MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF REGULATION AND LICENSURE
SECTION FOR LONG-TERM CARE REGULATION

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ANNUAL FIRE DEPARTMENT CONSULTATION

SNF/ICF – 19 CSR 30-85.022(33)(A) and RCF/ALF – 19 CSR 30-86.022(5)(A)
ALL FACILITIES SHALL REQUEST* CONSULTATION AND ASSISTANCE ANNUALLY FROM A LOCAL FIRE UNIT.

*DATE CONSULT REQUESTED	CONTACT PERSON	CONSULT REQUEST FULFILLED? ☐ YES ☐ NO	DATE OF OTHER ATTEMPTS

DATE	FACILITY ID NUMBER

FACILITY NAME	FACILITY TYPE ☐ RCF ☐ ALF ☐ ICF ☐ SNF

ADDRESS (STREET, CITY, ZIP CODE)	COUNTY

CONTACT NAME	TELEPHONE

OWNER	ADMINISTRATOR/MANAGER

This is to confirm that I, the undersigned, have consulted with the Administrator/Manager of the above-named facility and find that this facility is in compliance with all applicable city/county fire prevention codes, and the items indicated below were discussed.

	YES	NO
1. Was assistance given with an actual fire evacuation drill? If yes, please explain.	☐	☐
2. Was assistance given with fire safety training? If yes, please explain.	☐	☐
3. Was fire evacuation planning discussed and facility plans reviewed? If yes, please explain.	☐	☐
4. Was fire protection equipment inspected for maintenance and operation? If yes, please explain.	☐	☐
5. Is the Fire Department aware of special needs resident? If yes, please explain.	☐	☐

OTHER REMARKS

FIRE DEPARTMENT REPRESENTATIVE

REPRESENTATIVE NAME (PLEASE PRINT)	REPRESENTATIVE TITLE	TELEPHONE NUMBER

FIRE DEPARTMENT NAME AND ADDRESS (STREET, CITY, ZIP CODE)

FIRE DEPARTMENT REPRESENTATIVE SIGNATURE	DATE