

DHS Home Inspection Checklist

Family name: [Click here to enter text.](#)

Address: [Click here to enter text.](#)

Agency (if applicable): [Click here to enter text.](#)

Home Safety Requirements:

(both blank boxes means "not assessed")

- N Y** (Anything marked "no" requires follow-up remediation by agency and is reported to the [licensor](#))
- Address visible/home accessible 501-12-6-16
 - No child care (see statutory definition on licensor reference guide) or DHHS licensed services provided in this home 501-12-4-7.f
 - Interior/exterior and contents maintained/clean and safe condition 501-12-6-1/501-12-6-13
 - Hazards abated 501-12-6-12 (see licensor reference guide for specifics)
 - Swimming pools secured to prevent unsupervised access 501-12-6-18 N/A
 - All laws followed regarding care and number of pets. 501-12-7-11 No pets
Or, discussed with provider: Yes No
 - No smoking in presence of clients 501-12-7-1 No smokers in this home
 - 2 exits on each level of home adequately sized for emergency personnel with egress to ground level (safety ladders, stairway, etc) or automatic fire suppression system 501-12-6-14
 - Safety devices appropriate to age (outlet covers, safety gates, fireplace gates, etc) 501-12-6-15 Discussed with provider: Yes No
 - Protective gear is accessible/utilized (helmets, life vests, safety certification training, body padding 501-12-7-12-b Discussed with provider: Yes No
 - Working appliances/plumbing 501-12-6-11
 - Bathrooms have locking capability 501-12-6-5
 - Working smoke detector on each level 501-12-6-3
 - Carbon monoxide detector on each level 501-12-6-3
 - Extinguisher in home (min rated 2-A-10BC) 501-12-6-4
 - 911 recognizable phone on site 501-12-7-3
 - Emergency numbers posted visible to children (including address of the home) 501-12-7-3
 - Fully supplied first aid kit in home (meds removed) 501-12-7-4
 - Alcoholic beverages are monitored and inaccessible to children at all times 501-12-7-7 N/A
 - Hazardous chemicals are locked in original or manufacturer complaint packaging 501-12-7-8/8.ii see licensor reference guide. Where/How stored: [Click here to enter text.](#)
 - Medications (prescription, over-the-counter, vitamins, supplements) are locked and in original packaging or pharmacy bubble packs 501-12-10-7/8 Where/How stored:
 - Flammable substances (gas, kerosene) are locked in ventilated areas separate from living areas 501-12-7-9 Where/How stored:

Bedrooms: 501-12-6-6

Number of available bedrooms for fostering: [Click here to enter text.](#)

N Y

- Minimum 40 square feet per occupant 6.f
Measurements/Capacity:
- Not shared by opposite genders (over age 2) 6.a
- No placements over age 2 in parents' room 6.b
- Placements do not share bedrooms with adults 6.d
- Each placement has an individual bed/crib and mattress and linens adequate to their size 6.e
- Consumer bedrooms and beds are comparable to other bedrooms in the home (access, location, furnishings, finishing's) 6.e/h
- Source of natural light and screened window that opens with egress to the outdoors 6.i
- Closet and dresser provided 501-12-6-7
- No more than 4 total children in placement bedroom 501-12-6-6.g
- No more than 4 foster children in the home (see sibling and respite exceptions) 62A-2-101-16 a and b
- No more than 2 children under age 2 in the home (including bio/adopted, etc) 501-12-5-6
- No more than 2 non-ambulatory 501-12-5-7

Firearms: 501-12-7-6

N Y

- No firearms in this home **OR**
- Inaccessible to consumers at all times 501-12-7-6
- Unloaded, locked (or rendered inoperable) and ammo locked by a different key/combo elsewhere 6.c
- Stored together with ammo in gun safe (or other commercially manufactured gun storage container)
Where/How stored:
Written permission obtained from caseworker for child's firearm use 501-12-7-12.d N/A

