THE REFERRAL COMMISSION TRAP

Why "Free Placement Help" Can Function Like a Facility-Funded Sales Channel

MOST SENIOR-CARE REFERRAL SERVICES ARE PAID BY THE PROVIDER OR COMMUNITY, NOT BY THE FAMILY.
SENIOR CARE REMEDY WILL NEVER ACCEPT FACILITY REFERRAL COMPENSATION.

If the facility pays only when your mother moves in, the referral is part of the transaction whether the family receives an invoice or not.

WHAT THIS REPORT MEANS BY 'THE SCAM'

This report does not claim that every placement company, advisor, referral, or facility is fraudulent. Facility-paid referral arrangements are lawful in many settings. The deception risk appears when a commissioned lead-and-move-in business is understood by a stressed family as an independent safety-vetting service. The structural question is simple: who is the client in the economics, who pays when the transaction closes, and what safety work was actually performed before the recommendation?

Consumer protection brief | August 2026

Educational material. Not legal, medical, licensing, or individualized placement advice.

SENIOR CARE REMEDY

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A sales funnel can be useful. It should never be mistaken for a safety audit.

THE CORE STANDARD

A recommendation is not a safety finding. A directory listing is not a clinical match. A current license is not proof that a facility can safely manage one specific resident's foreseeable needs.

SENIOR CARE REMEDY

1. THE PROBLEM IN ONE SENTENCE

The family thinks it hired an advocate. The business model may be selling a move-in.

A senior-care placement service can feel like a buyer's agent: the family explains Mom's dementia, Dad's falls, medication needs, budget, location, and urgency, and an 'advisor' returns a short list of communities. The service may be described as free. The family naturally assumes the advisor has screened the options and is recommending the safest, best fit.

That assumption is the problem.

In much of the commercial senior-placement market, the family does not pay the referral company. The senior living provider pays the referral company when a referred person moves in, and some referral models also receive compensation for leads or enhanced directory features. A Place for Mom states that it is paid by participating senior living communities when a referred family moves in. Caring.com states that some providers pay a referral fee after a hire or move-in and that some pay when Caring sends the family's contact information. [1][2]

THE ECONOMIC TRIGGER

The event that creates revenue is not 'we proved this building is safe.' It is typically a referral, lead, hire, or move-in. That does not prove bad faith. It does mean the family's safety question and the referral company's revenue event are not the same thing.

The conflict is structural. Even if an individual advisor receives the same compensation regardless of which participating community is selected, the company can still earn revenue only inside a participating or monetized provider network. A Place for Mom says its individual advisors are not compensated based on which community in its network the family chooses. That is an important protection at the advisor level, but it does not remove the company-level network economics. [1]

Senior Care Remedy takes the opposite approach: the facility pays nothing. No referral fee. No pay-to-rank. No sponsored placement. No move-in bounty. The family and the resident are the only side whose interests determine the recommendation.

SENIOR CARE REMEDY

2. WHAT "FREE" ACTUALLY MEANS

"Free to the family" describes who receives the invoice. It does not answer who funds the recommendation.

Question	What it means
What the family hears	"This placement service costs you nothing."
What the business model can mean	A facility or provider pays the referral company if the consumer is referred, hired, or moved in.
What remains unanswered	Which facilities were considered? Which were excluded? What did the service verify? Was the facility actually inspected, or only listed as licensed?
The right consumer interpretation	Treat a facility-paid referral service as a commissioned transaction channel until you understand its network, payment rules, and safety process.

The California Assisted Living Association, an industry organization, tells consumers to ask exactly this question. Its referral-agency guide says that when the service is free to the consumer and paid by the community, consumers might be referred only to communities doing business with that referral agency, while some agencies may refer more broadly. The guide also warns that some agencies send a consumer's information to all communities they contract with, while others attempt to match needs and preferences. [3]

Texas went further in 2025. Its senior-living referral law requires a disclosure stating that a referral agency's list may not include all communities in the area that meet the consumer's stated preferences and needs. [7]

TRANSLATION

"Free" can be a perfectly legitimate pricing model. But a family should never translate "free" into "independent," "whole-market," "safety-audited," or "working only for us." Those are separate claims and require separate proof.

