing Employee Documentation

Existing Employees (listed in Personnel Section in previous year's recertification packet)

Verification of Current CPR and First Aid Certification*

*for employees with direct participant contact

**Also, not required for employees that are staff substitute only*

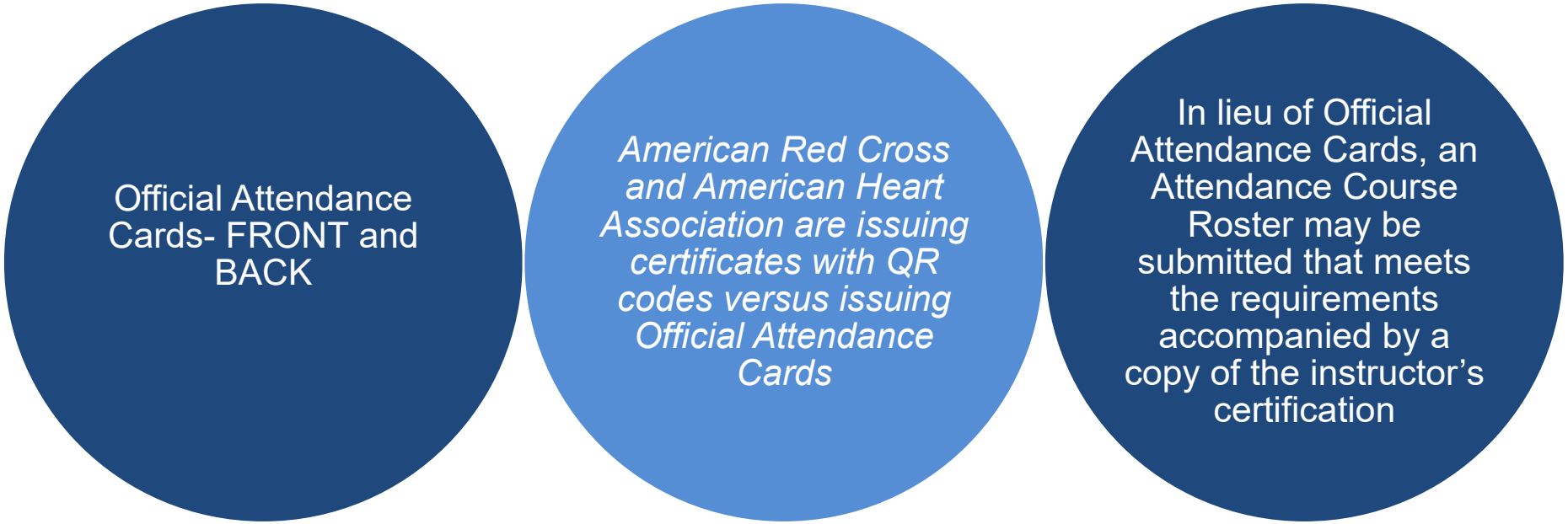
**Must be issued by a state approved agency*

Documentation of Current Nursing License to Practice in the state of NC, if applicable (ADH only or ADC/ADH, combination programs)

Organize Employee Documents as listed on Personnel Listing

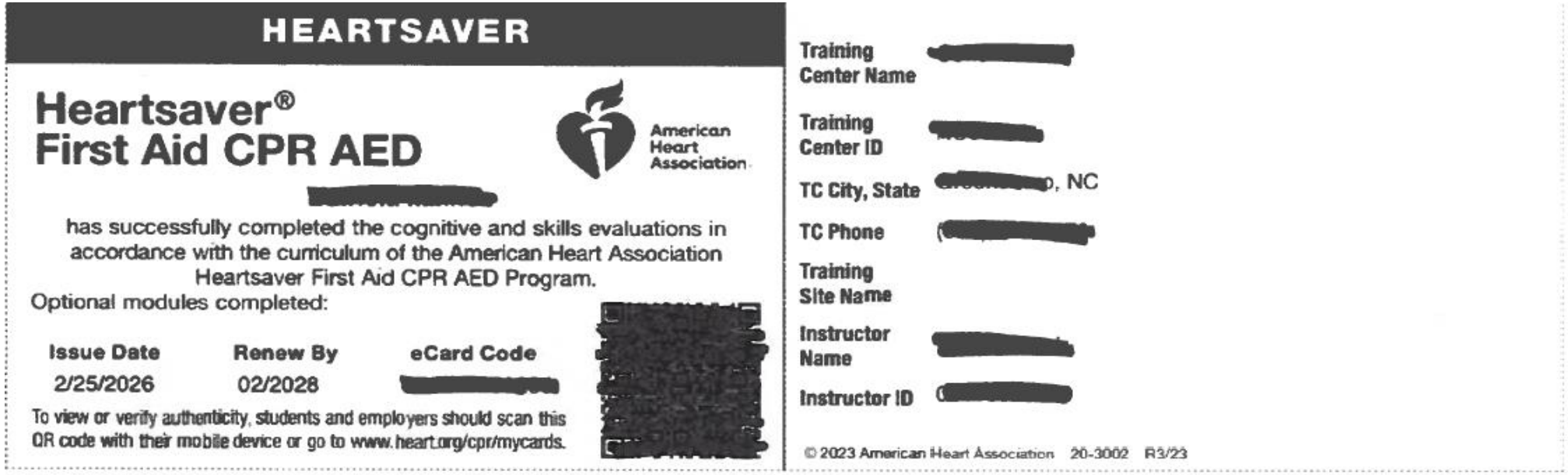
- Include all of the required personnel documentation
- Specific items required depends upon whether employee was hired after last year's recertification
- Organize employee documentation by employee in the same order as employees are listed in personnel listing

Verification of Current CPR and First Aid Certification



Approved agencies: **American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute (HSI), or Emergency Medical Services**

These are Samples ONLY…and are NOT all inclusive



HEARTSAVER

Heartsaver® First Aid CPR AED

American Heart Association

[redacted]

has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Heartsaver First Aid CPR AED Program.

Optional modules completed:

Issue Date	Renew By	eCard Code
2/25/2026	02/2028	[redacted]

To view or verify authenticity, students and employers should scan this QR code with their mobile device or go to www.heart.org/cpr/mycards.

[redacted]

Training Center Name [redacted]

Training Center ID [redacted]

TC City, State [redacted], NC

TC Phone [redacted]

Training Site Name

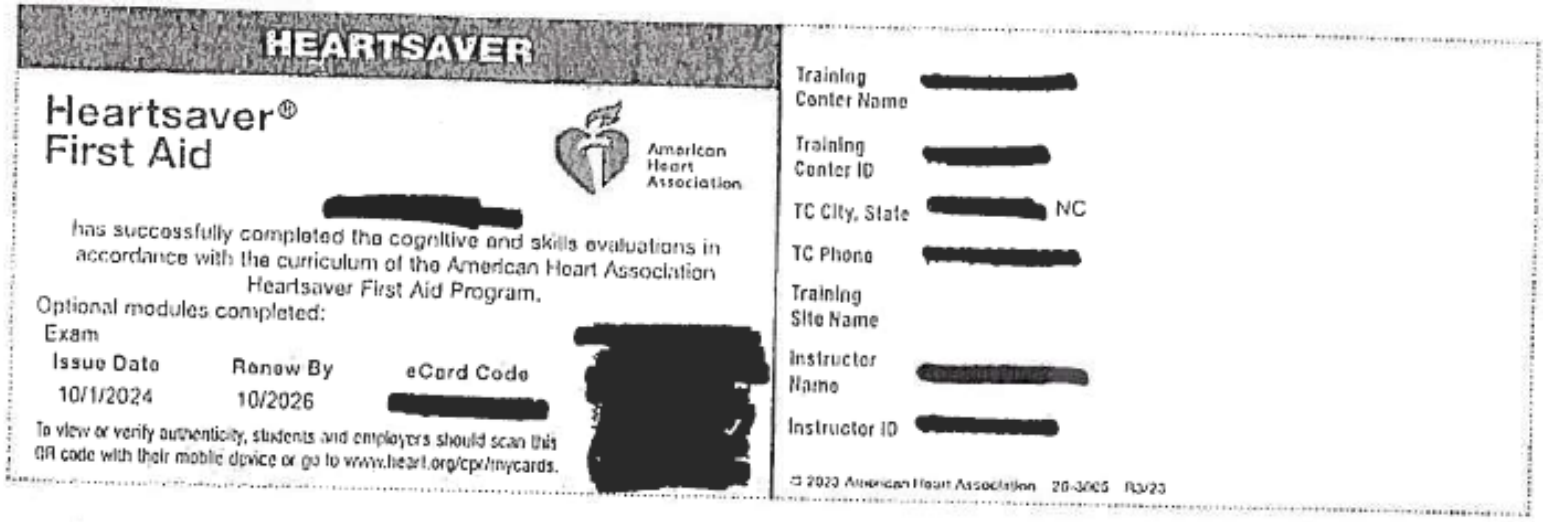
Instructor Name [redacted]

Instructor ID [redacted]

Directions

1. Cut along dotted lines
2. Fold both halves together
3. Use adhesive to combine halves

Samples



HEARTSAVER

Heartsaver®
First Aid

American Heart Association

[redacted] has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Heartsaver First Aid Program.

Optional modules completed:
Exam

Issue Date	Renew By	eCard Code
10/1/2024	10/2026	[redacted]

To view or verify authenticity, students and employers should scan this QR code with their mobile device or go to www.heart.org/cpr/mycards.

[redacted]

Training Center Name [redacted]

Training Center ID [redacted]

TC City, State [redacted] NC

TC Phone [redacted]

Training Site Name

Instructor Name [redacted]

Instructor ID [redacted]

© 2023 American Heart Association 20-3065 R3/23

Directions

1. Cut along dotted lines
2. Fold both halves together
3. Use adhesive to combine halves

Samples

American Red Cross
Training Services

Certificate of Completion

[redacted]

has successfully completed requirements for

Adult First Aid/CPR/AED

Date Completed: 5/29/2024
Validity Period: 2 Years

Conducted by: American Red Cross

To verify certificate, scan code or visit redcross.org/digitalcertificate and enter ID.

Learn and be inspired at LifesavingAwards.org

HSI
1450 Westec Drive
Eugene, OR 97402
800-447-3177

2/10/2025
[redacted]

Dear [redacted]

Congratulations on successfully completing your HSI Adult First Aid | CPR AED All Ages (2020) -DC class. This HSI-Approved Training Center has chosen to issue your certification card digitally.

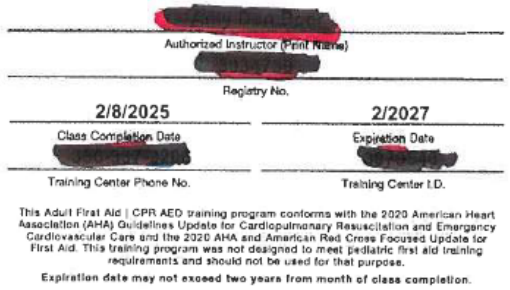
The digital certification card below is identical to a printed version of the card. It documents that you have demonstrated achievement of the required knowledge and hands-on skill objectives of the training program to the satisfaction of a currently authorized HSI Instructor. Your digital certification card may be printed for validation of certification. If further proof is required, scan the QR Code or go to www.hsi.com/validation and follow the instructions. The QR Code link in this letter will stay active. If you lose this letter, you may request a copy from the Training Center named below.

We strongly recommend that you download and save a copy of this letter for safekeeping.