Vehicles: 501-12-11

N Y

- Enclosed and registered (no motorcycles transporting foster children)
- Vehicles have adequate functional seatbelts
- Emergency contact info (including agency/caseworker or RFC info) posted in vehicle
- First Aid kit in each vehicle
- Age appropriate car/booster seat N/A

Safety plan initiated by OL (or OL follow-up required): Yes No

DSPD Provider Homes:

N Y

- PCSP plans are prepared to meet individual needs
- Adaptive equipment is in good repair
- Physical environment meets client's needs
- Medication sheets are signed
- Information on medical conditions and medication distribution is available
- Healthy/specialized diet is followed

- DSPD variance request completed
- Interviews conducted with clients (see template)
- Interviews conducted with parents (see template)

Overall comments/recommendations:

(Address all boxes checked “no”/Safety plan details/hazards or violations observed/restrictions/monitoring assignments)

[Click here to enter text.](#)

Printed name of person completing inspection: [Click here to enter text.](#)

Date: [Click here to enter a date.](#)

***Note:** This checklist is a tool for convenience and does not modify R501-12 or represent the rule in its entirety. It represents observations specific to the date above. Licensee remains responsible for full compliance with R501-12 and all DHS requirements.*

Licensors/Certifier use only:

1. Type: OL LFC OL LSC CPF Certified DSPD Certified
2. Licensed/Certified Capacity: One Two Three Four
3. Maximum capacity (per 62A-2-116.5): [Click here to enter text.](#)
4. Gender: Male Female Both
5. Immunized foster children only:
 - No (proof provided for all household members)
 - Yes (if all household members did not provide proof of immunization; make note on license/certificate)
6. Ages: [Click here to enter text.](#)

Comments on current capacity/maximum capacity/level of care /gender groupings, etc.: [Click here to enter text.](#)

DSPD Client Interview Name: [Click here to enter text.](#)

N Y (Anything marked “no” requires follow-up remediation by the agency and is reported to the [DSPD worker](#))

- 1. Do you like your home and the people you live with?
[Click here to enter text.](#)
- 2. Does the staff help you with your goals?
[Click here to enter text.](#)
- 3. Are you treated fairly by those you live with and other staff who help you?
[Click here to enter text.](#)
- 4. Do you know what to do if you have a problem or concern?
[Click here to enter text.](#)
- 5. Are you receiving supports and services you need?
[Click here to enter text.](#)

- 6. Are you satisfied with your provider?
Click here to enter text.
- 7. Who chose the home you are living in?
Click here to enter text.
- 8. Any other comments we need to consider?
Click here to enter text.

Click here to open a new client interview template (or cut and paste new one in Word if not electronically available)

DSPD Certified Parent Interview Name [Click here to enter text.](#)

N Y (Anything marked “no” requires follow-up remediation by DSPD) *=federal reporting requirement

- 1. Do you feel you’ve received adequate training? *
Click here to enter text.
- 2. Do you feel adequately prepared to provide these services?
Click here to enter text.
- 3. Do you know what to do in case of emergency? Do you have backup plans?
Click here to enter text.
- 4. Are you familiar with the agency’s grievance procedure? Explain.
Click here to enter text.
- 5. What is the process for reporting incidents that may occur with individuals you support?
Click here to enter text.
- 6. If you suspect abuse, neglect or exploitation what do you do? *
Click here to enter text.
- 7. Do you have concerns regarding the people you support?
Click here to enter text.
- 8. Who (at the agency) can you turn to for help if you have concerns? When you need support/direction, do you receive it? Do you have the support you need to meet the individual’s needs (transport, medical, behaviors, goals etc)?
Click here to enter text.
- 9. How often are you in contact with a person from the agency you work for?
Click here to enter text.
- 10. Verify that staff is knowledgeable of people’s goals/supports?
Click here to enter text.
- 11. Staff is knowledgeable of and following the Behavior Plan and support plan?
Click here to enter text.
- 12. How is the consumer’s money being handled?
Click here to enter text.
- 13. Any other comments we need to consider?
Click here to enter text.