SENIOR CARE REMEDY

3. THE REFERRAL FUNNEL AND THE MONEY TRIGGER

Follow the transaction from crisis to commission.

Stage	What happens	Consumer risk
1. Family crisis	Hospital discharge, fall, dementia progression, caregiver burnout, unsafe home, or urgent move.	High urgency reduces time to investigate.
2. Intake	Family gives care needs, budget, location, preferences, and often contact information.	The quality of this intake determines whether true capability needs are even captured.
3. Candidate list	Service produces a list from its directory or network.	The critical question: whole market or monetized/contracted subset?
4. Contact and tours	Family and communities communicate; tours and sales follow-up begin.	Amenities and sales responsiveness can dominate attention.
5. Move-in	Resident signs and moves.	For many commercial models, this is the revenue event.
6. Referral payment	The provider pays the referral company under its contract.	The family may never see the payment because the facility pays it.

Nothing in that sequence requires the referral company to prove that the community is clinically capable of managing the resident. A service can be excellent at intake, lead routing, scheduling tours, and closing a placement while still doing far less safety analysis than the family assumes.

That distinction matters because senior living is not ordinary retail. A poor mattress recommendation is inconvenient. A poor dementia, medication, fall-risk, wound-care, or night-coverage placement can become an emergency.

THE TEST

Before trusting any list, ask: What exact evidence did you use to conclude that each facility can safely manage this person's foreseeable needs? If the answer is amenities, price, proximity, availability, reviews, and an active license, the safety question has not been answered.

SENIOR CARE REMEDY

4. THE INDUSTRY'S OWN DISCLOSURES

The strongest case does not require speculation. Read what the platforms say about themselves.

A Place for Mom says its recommendations are free to families because participating communities pay when a referred family moves into senior living. It says it refers families to partners from a network of more than 15,000 senior living communities and home care agencies. It also says its advisors are not compensated based on which community in its network a family chooses. [1]

On the same public 'How Our Service Works' page, A Place for Mom describes twice-yearly reviews of its senior living network to verify that communities maintain valid licenses. Its community pages describe 'Verified Partner' in terms of current state licensing status. [1]

That is useful. It is also much narrower than a facility-specific safety and capability audit.

Caring.com says its revenue comes from referrals, advertising, affiliates, partnerships, and sponsorships. It states that some providers pay a referral fee when a family hires them or moves into a senior living community; other providers pay when Caring sends the family's name and contact information. Caring also expressly tells consumers that its referral service is informational, that it does not endorse providers in its directory, and that families should do their own homework, tour, read reviews, and interview providers. [2]

IMPORTANT FAIRNESS POINT

These companies publicly argue that their compensation models do not dictate which option is best for a family. This report does not claim that every recommendation is biased or unsafe. The objection is narrower and stronger: a facility-funded referral model is not the same thing as an independent safety-verification service, and families should be told exactly which function they are receiving.

The California Assisted Living Association's own consumer guide makes the structural issue explicit: community-paid agencies may refer only to communities doing business with them, depending on the agency, and consumers should understand how payment affects referrals. [3]

If an industry's own consumer guidance tells families to ask whether payment limits the referral universe, the issue is not paranoia. It is a recognized conflict that requires disclosure and verification.

SENIOR CARE REMEDY

5. A LICENSE IS NOT A SAFETY AUDIT

Licensed means legally authorized to operate. It does not answer whether this building is safe for this resident.

Data point	What it actually tells you
Active license	Confirms current authorization status under the applicable state licensing framework.
Inspection history	Shows what regulators found during surveys or investigations, including deficiencies and whether problems were corrected or contested.
Complaint history	Shows allegations or investigations where public. Complaint data must be interpreted carefully; a complaint is not automatically a proven violation.
Enforcement / legal orders	Shows sanctions, orders, fines, or other formal actions where public.
Actual staffing capability	Who is physically present, with what credentials, on days, nights, weekends, and during predictable high-risk periods.
Medication capability	Whether the facility can safely manage the resident's actual medication complexity, monitoring needs, and change-of-condition risk.
Dementia capability	Whether staffing, training, supervision, wandering risk controls, behavior support, and escalation match the resident.
Emergency response	How deterioration is recognized, escalated, documented, and transferred.
Ownership pattern	Whether the same owner or management company has repeat problems across multiple facilities.
Patient-specific fit	Whether the resident's vulnerabilities are within the facility's real operating capability.