To download the digital student book for this class or to complete a short evaluation of your class and instructor, please go to www.hsi.com/passport and register using the following number [redacted]

[redacted]

Certification Validation QR Code



Samples

nsc
National Safety Council

SECURITY CONTROL NO.
[redacted]E

Certification Card

[redacted]

has successfully completed the cognitive and skills evaluations for the following:

First Aid, Adult CPR & AED
8.00 hrs

COMPLETION DATE
10/15/2025

EXPIRATION DATE
10/31/2027

INSTRUCTOR
[redacted]

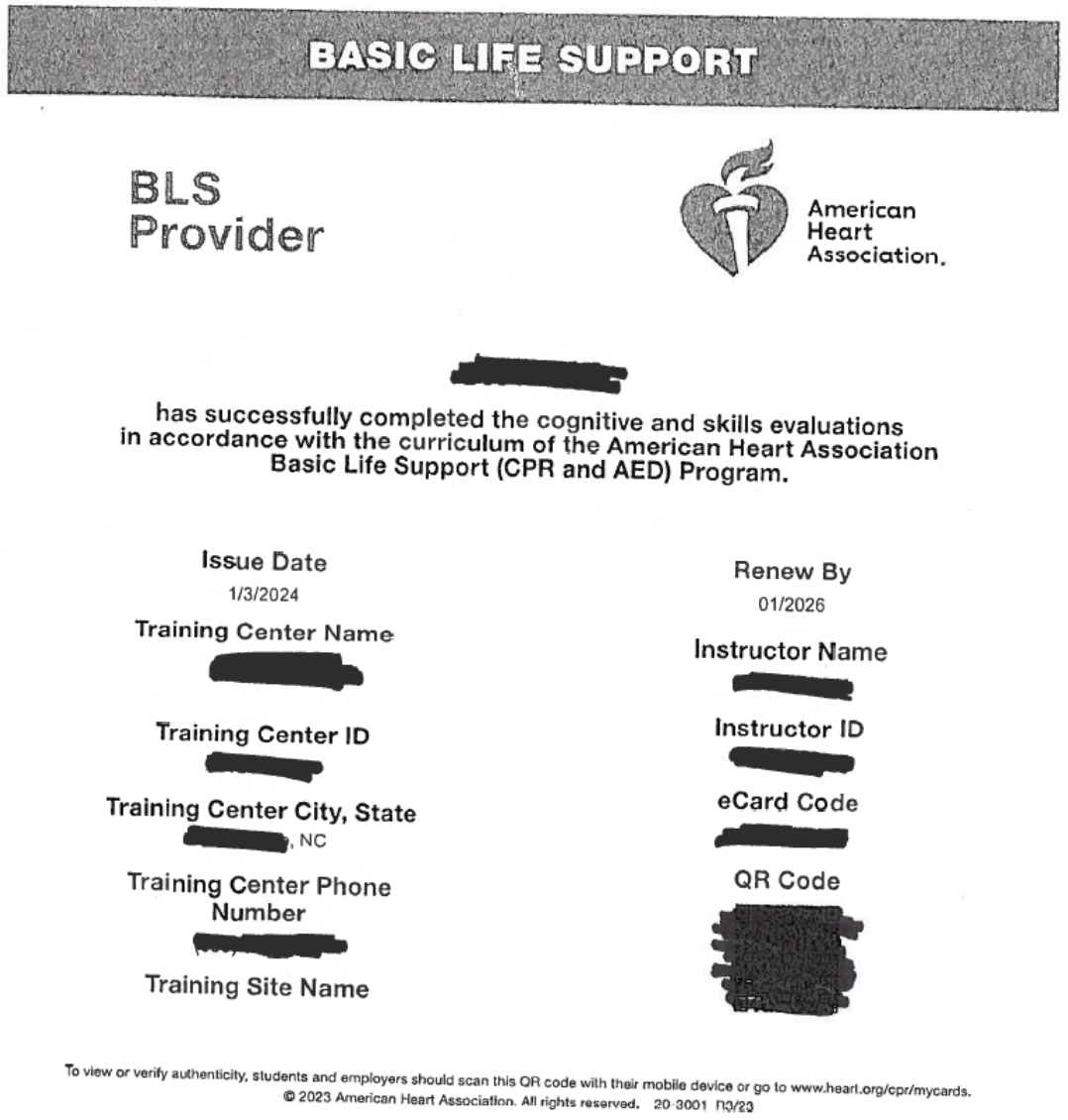
TRAINING CENTER
Safety and Health Council of North Carolina

TRAINING CENTER ID
207230

This course is equivalent to AHA and meets ECC and ILCOR guidelines.

This credential can be verified at nsc.org/FAverify

Samples



BASIC LIFE SUPPORT

BLS
Provider

American
Heart
Association.

[redacted]

has successfully completed the cognitive and skills evaluations
in accordance with the curriculum of the American Heart Association
Basic Life Support (CPR and AED) Program.

Issue Date
1/3/2024

Renew By
01/2026

Training Center Name
[redacted]

Instructor Name
[redacted]

Training Center ID
[redacted]

Instructor ID
[redacted]

Training Center City, State
[redacted], NC

eCard Code
[redacted]

Training Center Phone
Number
[redacted]

QR Code
[redacted]

Training Site Name

To view or verify authenticity, students and employers should scan this QR code with their mobile device or go to www.heart.org/cpr/mycards.
© 2023 American Heart Association. All rights reserved. 20-3001 03/23

BLS does not include First Aid (CPR Only)

Nursing Employee Documentation

Verification that each employee functioning as a nurse (LPN or RN) at the program is currently licensed to practice nursing in NC

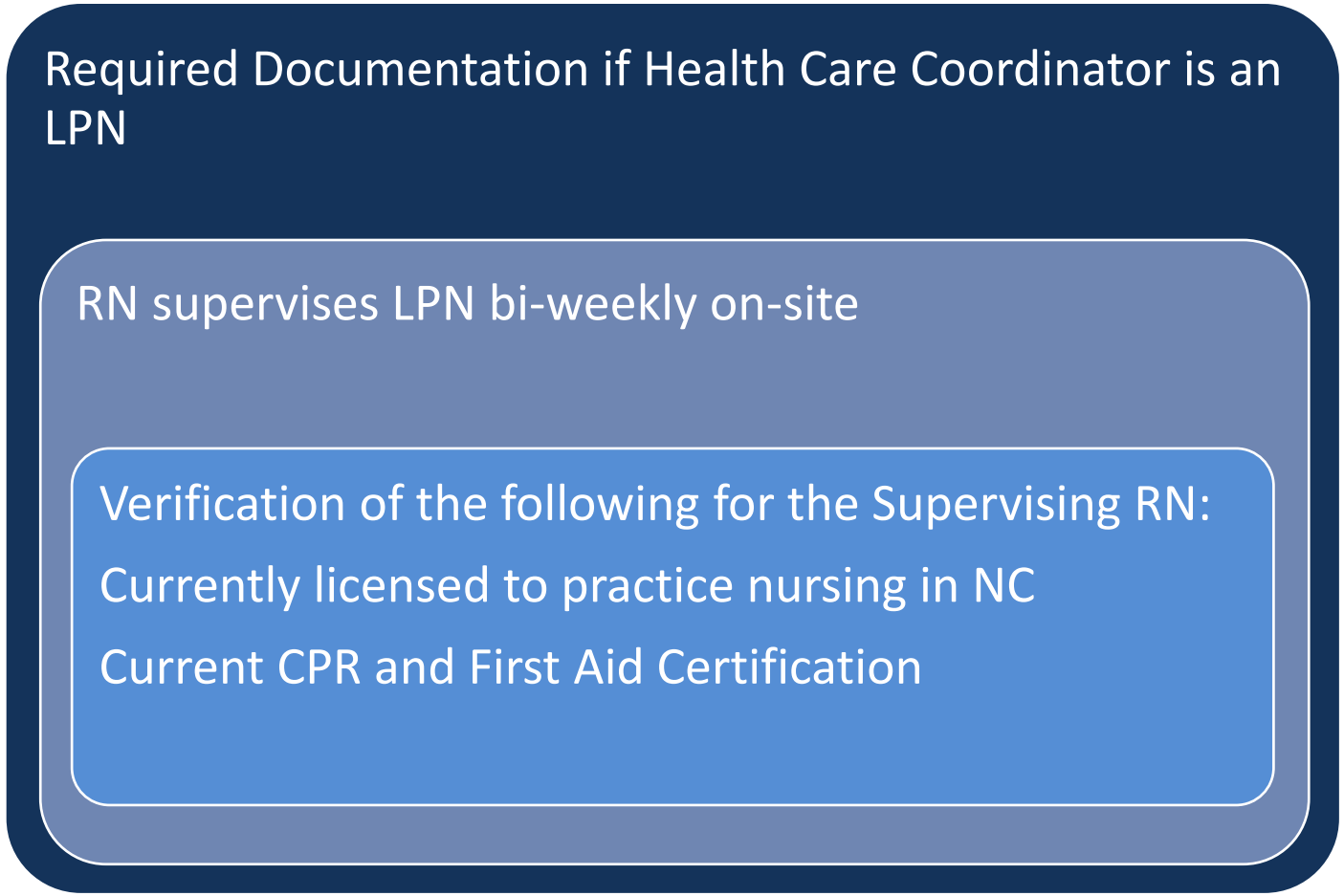
Can be retrieved from:

The NC Board Of Nursing (NC BON) website

NURSYS for multi-state compact nursing licenses

https://www.ncbon.com/verify-nc-license
https://www.nursys.com/

Required Documentation if Health Care Coordinator is an LPN



Supervising RN's Duties

Complete participant assessments

Complete the health care portion of participant care plan/service plans

In NC, an LPN cannot complete assessments or write the health care portion of the care plan/service plan per the NC Board of Nursing

Documentation for Employees Newly Hired Since Last Recertification

Evidence that a statewide criminal history records search for NC for the past 5 years was conducted by an agency approved by the Administrative Offices of the Courts

Current Certified Employee Medical Statement on required Form

Per DAAS Administrative Letter 17-04, Specific Certified Employee Medical Statement must be submitted for all newly hired employees

https://www.nccourts.gov/documents/publications/criminal-background-check-companies
https://www.ncdhhs.gov/documents/files/adult-day-care-certified-employee-medical-statement-per-rule-5

WRITTEN EMPLOYEE MEDICAL STATEMENT
SIGNED BY A PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT FOR EMPLOYMENT AT AN ADULT DAY CARE/ADULT DAY HEALTH PROGRAM

I. EMPLOYEE/EMPLOYER SECTION *(To be completed by Employee/Employer)*

EMPLOYEE'S NAME:	
EMPLOYEE'S DATE OF BIRTH:	
EMPLOYEE'S ADDRESS:	

A. EMPLOYEE RELEASE OF PERTINENT INFORMATION FROM PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT

I, _____, agree to the release of pertinent information by my physician, nurse
(EMPLOYEE'S NAME)

practitioner or physician's assistant, _____, to my employer listed below.
(PHYSICIAN, NURSE PRACTITIONER OR PHYSCIAN'S ASSISTANT NAME)

EMPLOYEE SIGNATURE: _____ DATE: _____

B. EMPLOYER INFORMATION *(Adult Day Care or Adult Day Health Program)*

EMPLOYER NAME:	
ADDRESS:	
PHONE NUMBER:	

ADDRESS:	
PHONE NUMBER:	

II. PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT SECTION

PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT NAME:	
PRACTICE ADDRESS:	
PRACTICE PHONE NUMBER:	

