



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Bland Bryant Building • Spring Grove Center
55 Wade Avenue • Catonsville, Maryland 21228

Census Guidelines

In an effort to assure that the survey sample composition is representative of the individuals your agency serves and their current staff, the following forms have been developed by the Office of Health Care Quality. We are asking that you complete the attached “*Licensee Census Forms*” in their entirety for all programs offered by you agency

Please submit these Program Census Forms to The Office of Health Care Quality. OHCQ will then use this data to determine which individuals and records to assess during the on-site review.

Instructions for the Program Census Form: Please identify all locations for Residential Rehabilitation Programs (RRP), Group Homes (GH), Outpatient Mental Health Clinics, Mobile Treatment Services, Partial Hospitalization Programs and Psychiatric Rehabilitation Programs (PRP). **Please omit for Therapeutic Group Homes.**

1. Business Organization: Corporate Name
2. Date: Date of Completion
3. Address: Address of Business Organization
4. Contact Name: Primary Contact
5. Contact Number: Primary Contact Number
6. Program Name: Site Name
7. Type of Program: Identify RRP, PRP, GH
8. Address: Address of site
9. Licensed Capacity
10. Current Capacity

Instructions for the Licensee Census Form for Individuals: Please fill out one form per **service** site. This document is to be submitted prior to scheduled survey.

1. Licensee- Licensee’s Corporate Name
2. Program Name and Type:
3. Contact Person- Lead or primary representative for the licensee during a licensure survey.
4. Telephone Number- Cell and office number at which contact person is readily accessible.
5. Individual Name- List all individuals currently served
6. Date of Birth- Enter month and day using 2 digits and 4 digits for year, for example 04/17/2003
7. Identify OHMC or PRP Services individual is currently enrolled in (if applicable)
8. Sex- Enter one letter only (M or F)
9. Date of Admission- Enter date individual was admitted to the program
10. Please Indicate yes or no to the following questions:

Medical Concerns Yes/No
Psychotropic Medications Yes/No
Special Diet Yes/No

11. Intensive or General Support – Please identify what type the individual is to receive

Instructions for the Licensee Census Form for Staff: Please fill out one form per **service** site. This should represent, at a minimum, all direct care staff, psychiatrist(s), Rehabilitation Specialists, volunteers, clinical coordinators, and the Program Director assigned to the at the identified sites.

1. Licensee- Licensee's Corporate Name
2. Program Name and Type- Name and Type
3. Contact Person- Lead or primary representative for the licensee during a licensure survey.
4. Telephone Number- Cell and office number at which contact person is readily accessible.
5. Staff Name – Please indicate staff's full name
6. Job Title and Position – Please indicate staff's Job Title and Position
7. Date of Hire – Please indicate month and year
8. Date of Birth – Please indicate staffs date of birth
9. Type of Professional License (if applicable)
10. Full Time (FT)/Part Time (PT) – Please indicate staffs assignment
11. Work Schedule– Please indicate shift staff is assigned
12. Please indicate Yes or No to the following questions
 - Monitors Medication Yes/No
 - Transports Residents Yes/No

Thank you for your assistance. Please remember to update this form periodically.

Sincerely,

Wendy T. Kanely
Community Programs Surveyor
Office of Health Care Quality
Mental Health Unit

Attachments: 3