Florida's Agency for Health Care Administration maintains public inspection records. The agency explains that a Statement of Deficiencies displays violations found during an inspection or investigation and that the records should be interpreted carefully because findings may be contested. The public database can show standard inspections, complaint inspections, deficiencies, corrections, and legal orders. [8]

That illustrates the core problem with a license-only screen. The regulator may publish far more information than 'license active.' If a referral service does not review the deeper public record, it cannot honestly claim that license verification proves safety.

HARD RULE
CURRENT LICENSE = MINIMUM ENTRY CHECK. It is not a safety score. It is not a clean inspection history. It is not staffing adequacy. It is not patient fit.

SENIOR CARE REMEDY

6. WHY ASSISTED LIVING IS UNUSUALLY HARD TO VET

There is no single national assisted-living dashboard that answers the family's real question.

Nursing homes and assisted living are not regulated or reported in the same way. CMS maintains a national Nursing Home Care Compare system for Medicare- and Medicaid-certified nursing homes. Its current Five-Star system includes separate ratings for health inspections, staffing, and quality measures. [9]

Assisted living is much more state-fragmented. A 2026 GAO report noted that assisted living facilities are not a uniformly defined provider type and are therefore not consistently identified in federal data. The same report found that Medicaid programs in 44 states covered assisted living services as of March 2025, illustrating how widely state structures differ. [10]

An older GAO oversight investigation, published in 2018, found substantial critical-incident reporting gaps in Medicaid assisted living. Twenty-six state Medicaid agencies could not report the number of critical incidents in assisted living, for reasons including inability to distinguish provider type and missing data systems. The exact 2018 counts should not be treated as a current 2026 scorecard, but they remain strong evidence of the structural fragmentation families face. [11]

State Long-Term Care Ombudsman programs exist specifically to address health, safety, welfare, and rights problems in nursing homes, board-and-care homes, assisted living, and similar residential settings. Their existence is another reminder that a beautiful building and an active license do not eliminate resident-risk questions. [12]

Issue	Nursing home	Assisted living
National comparison system	CMS Care Compare and Five-Star for certified nursing homes.	No equivalent single national assisted-living quality system with the same uniformity.
Primary regulation	Federal requirements plus state survey functions.	Primarily state licensing/regulation; terminology and scope vary.
Inspection/staffing data	Nationally accessible standardized datasets exist.	Often scattered across state systems and not standardized nationwide.
Patient fit	Still requires individual clinical judgment.	Especially important because service capability varies widely within the same broad 'assisted living' label.

SENIOR CARE REMEDY

7. THE LAW ALREADY RECOGNIZES THE CONFLICT

Different states regulate the same structural problem in very different ways.

State	What the law does	Why it matters
Arizona	Referral agency must disclose that the facility pays a fee and disclose the amount or good-faith estimate. Current statutory disclosure tells consumers the agency will be paid if they move into a referred facility. [4]	Payment conflict is material information.
Washington	Requires fee disclosure, a standardized intake covering medical history, medications, diagnoses, dementia, ADLs and other needs, provider information, tour disclosure, and a recent enforcement-status search before referral. [5]	A serious referral standard can require more than an active license.
Texas	Chapter 121 requires fee-source disclosure, warns the list may not include all matching communities, prohibits knowingly referring to an unlicensed community, requires license audits, training and other duties. [7]	Network limits and licensing are explicit consumer-protection issues.
Florida	Florida law expressly exempts certain non-Medicaid assisted-living referral-service payments from the state's ALF rebate prohibition. [6]	Facility-paid referral compensation can be lawful. Lawfulness does not convert it into independent advocacy.