A. STATEMENT FROM A PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT FOR ABOVE NAMED EMPLOYEE

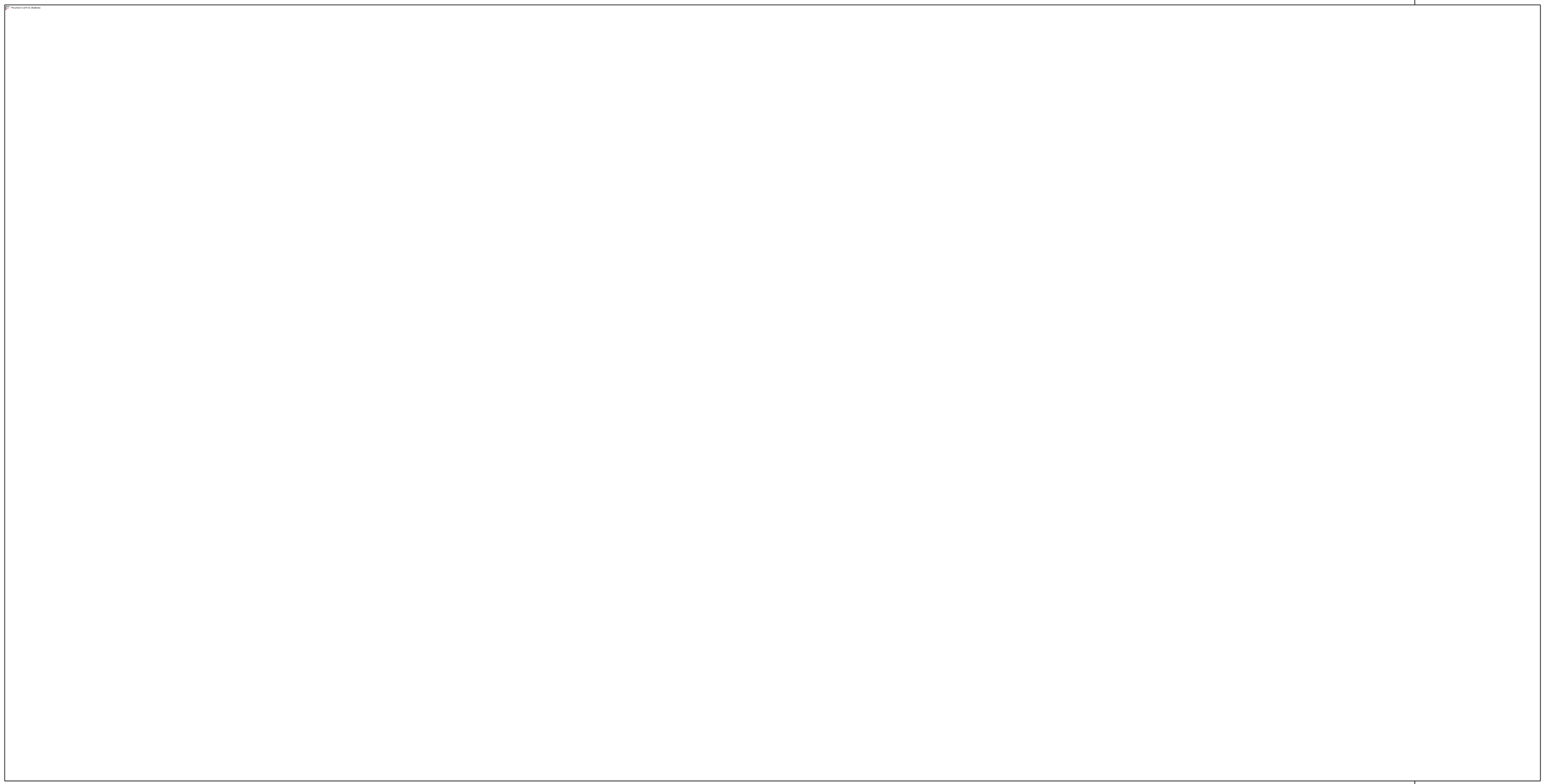
I certify that the employee listed above has an absence of a health condition that would pose a risk to others and that the employee can perform the duties normally assigned on the job.

PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT SIGNATURE:

_____

OFFICIAL TITLE: DATE: _____

5/4/2017



ONLY Submit if changed since program's last recertification

Personnel Policies

Please highlight changes made to policies for more time efficient review by Consultants

Floor Plan (change of address, change of capacity, or when structural changes have been made)

Building Inspection Report, DOA-1499 or equivalent (change of address or when structural building modifications done)

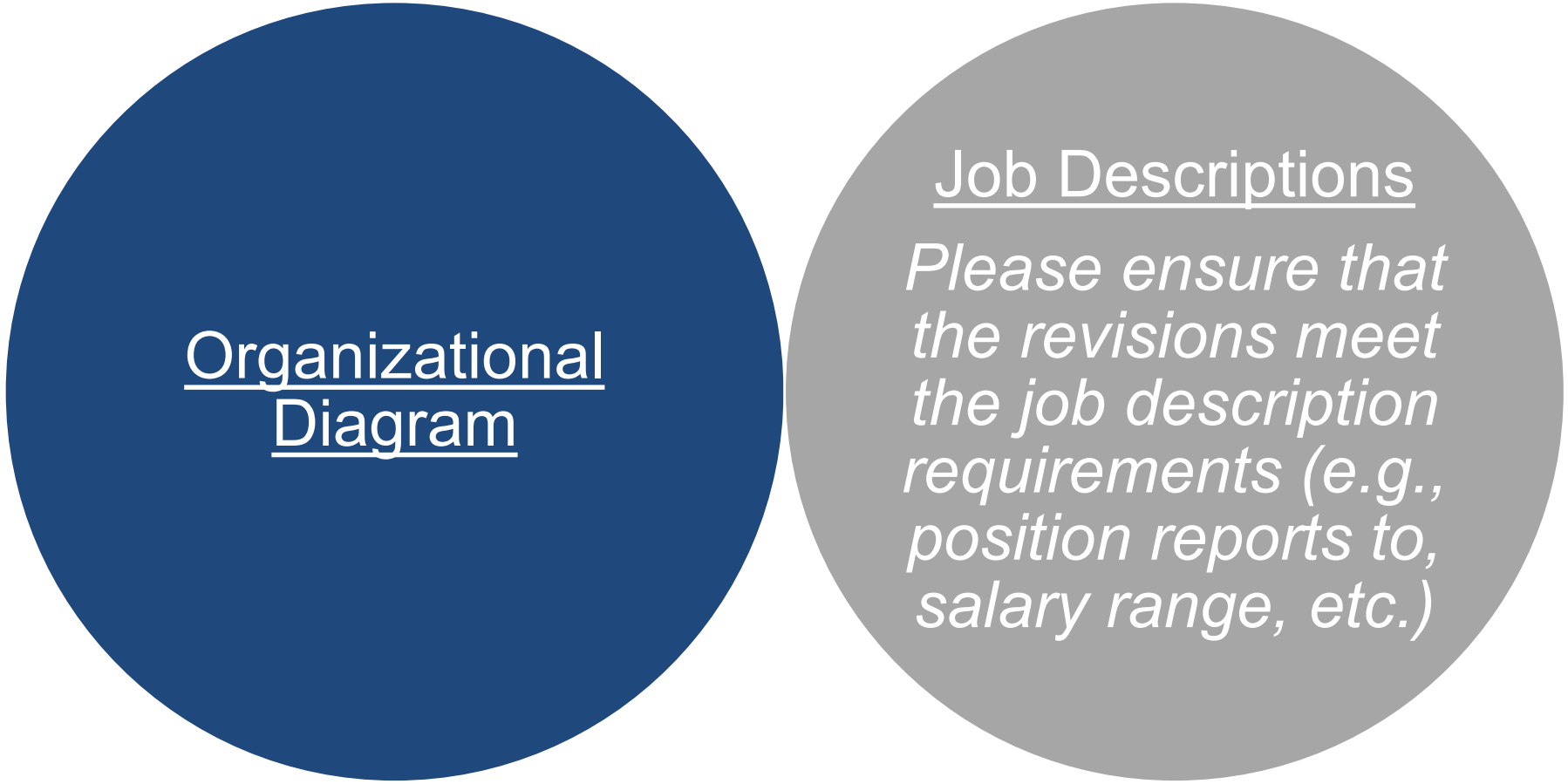
ONLY Submit if changed since program's last recertification

Articles of incorporation, Bylaws, names and addresses of board members, if applicable

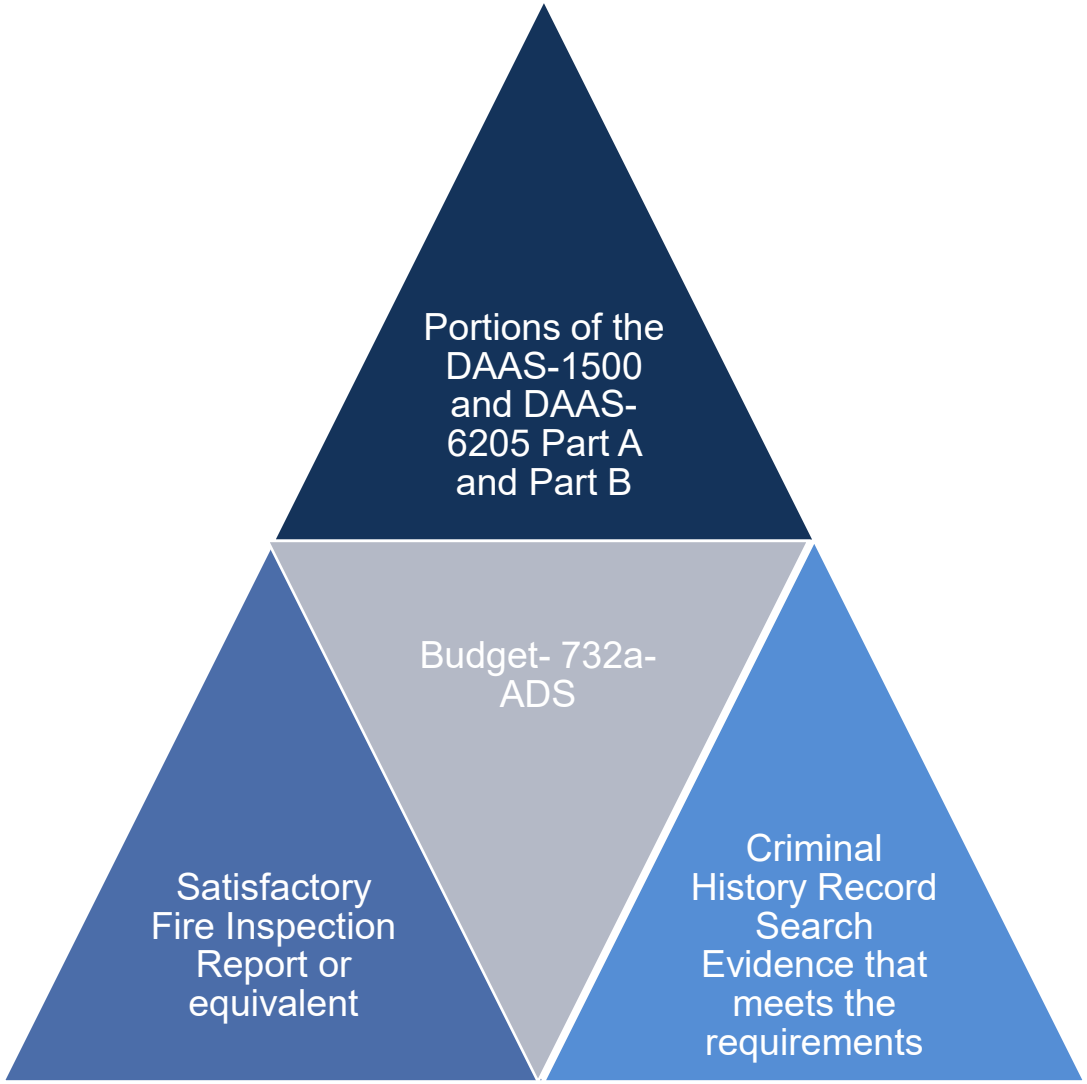
Program Policies

Please highlight changes made to policies for more time efficient review by Consultants