Click here to open a new client interview template (or cut and paste new one in Word if not electronically available)

DCFS/DJJS Client Interview Name [Click here to enter text.](#)

N Y
□□

(*no" indicates inadequate response and requires follow-up remediation by the agency. *items=OL follow-up)

1. Explain to me what you need to do to complete this program and what are your plans after you have finished?

[Click here to enter text.](#)

2. Explain your treatment goals and how did you and your therapist develop them?

[Click here to enter text.](#)

3. Rate your relationship with your therapist on a scale of 1-10

[Click here to enter text.](#)

4. Tell me about your treatment team meetings:

[Click here to enter text.](#)

*5. When and how are you told about the rules of this program?

[Click here to enter text.](#)

6. Please give examples of the rewards and consequences offered by this program:

[Click here to enter text.](#)

7. What are some of the PRS groups you have?

[Click here to enter text.](#)

8. for YAC/TAL clients: Do you have a copy of your weekly program schedule of planned activities? How was it developed?

[Click here to enter text.](#)

*9. How often do you have contact with your family?

[Click here to enter text.](#)

10. How are you supervised when you're in school?

[Click here to enter text.](#)

11. Tell me about the money the program gives you to buy clothing and hygiene items:

[Click here to enter text.](#)

12. How does the program keep track of your belongings while you're here?

[Click here to enter text.](#)

*13. Do you have any medical or dental concerns?

[Click here to enter text.](#)

*14. What is the medication process here?

[Click here to enter text.](#)

15. Rate your relationship on a scale of 1-10 with your proctor parents and explain:

[Click here to enter text.](#)

*16. Do you feel safe here?

[Click here to enter text.](#)

17. Rate your relationship with your mentor on a scale of 1-10 and explain:

[Click here to enter text.](#)

18. DJJS clients: How do searches work here?

[Click here to enter text.](#)

19. DJJS clients: What is the drug testing process?

[Click here to enter text.](#)

20. Is there anything else you wish to share? Anything we can do to better serve you?

[Click here to enter text.](#)

Click here to open a new client interview template (or cut and paste new one in Word if not electronically available)

DCFS/DJJS Proctor Parent Interview Name: Click here to enter text.

N Y

("no" indicates inadequate responses and requires follow-up remediation by the agency. *items=OL follow-up)

1. How accessible is administration?

[Click here to enter text.](#)

*2. What are the names and ages of all residents of this home? (check BCI compliance)

[Click here to enter text.](#)

3. How do you support youth's educational goals and how do you measure their progress?

[Click here to enter text.](#)

*4. Explain how the program trained you:

[Click here to enter text.](#)

5. Explain a youth's treatment goals and how they were developed:

[Click here to enter text.](#)

6. Explain the Child and Family Team Meeting process and your involvement in it:

[Click here to enter text.](#)

7. Describe the youth mentor and what activities they do together:

[Click here to enter text.](#)

*8. Explain how youth are supervised in this program:

[Click here to enter text.](#)

*9. Explain the processes for family contact and off site visits:

[Click here to enter text.](#)

*10. What is the medication process?

[Click here to enter text.](#)

*11. What is considered an incident and how are they classified/documented/reported?

[Click here to enter text.](#)

*12 describe the behavior management training you've received:

[Click here to enter text.](#)

13. What are the rewards/consequences you utilize with youth?

[Click here to enter text.](#)

14. How are clothing/hygiene/food items purchased? What is done with monies from youth employment?

[Click here to enter text.](#)

15. YAC/TAL do you have a copy of the weekly program schedule? How was it developed?

[Click here to enter text.](#)

*16. How often have program representatives inspected your home? What have you been asked to correct?

[Click here to enter text.](#)

17. Is there anything else you wish to share? Is there anything else we can do to better serve you?

[Click here to enter text.](#)

Click here to open a new client interview template (or cut and paste new one in Word if not electronically available)