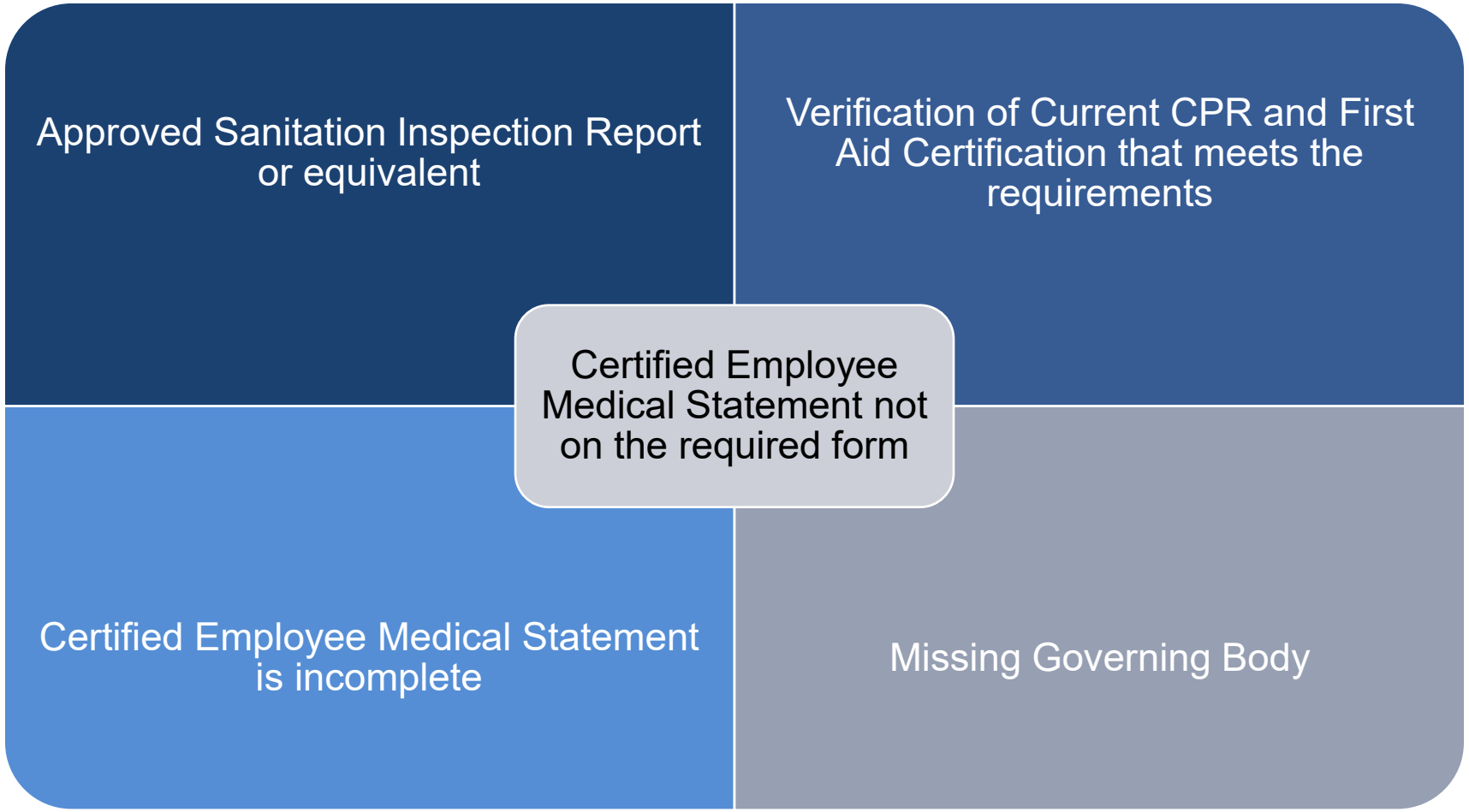
ONLY Submit if changed since program's last recertification



Common missing/incomplete items



Common missing/incomplete items



DAAS-1500 & DAAS – 6205 Part A- FACE SHEET

Following are incomplete or completed incorrectly:

“Type of Program”

“Program Offers Specialized Care for”

“Certification Period” dates are often completed incorrectly

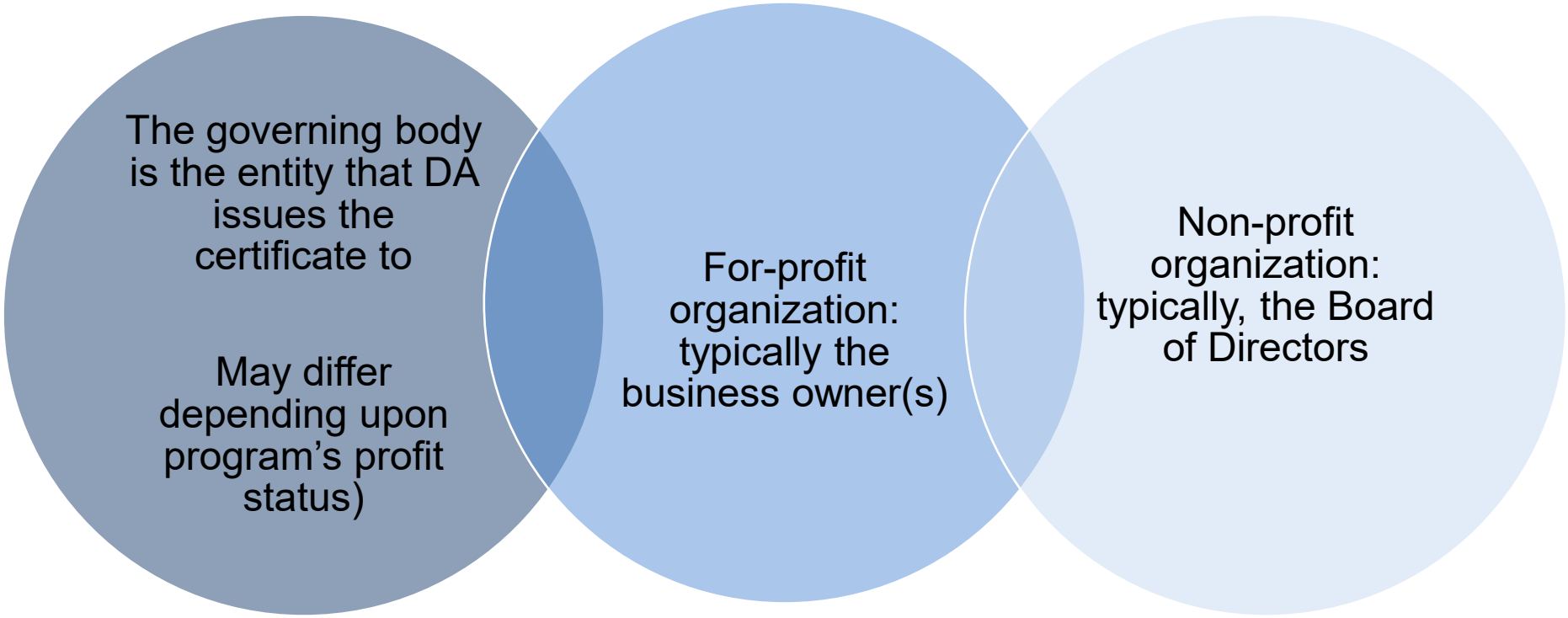
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF AGING AND ADULT SERVICES
ADULT DAY HEALTH SERVICES
PROGRAM CERTIFICATION REPORT
FACE SHEET

ACTION REQUESTED

( ) Certification
( ) Recertification
( ) Denial or Revocation
( ) Change in Program Director/Operator
( ) Change of Capacity
( ) Change of Address
( ) Provisional

Type of Program ( ) Public ( ) Profit ( ) Adult Day Health Center ( ) Adult Day Health Home ( ) Non-Profit ( ) Combination Program Program Offers Specialized Care for ( ) Dementia/Alzheimer's ( ) Developmental Disabilities ( ) NONE ( ) OTHER:	Date of Report: _____ Certification Period: FROM: TO:
Name of Program:	Capacity:
Address (Street, City, Zip Code):	County:
Mailing Address (if Different from Above):	Program Telephone (Area Code and No.):
Name of Director/Operator:	
Email Address/Web Address:	

Governing Body of the DAAS-1500 & DAAS – 6205 Part A



STANDARDS REVIEW

I. ADMINISTRATION

A. Governing Body

YES	NO		
		1.	Adult Day Health Center Governing Body: _____ ***Board of Directors or Owner(s)*** Auspices Under Which Center Operates
		2.	Governing Body or Operator Carries Out Responsibilities As Specified. Responsibilities Include:
( )	( )		a. Approval of Organizational Structure (Centers only)
( )	( )		b. Adoption or Development of Annual Budget
( )	( )		c. Regular Review of Financial Status, Including Annual Budget, Monthly Accounts of Income and Expenditures to Reflect Against Budget, and Annual Audit for Centers; or Maintenance of Monthly Accounts of Income and Expenditures for Homes
( )	( )		d. Appointment of Program Director for Centers
( )	( )		e. Establishment of Written Policies Regarding Operation in Direct and Understandable Language which includes: ☐ Program Policies ☐ Personnel Policies ☐ Any other policies deemed necessary, such as arrangement with other agencies and organizations

(☐) (☐) 12. Telephone Available as Required.

B. Additional Facility Requirements for Adult Day Health

(☐) (☐) 1. Facility Space Provides Sufficient Dimension and Size to Allow for Required Group Activities.

(☐) (☐) a. **Day Health** Centers and Homes Provide at Least 60 Square Feet of Indoor Space Excluding Hallways, Offices and Restrooms for Each Participant.
If N/A, check (☐)

(☐) (☐) b. **Combination** Programs Provide at Least 50 Square Feet of Indoor Space Excluding Hallways, Offices and Restrooms for Each Participant.
If N/A, check (☐)

(☐) (☐) c. Day Health Programs or Combination Programs In A **Multi-Use Facility** Must Have a Nucleus Area Separate from Other Activities in the Rest of the Building.
If N/A, check (☐)

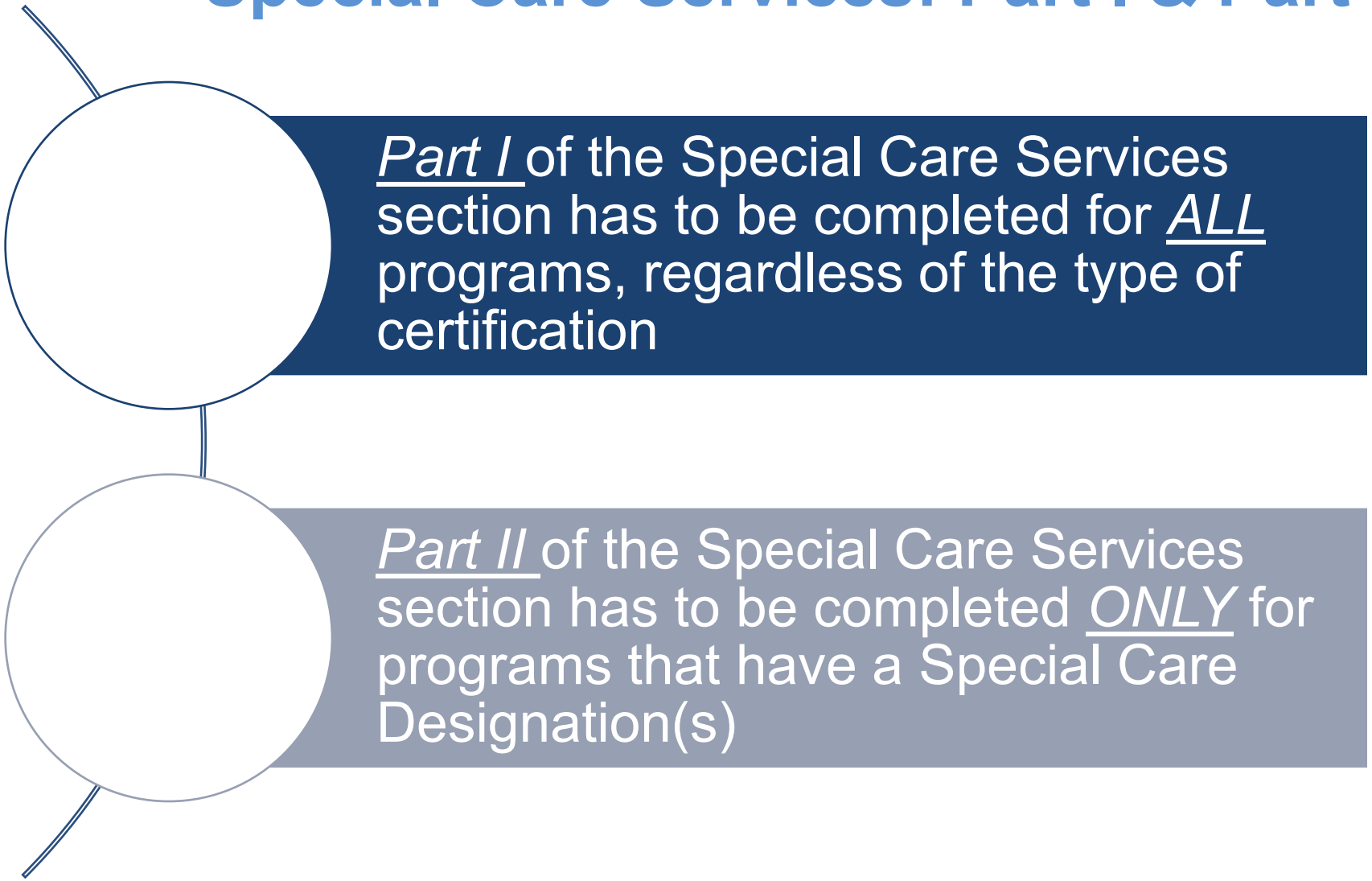
(☐) (☐) (1) Nucleus area provides at least 40 Square Feet of Indoor Space As Specified in Standards, and a Minimum of 20 Square Feet Per Participant Must Be Provided in Other Space in the Facility Designated for Use by the Day Health Program.

YES NO

(☐) (☐) (2) Participation is Open Only to Persons Enrolled in the Program and to Visitors on a Planned Basis.

2. **Reviewed in Part B of This Report**

Special Care Services: Part I & Part II



Part I of the Special Care Services section has to be completed for *ALL* programs, regardless of the type of certification

Part II of the Special Care Services section has to be completed *ONLY* for programs that have a Special Care Designation(s)

YES	NO		**** Complete This Part on ALL Programs ****
		VI.	**SPECIAL CARE SERVICES (Part 1)**
		A.	**Screening For Special Care Services (All Renewal Or New Certifications Must Complete And Submit This Section)**
( )	( )	1.	The Program's Name Includes or Mentions a Disease, Condition or Disability Group.
( )	( )	2.	In the Program Policy Statement or the Program Brochure, the Program Advertises, Claims or Markets Special Care Services by Name for Any Disease, Condition or Disability Group.

Do Not Skip This Section

YES	NO		
		VI.	**SPECIAL CARE SERVICES (Part 1)**
		A.	**Screening For Special Care Services (<u>All Renewal Or New Certifications Must Complete And Submit This Section</u>)**
( )	( )	1.	The Program's Name Includes or Mentions a Disease, Condition or Disability Group.
( )	( )	2.	In the Program Policy Statement or the Program Brochure, the Program Advertises, Claims or Markets Special Care Services by Name for Any Disease, Condition or Disability Group.
( )	( )	3.	Program Goals Refer to Specialized Services or Care for Persons with Certain Conditions or Disabilities.
( )	( )	4.	Enrollment Policies Target or Mention Specialized Care for Persons with Alzheimer's Disease or Other Dementia, Developmental Disabilities, Persons with HIV-AIDS or Other Special Conditions or Disabilities.
( )	( )	5.	Brochures, Pamphlets, Posters or Other Outreach or Publicity Material Reference Special Care or Special Programming for Persons With:
( )	( )		Alzheimer's Disease or Other Dementia
( )	( )		Developmental Disabilities
( )	( )		Parkinson's Disease
( )	( )		HIV-AIDS
( )	( )		Others: Specify_____
( )	( )	6.	Brochures or Pamphlets Refer to Care for Persons with a Special Disability or Condition by Separate Programming.
		7.	**If "Yes" Is Checked In Any Of The Above, Determine That:**
( )	( )	**a.**	The Program Provides Specialized Care for One or More of the Above Groups, **OR**
( )	( )	**b.**	The Program Does Not Provide Specialized Care.
			If "yes" for 7b above is checked, <u>Do Not</u> Complete Part 2 below (Specialized Care).
			If "yes" for 7a above is checked, <u>Complete</u> Part 2 below (Specialized Care).

Special Conditions or Disabilities:

( ) ( ) 5. Brochures, Pamphlets, Posters or Other Outreach or Publicity Material Reference Special Care or Special Programming for Persons With:

( ) ( ) Alzheimer's Disease or Other Dementia

( ) ( ) Developmental Disabilities

( ) ( ) Parkinson's Disease

( ) ( ) HIV-AIDS

( ) ( ) Others: Specify

( ) ( ) 6. Brochures or Pamphlets Refer to Care for Persons with a Special Disability or Condition by Separate Programming.

7. **If "Yes" Is Checked In Any Of The Above, Determine That:**

( ) ( ) **a.** The Program Provides Specialized Care for One or More of the Above Groups, **OR**

( ) ( ) **b.** The Program Does Not Provide Specialized Care.

If "yes" for 7b above is checked, <u>Do Not</u> Complete Part 2 below (Specialized Care).

If "yes" for 7a above is checked, <u>Complete</u> Part 2 below (Specialized Care).

VII. SPECIAL CARE SERVICES (Part 2)

Program Policies and Implementation for the Special Care Group Includes the Following:

1. The Statement of Mission and Objectives For Special Care Addresses:

( ) ( ) a. Environmental Safety and Appropriateness

( ) ( ) b. Type and Frequency of Daily Activities With Regard to Specialized Service

( ) ( ) c. Service Plans that Emphasize Capacities as Well as Deficits

( ) ( ) d. Methods of Behavior Management Which Preserve Dignity Through Design of Physical

Special Care Designation . DAAS 6205-A or 1500 Page 12

VII. SPECIAL CARE SERVICES (Part 2)

Program Policies and Implementation for the Special Care Group Includes the Following:

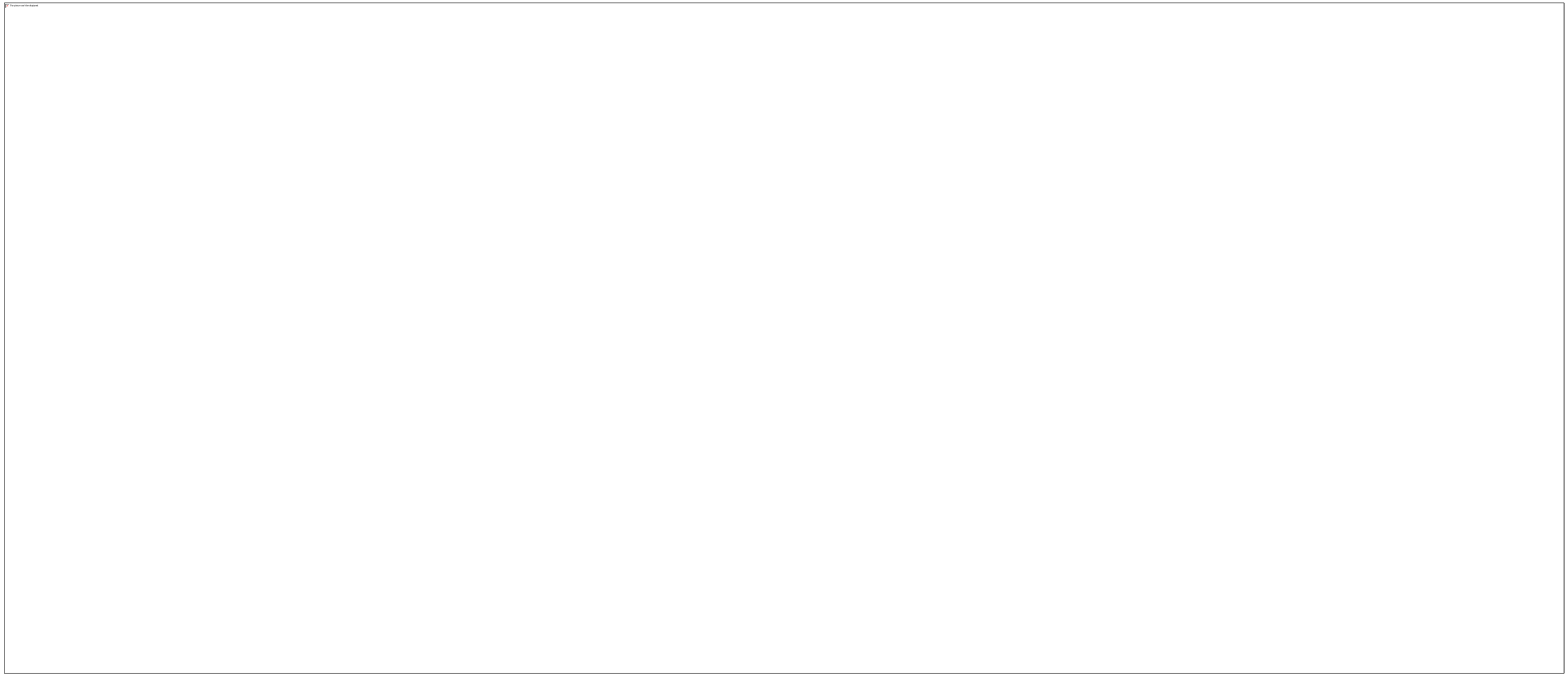
		1.	The Statement of Mission and Objectives For Special Care Addresses:
( )	( )	a.	Environmental Safety and Appropriateness
( )	( )	b.	Type and Frequency of Daily Activities With Regard to Specialized Service
( )	( )	c.	Service Plans that Emphasize Capacities as Well as Deficits
( )	( )	d.	Methods of Behavior Management Which Preserve Dignity Through Design of Physical Environment, Physical and Social Activity, Appropriate Medication Administration, Proper Nutrition and Health Maintenance.
( )	( )	2.	Process and Criteria for Enrollment and Discharge From Special Care.
( )	( )	3.	The Policies Describe Accurately the Special Care Services in the Center.
( )	( )	4.	Participant Assessment and Service Planning Includes Opportunity for Family Involvement in Planning and Implementation of the Service Plan, **AND** Participant Assessment and Service Planning Provides for Appropriate Response to Changes in the Participant's Condition.
( )	( )	5.	Safety Measures Address Specific Dangers Such as Wandering, Ingestion, Falls, Smoking, and Aggressive Behavior.
( )	( )	6.	Emergency Procedures Address Possible Lost or Missing Participants.
( )	( )	7.	The Specialized Service is Staffed to Meet the Needs of Participants.
( )	( )	8.	The Staff Annually Receives Training in Specialized Care for the Population.
( )	( )	9.	Physical Environment and Design Features Address the Needs of the Special Care Population.
( )	( )	a.	Locking Devices (If Used In Program) Meet Requirements in N.C. State Building Code for Locking Devices.
( )	( )	b.	If Program Does Not Have Locked Doors, a System of Security Monitoring is Provided.
( )	( )	10.	Activities Offer Options Depending on Personal Preferences and Abilities of Participants.
( )	( )	11.	The Program Offers Involvement for Family/Caregivers.

DAAS–6205 Part B: Local Departments of Health, Standards Review

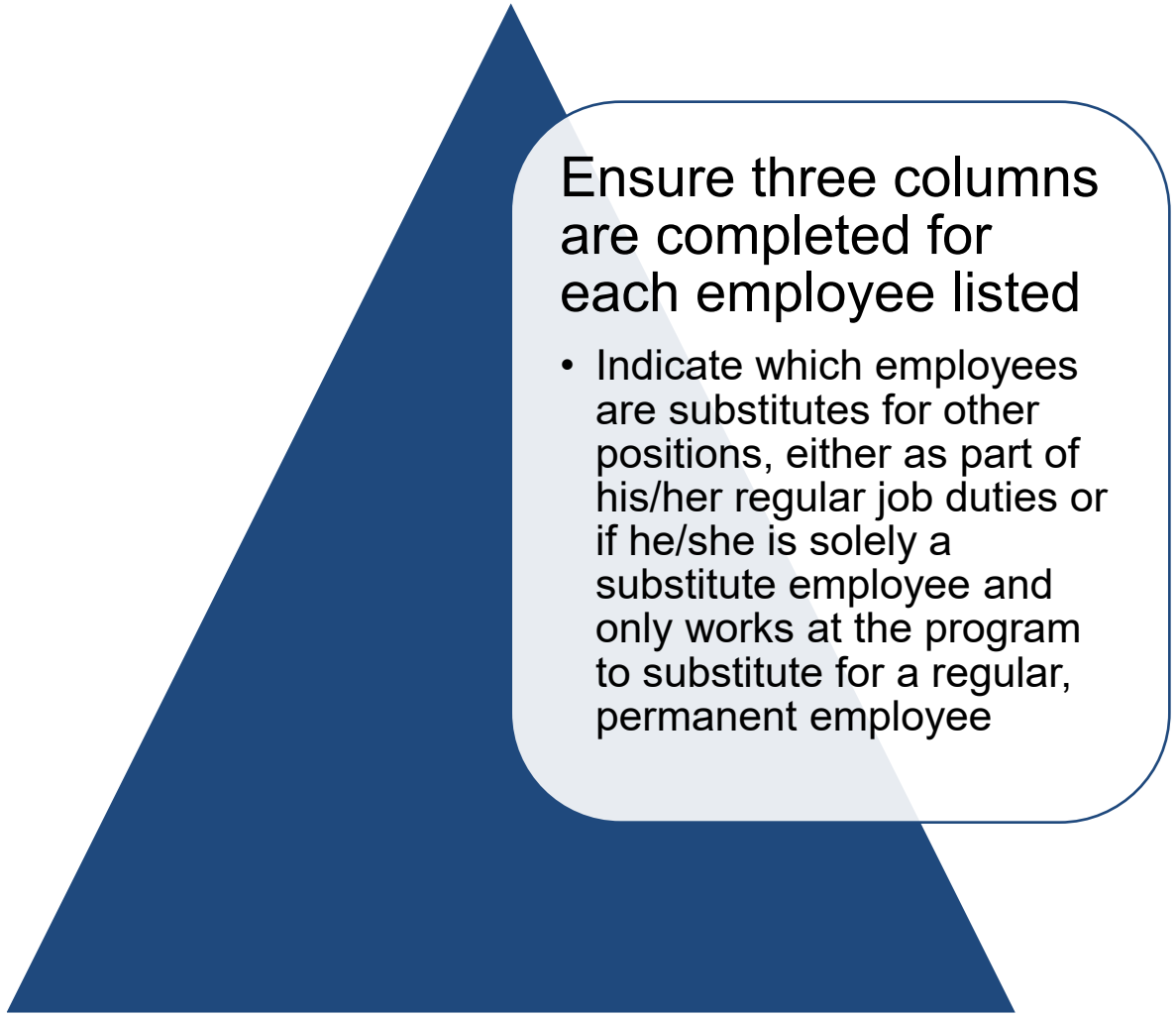
"Name of Health Care Coordinator" is completed incorrectly

The individual that is to be listed on this line is the program employee who is fulfilling the Health Care Coordinator role

The content of the DAAS-6205 Part B is to be completed based on the Health Care Coordinator's qualifications, etc.



DAAS-1500 & DAAS-6205 Part A: Personnel Page



Ensure three columns are completed for each employee listed

- Indicate which employees are substitutes for other positions, either as part of his/her regular job duties or if he/she is solely a substitute employee and only works at the program to substitute for a regular, permanent employee

II. PERSONNEL

1. List Names and Positions of ALL Paid Staff Positions
2. List Names and Positions of Volunteers ONLY used for coverage of usual responsibilities and maintenance of staff to participant ratio.

EMPLOYEE/VOLUNTEER NAME	POSITION TITLE *Next to position title, write/type "Volunteer" if individual is a Volunteer used for coverage of usual responsibilities and maintenance of staff to participant ratio.*	INDIVIDUAL IS A SUBSTITUTE FOR ANY STAFF POSITION *Applies to all Paid/Volunteer Staff Positions that substitute for any Paid/Volunteer Staff Position.* *Check Yes or No*	HIRED/BEGAN VOLUNTEERING SINCE LAST RECERTIFICATION *Check Yes or No*
		Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐	Yes ☐ No ☐

** Use Additional Sheet for larger programs**

II. PERSONNEL

1. List Names and Positions of ALL Paid Staff Positions
2. List Names and Positions of Volunteers ONLY used for coverage of usual responsibilities and maintenance of staff to participant ratio.

EMPLOYEE/VOLUNTEER NAME	POSITION TITLE *Next to position title, write/type "Volunteer" if individual is a Volunteer used for coverage of usual responsibilities and maintenance of staff to participant ratio.*	INDIVIDUAL IS A SUBSTITUTE FOR ANY STAFF POSITION *Applies to all Paid/Volunteer Staff Positions that substitute for any Paid/Volunteer Staff Position.* *Check Yes or No*	HIRED/BEGAN VOLUNTEERING SINCE LAST RECERTIFICATION *Check Yes or No*
Jane Daycare	Program Director	Yes ☐ No ☒	Yes ☒ No ☐
John Employee	Assistant Program Director	Yes ☒ No ☐	Yes ☐ No ☒
		Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐	Yes ☐ No ☐

** Use Additional Sheet for larger programs**

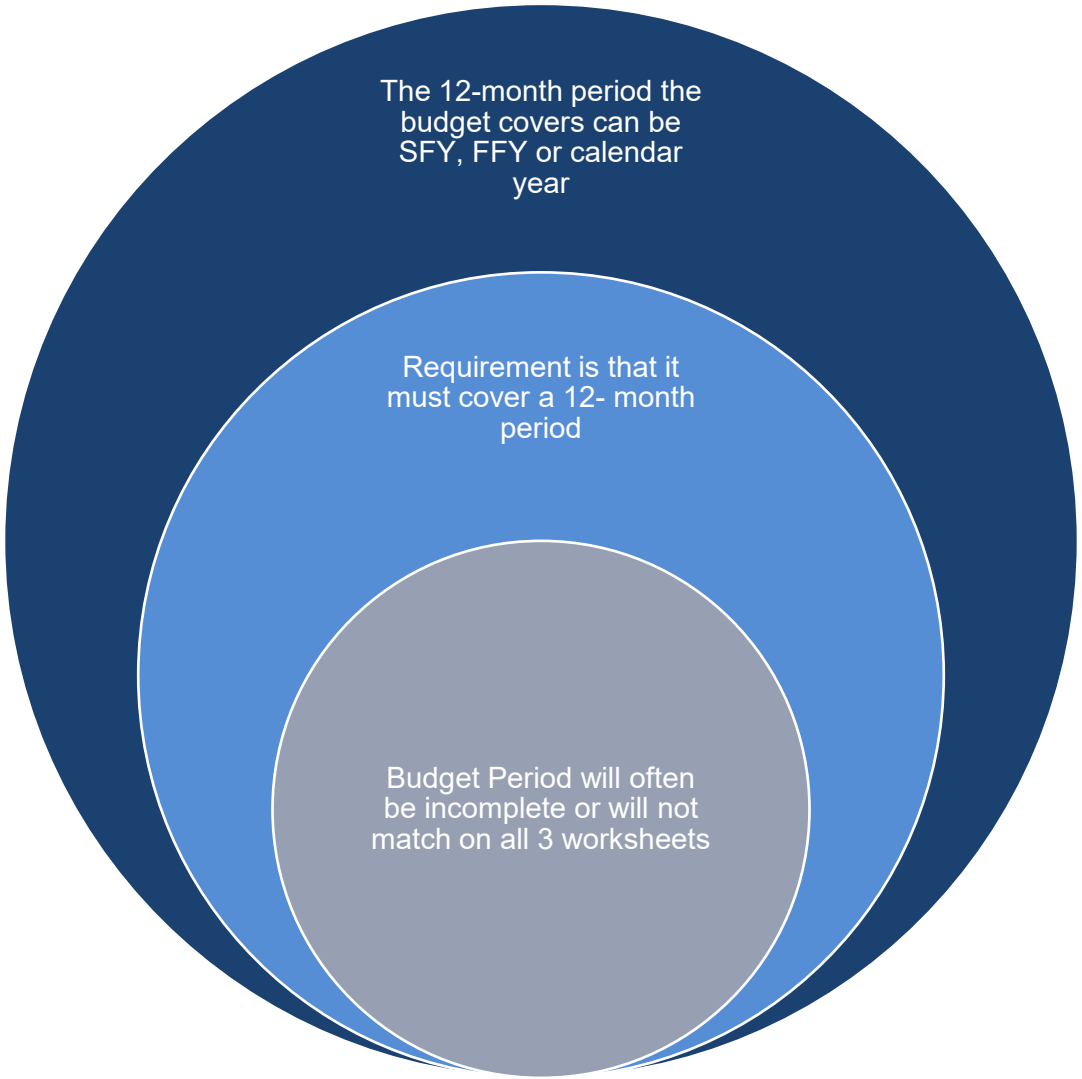
732a-ADS

732a-ADS or equivalent is not submitted

1 or more of the 3 sheets of the 732a-ADS is missing

If all 3 sheets of the 732a-ADS are submitted, information is often missing or is incomplete

Headers on All 3 Sheets of the 732a-ADS



North Carolina Division of Aging and Adult Services Adult Day Services Projected Revenues

Adult Day Services Program: _____

County:

Budget Period: through

Projected Revenues	Grand Total	Adult Day Care	Adult Day Health Care
A. Fed/State Funding From the Division of Aging and Adult Services	////////////	////////////	////////////
Home and Community Care Block Grant (HCCBG)	0		
State Adult Day Care Fund (SADCF)	0		
Family Caregiver Support	0		
Total Fed/State Funding Through Division of Aging and Adult Services	0	0	0

North Carolina Division of Aging and Adult Services

Adult Day Services Client Transportation Worksheet C:732Aadsdailyrate.xls

Provider:

County:

Current Budget Period through

	Grand Total	Adult Day Care	Adult Day Health Care
A. Total Projected Client Transportation Costs			

Projected Revenue Sheet: HCCBG & SADCF Required Minimum Matches

Required HCCBG & SADCF minimum matches are not included on the Projected Revenue Sheet or are not the correct percentages

The HCCBG & SADCF contract with the provider should include these figures

For HCCBG, the funder may be the Area Agency on Aging (AAA) or the Community Service Provider

For SADCF, the funder is the County Department of Social Services

North Carolina Division of Aging and Adult Services Adult Day Services Projected Revenues

Adult Day Services Program: _____

County:

Budget Period: through

Projected Revenues	Grand Total	Adult Day Care	Adult Day Health Care
A. Fed/State Funding From the Division of Aging and Adult Services	//////////////	//////////////	//////////////
Home and Community Care Block Grant (HCCBG)	0		
State Adult Day Care Fund (SADCF)	0		
Family Caregiver Support	0		
Total Fed/State Funding Through Division of Aging and Adult Services	**0**	**0**	**0**
B. Required Minimum Match (Cash or In-Kind) Paid by Center or County	//////////////	//////////////	//////////////
1) HCCBG (10%)	0	0	0
2) SSBG (12.5%)	0	0	0
No local match required for Family Caregiver Support Program	//////////////	//////////////	//////////////
Total Required Minimum Match	**0**	**0**	**0**
C. Total Fed/State Funding and Required Minimum Match	**0**	**0**	**0**

Daily Cost Computation Worksheet

Often this worksheet is submitted, but the required Daily Cost Per Client calculation is incomplete

If the required Daily Cost Per Client calculation is completed, it is incorrect

North Carolina Division of Aging and Adult Services
Adult Day Services Daily Cost Computation Worksheet c:732Aadsdailyrate.xls
Provider:
County:
Current Budget Period: through

Do not include any client transportation costs such as drivers, fuel, vehicle maintenance, etc.

Projected Line Item Expense	Grand Total	Adult Day Care	Adult Day Health Care
Staff Salary	//////////////	//////////////	//////////////
	0		
	0		
	0		
	0		
A. Subtotal, Staff Salary	0	**0**	**0**
Fringe Benefits	//////////////	//////////////	//////////////
1) FICA	0		
2) Health Ins.	0		
3) Retirement	0		
4) Unemployment Insurance	0		
5) Worker's Compensation	0		
6) Long Term Disability	0		
7) Dental Insurance	0		
8) Life Insurance	0		
9) Other	0		
B. Subtotal, Fringe Benefits	0	**0**	**0**
Staff Travel	//////////////	//////////////	//////////////
1) Lodging and Meals	0		
2) Mileage Reimbursement	0		
3) Commercial Transportation	0		
4) Other Travel Cost:	0		

C. Subtotal, Staff Travel	0	**0**	**0**
Other Operating Expenses	//////////////////	//////////////////	//////////////////
1) Rent	0		
2) Telephone	0		
3) Postage/Shipping	0		
4) Printing/Publications	0		
5) Copying	0		
6) Equipment Rental	0		
7) Equipment Purchase/Depreciation	0		
8) Equipment Maintenance	0		
9) Contracted Labor	0		
10) Activity/Program Supplies	0		
11) Office Supplies	0		
12) Conference Registration	0		
13) Auto Liability Insurance	0		
14) Client Meals	0		
15) Advertising	0		
16) Employee Recruitment	0		
17) Other:	0		
18) Other:	0		
D. Subtotal, Other Operating Expenses	**0**	**0**	**0**
E. Grand Total, Expenses	**0**	**0**	**0**
F. Total Projected Service Days	//////////////////		
G. Projected Average Daily Participation	//////////////////		
H. Daily Cost Per Client (E divided by F, divided by G)	//////////////////	**#DIV/0!**	**#DIV/0!**

E. Grand Total, Expenses

E. Grand Total for Expenses	Is the amount of money the program needs in order to meet its expenses to provide the service
F. Total Projected Service Days	The number of days the program anticipates that it will be open and operational.

Calculating the Daily Cost

G. Projected Average Daily Participation

Is the number of participants the program anticipates will attend the program on the days the program is open and operational.

E. Grand Total is divided by F. Total Projected Service Days

The figure that results from the operation is then divided by G. Projected Average Daily Participant

This final figure resulting from the second operation is the program's *Daily Cost Per Client*

C. Subtotal, Staff Travel	**1,712**	**1,712**	**0**
Other Operating Expenses	//////////////	//////////////	//////////////
1) Rent $13/sq.ft x 2500 sq.ft.	32,500	32,500	
2) Utilities water @ $30; electricity @ $350; gas @ $375 X 12	9,060	9,060	
3) Telephone $110 X 12	1,320	1,320	
4) Postage/Shipping $50 X 12	600	600	
5) Printing/Publications/Memberships $50 X 12	600	600	
6) Copying	0		
7) Equipment Lease copier 25,000 copies @ .05	1,250	1,250	
8) Equipment Purchase/Depreciation	2,500	2,500	
9) Equipment Maintenance	1,000	1,000	
10) Contracted Labor	0		
11) Activity/Program Supplies $300 X 12	3,600	3,600	
12) Office Supplies $125 X 12	1,500	1,500	
13) Conference Registration/ in-service training	675	675	
14) General Liability Insurance	2,000	2,000	
15) Meals/snacks $4.90 X 250 days X 16 clients avg attendance	19,600	19,600	
16) Advertising	250	250	
17) Employee Recruitment	0		
18) Other: Fund Raising	300	300	
19) Other: audit service	1,000	1,000	
D. Subtotal, Other Operating Expenses	**77,755**	**77,755**	**0**
E. Grand Total, Expenses	**175,724**	**175,724**	**0**
F. Total Projected Service Days	//////////////	250	
G. Projected Average Daily Participation	//////////////	16	
H. Daily Cost Per Client (E divided by F, divided by G)	//////////////	**43.93**	**#DIV/0!**

Client Transportation Worksheet

Often this worksheet is submitted, but the required “Average Daily Cost of Round Trip per Client” is incomplete or incorrect

If a provider does not provide or arrange (has no cost for transportation), the Client Transportation Worksheet should still be completed

Complete the header

0s should be listed in all columns

Client Transportation Worksheet

If the completed Certification Report (DAAS-1500 or DAAS-6205 Part A) indicates that a program provides or arranges transportation for participants to and from the program

transportation worksheet should be completed

Transportation Calculations

A. Is the amount of money it costs the program to directly provide transportation or to contract for transportation for its participants to and/or from the program location.

B. Is the number of days the program anticipates that it will be open and operational.

C. Is the number of participants the program anticipates will attend the program on the days the program is open and operational and will utilize the transportation the program directly provides or contracts to provide.

North Carolina Division of Aging

Adult Day Services Client Transportation Worksheet c:732Aadsdailyrate.xls

Provider:

County:

Current Budget Period July 1, 2015 through June 30, 2016

	Grand Total	Adult Day Care	Adult Day Health Care
A. Total Projected Client Transportation Costs*	15,685	15,685	
B. Total Projected Service Days	//////////////	250	
C. Average Daily Participation Utilizing Transportation	//////////////	11	
D. Average Daily Cost of Round Trip Per Client*	//////////////	5.70	#DIV/0!

* A divided by B, divided by C

calculation is based on $1.5685 per mile @ 10,000 est. miles

North Carolina Division of Aging

Adult Day Services Client Transportation Worksheet c:732Aadsdailyrate.xls

Provider:

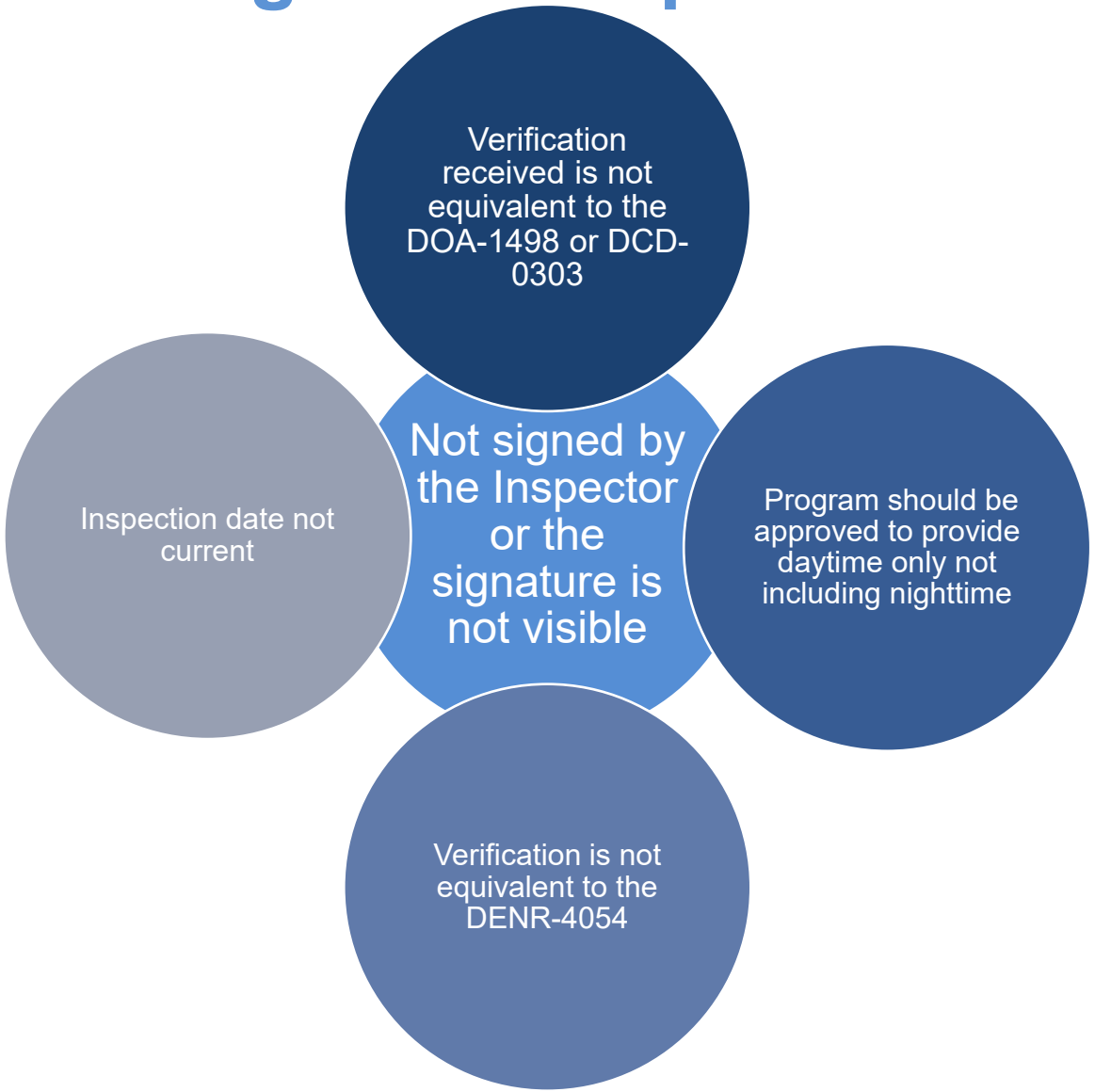
County:

Current Budget Period July 1, 2015 through June 30, 2016

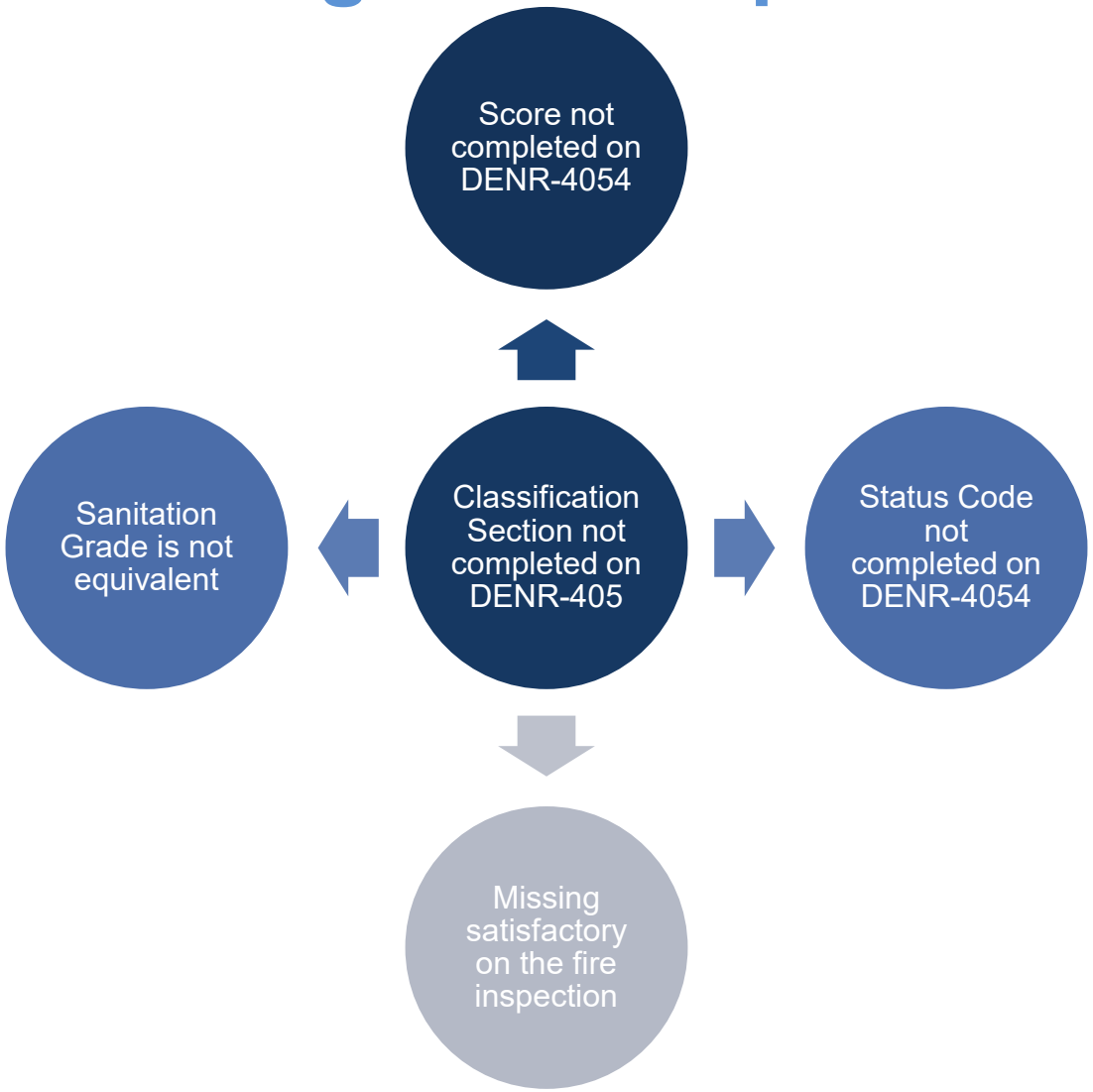
	Grand Total	Adult Day Care	Adult Day Health Care
A. Total Projected Client Transportation Costs*	15,685	15,685	
B. Total Projected Service Days	//////////////	250	
C. Average Daily Participation Utilizing Transportation	//////////////	11	
D. Average Daily Cost of Round Trip Per Client*	//////////////	5.70	#DIV/0!

* A divided by B, divided by C

Common Missing or Incomplete with Inspections



Common Missing or Incomplete with Inspections



N.C. Department of Environment and Natural Resources
Division of Environmental Health

Inspection of Adult Day Service Facility

Score: _____ _____

Date of Insp/Chg _____

Status Code: _____

Health Department _____

Current Facility ID _ _ _ _ _ _ _ _ _ _ _ _

Old Facility ID _ _ _ _ _ _ _ _ _ _ _ _

Classification: ☐ Superior ☐ Approved ☐ Provisional ☐ Disapproved

Water Supply: [1] Community [2] Transient Non-Community [3] Non-Transient Non-Community [4] Non-Public Water Supply

Water sample taken today? ☐ Yes ☐ No

[1] Inspection [2] Re-Inspection [V] Visit ☐ Name Change ☐ Verification of Closure ☐ Status Change

Wastewater System: [1] Community [2] On-Site System

Maximum Capacity _____

Name of Facility: _____ Operator: _____

Address (City, Zip Code): _____

FOOD: (.3304, .3305, .3306, .3307, .3308, .3310)		Demerits
*1. From approved sources, free from spoilage and adulteration	6	
2. Potentially hazardous food temperatures	5	
3. Properly prepared, handled, packaged, and identified	4	
4. Not re-served	4	
5. Protected at all times according to these rules	4	
6. Refrigerators with thermometers, product thermometers provided	3	

FOOD SERVICE EQUIPMENT AND UTENSILS: (.3304, .3306, .3307, .3309, .3310, .3311, .3312, .3313, .3314, .3316)		
*7. Meets specifications for refrigeration, sinks, and dishwashing equipment according to type of service	6	
8. Meets requirements for handwash lavatories	5	
9. Meets specifications for other equipment and utensils, approved material and construction, in good repair	4	
*10. Food contact surfaces, including multi-use utensils, properly washed, rinsed and sanitized	6	
*11. Single-service articles not reused	6	
12. Single-use articles not reused	2	
13. Non-food contact surfaces clean	4	
14. Equipment and utensils, including single-service articles,		

STORAGE: (.3317, .3320)		Demerits
*30. Medications and hazardous products properly stored and locked	6	
31. Facilities provided for proper storage, kept clean	3	

BEDS, LINENS, FURNITURE AND EQUIPMENT: (.3321, .3322)		
32. Beds, chairs, cots, or mats clean and in good repair, stored properly	5	
33. Mattress covers, individual linen provided	5	
34. Linen clean, in good repair; properly handled and stored	4	
35. Other furniture and equipment easily cleanable, good repair clean	4	

PERSONNEL: (.3323)		
36. Approved hygienic practices, clean clothes, hair restraints where required	3	
37. Tobacco not used in food prep areas or areas occupied by non-smokers	5	
*38. Persons with communicable disease or a communicable condition excluded from situations in which transmission can reasonable be expected to occur, in accordance with 15A NCAC 19A.0200	6	
*39. Wounds or lesions properly bandaged	6	

Insufficient Verification of Current CPR and First Aid Certification

The skills portion has not been completed

- Certificates drafted by the instructor (does not follow agency process for issuing certifications)

Attendance Course Roster missing one or more of the required elements

- Training for the CPR and/or First Aid Certification is completed by an agency that is not state approved

Insufficient Evidence of Criminal Background Check

County wide only search was completed

No indication that check went back a minimum of 5 years

Search for Nationwide only (not all nationwide searches include NC)

Agency NOT approved by the Administrative Offices of the Courts

No indication that check was NC statewide

https://www.nccourts.gov/documents/publications/criminal-background-check-companies

Executive Summary	[redacted]	COMPLETE
Statewide Criminal Search	NORTH CAROLINA	COMPLETE
Sex Offender Records Search	NATIONWIDE	COMPLETE

COMMENT

CAUTION: Based on the information provided Catapult Services Corporation searched for public records in the sources referenced herein for criminal history information as permitted by applicable laws. 'No Reportable Records Found' means that our researchers could not locate a record that matched. Further investigation into additional jurisdictions, or utilization of additional identifying information, may be warranted. Please call for assistance.

Disclaimer

In the process of completing this background report, the Person Search address history product was utilized to assist in the determination of criminal jurisdictions.

Investigative

Statewide Criminal Search

RESULTS: No Reportable Records Found
NAME SEARCHED: [redacted]
DOB SEARCHED: [redacted]XXXX
JURISDICTION: NORTH CAROLINA
SEARCH DATE: 07-24-2025 10:22 AM MDT
SEARCH SCOPE: Search Not Limited In Years

CAUTION: Based on the information provided Catapult Services Corporation searched for public records in the sources referenced herein for criminal history information as permitted by federal and state law. 'No Reportable Records Found' means that our researchers could not locate a record that matched at least two personal identifiers (i.e., Name, SSN, Date of Birth, Address) for the subject in that jurisdiction. Further investigation into additional jurisdictions, or utilization of additional identifying information, may be warranted. Please call for assistance.

Sex Offender Records Search

RESULTS: No Reportable Records Found
NAME SEARCHED: [redacted]
DOB SEARCHED: [redacted]
JURISDICTION: NATIONWIDE
SEARCH DATE: 07-22-2025 1:22 PM MDT
SEARCH SCOPE:

CAUTION: Based on the information provided Catapult Services Corporation searched for public records in the sources referenced herein for criminal history information as permitted by applicable laws. 'No Reportable Records Found' means that our researchers could not locate a record that matched. Further investigation into additional jurisdictions, or

RESULTS SUMMARY

CASTLEBRANCH
www.castlebranch.com
PH: (910) 815-3880 FAX: (910) 815-3881

Company Name: [redacted]
Order Date: 07/01/2025
Company ID: [redacted] Order ID: [redacted]

ePass [redacted] date 07-07-2025

First Name: [redacted]
Middle Name: [redacted]
Last Name: [redacted]

Date of Birth (DOB): [redacted]
Social Security Number (SSN): ***-** [redacted]

Social Security Alert

ssn	status
***-[redacted]	COMPLETED

Criminal Records

records found	name	location	status
NO*	[redacted]	US - NC	COMPLETED

County Civil

records found	name	location	status
NO	[redacted]	US - NC - [redacted]	COMPLETED

*Castle Branch is not affiliated with the judicial branch of the State of North Carolina or with the North Carolina Administrative Office of the Courts (NCAOC), and can not provide a certified or other official record of any court proceeding. Castle Branch is solely responsible for the content of this report. Questions or concerns about any content must be directed to Castle Branch.

The official custodian of all official court records for each county in North Carolina is the clerk of superior court of that county. The North Carolina Administrative Office of the Courts (NCAOC) is not the official custodian of any case record and provides only copies of data entered by the clerks. Data provided through this service may not reflect pending or post-disposition activity on a case. The NCAOC does not warrant the accuracy of the data. To verify a record's accuracy, contact the clerk of the county of record.

All searches have a minimum scope of 7 years unless otherwise noted. The proceeding records may belong to the individual in question. A series of identifiers, including all or some combination of the following, were used in reporting these records: name, date of birth, address, sex, race, and social security number. Criminal records generally do not include a social security number. As a result, Castle Branch makes no claim or guarantee that these records belong to the individual in question. It is possible that the proceeding records do not apply to the name submitted. Castle Branch urges all organizations to investigate any claims that these records are not those of the individual in question. For questions concerning these records please call (910) 815-3880.

Incomplete/Unacceptable Certified Employee Medical Statements

Per DAAS Administrative Letter 12-17, the Certified Employee Medical Statement must be used. No other medical accepted.

- Section II must be completed in its entirety and be legible so that the licensure of the Health Care Professional that signed the certified statement can be verified if needed

Recertification Packet: Preferred Order

1. Completed DAAS-1500 or DAAS-6205 Part A and DAAS-6205 Part B (depending upon model of care)

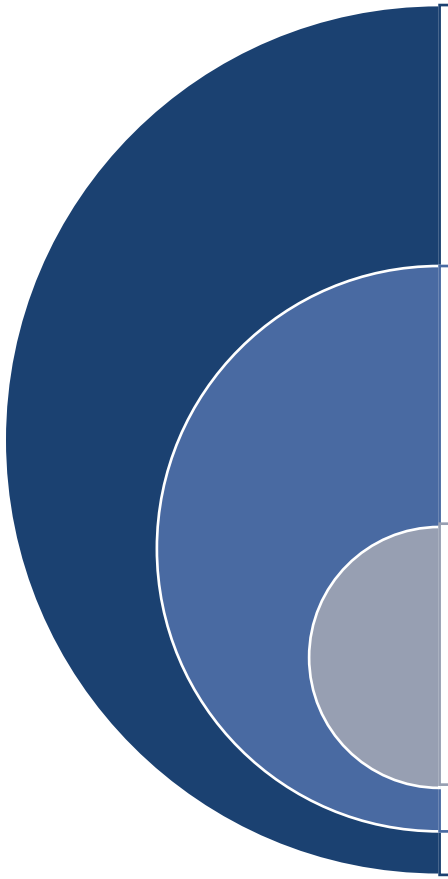
2. Completed 732a-ADS

3. Current, Approved Fire Inspection or equivalent

4. Current, Approved Sanitation Inspection or equivalent

Please do not group employee documentation by type (e.g., verification of current CPR and First Aid certification followed by certified employee medical statements, etc.)

Helpful Tips



NO Unchecked Boxes or Blank Lines	• If “No” is checked- explain why • Not applicable “N/A” - if an option
Check all dates	• Don’t forget to indicate substitute staff • Special Care Part I applies to all programs
For errors, strike through the error with a line, initial and date the line	• Make sure all documents are signed and dated by the appropriate person

Questions?

Contact Information

Terrie Deal

Cell: (919) 917-4060

Email: terrie.deal@dhhs.nc.gov

Glenda Artis

Office: (919) 855-3412

Email: glenda.artis@dhhs.nc.gov