Washington is particularly instructive because it operationalizes what families often assume has already happened. The referral agency must collect a detailed intake, obtain information from the provider, disclose whether it toured the facility, and search the regulator's website for enforcement status within a defined time window before making the referral. [5]

THE POLICY LESSON

If the law in one state has to require disclosure of the fee, the service, facility tours, intake details, and enforcement-status searches, those are not trivial details. They are the difference between a lead-generation transaction and a defensible referral process.

SENIOR CARE REMEDY

8. FIVE WAYS THE MODEL CAN FAIL A FAMILY

None of these failures requires an evil advisor. The incentives and information gaps can do the damage on their own.

Failure 1 - The payor filter

A non-paying facility may be absent from the list even if it is the best match. Texas now requires a warning that the list may not include every matching community. CALA warns that community-paid agencies may limit referrals to communities doing business with them.

Failure 2 - License-only vetting

An active license can coexist with prior deficiencies, complaint investigations, weak staffing, or a capability mismatch. Licensing is the floor, not the full safety review.

Failure 3 - Amenities outrank clinical capability

Families under stress can be sold on a beautiful lobby, dining room, activities calendar, apartment layout, or 'memory care' label without a rigorous analysis of medication surveillance, RN assessment needs, fall risk, wound care, behavior support, and night/weekend response.

Failure 4 - Speed becomes success

A referral business earns nothing from an endless investigation. The commercial process naturally rewards movement from lead to tour to move-in. That does not prove improper pressure, but it means speed and conversion can be economically valuable while a longer safety investigation is a cost.

Failure 5 - No closed-loop accountability

A referral can look successful on move-in day and fail two weeks later. A defensible safety system should track transfers, early moves, complaints, capability failures, and corrections. Otherwise the system learns little from bad placements.

A CRITICAL DISTINCTION

A referral service can be helpful and still not be a safety service. The harm happens when those two functions are mentally merged by the family.

SENIOR CARE REMEDY

9. THE SAFETY-FIRST STANDARD

What should be checked before any facility is ranked as a serious option.

Required check	Minimum safety question
Resident needs first	Current diagnoses, cognition, self-report ability, ADLs, fall risk, wounds, infection risk, hydration/nutrition, swallowing, diabetes, behaviors, medication complexity, likely deterioration patterns.
License and scope	Correct license, specialty permissions, restrictions, status, and whether the facility is legally allowed to serve the resident's needs.
Inspection record	Recent standard inspections, complaint inspections, deficiencies, repeat patterns, corrections, and contested findings.
Enforcement record	Orders, sanctions, fines, conditional licenses or other formal actions where public.
Staffing reality	Credential mix and who is actually present on days, nights, weekends, holidays, and high-risk shifts.
RN assessment access	Who performs nursing assessment, how fast, on-site vs on-call, and what triggers escalation.
Medication surveillance	Beyond passing pills: monitoring effects, refusals, omissions, PRNs, high-risk drugs, change-of-condition recognition, and provider notification.
Dementia capability	Wandering/elopement, behavior support, supervision, communication, intake/retention limits, and overnight coverage.
Falls and emergency response	How falls and deterioration are recognized, documented, escalated, and transported; patterns matter when reliable data exist.
Skin/wound capability	Prevention, monitoring, treatment coordination, documentation, and escalation.
Ownership/management	Parent company, management company, ownership changes, and repeat patterns across related facilities.
Ombudsman / complaint channels	State ombudsman and regulator information available to the family before placement.
Contract and pricing	Base rate, care-level charges, medication fees, move-in fees, rate increases, discharge/transfer provisions, refund rules, and ancillary charges.
Evidence date	When every material record was last checked. Old safety information should not silently be treated as current.
Unknowns	Missing data remain UNKNOWN. Unknown is never converted into safe.

SENIOR CARE REMEDY

10. SENIOR CARE REMEDY'S NO-COMMISSION ARCHITECTURE

Remove the conflict instead of explaining it away.

SENIOR CARE REMEDY POLICY

Senior Care Remedy will accept $0 from facilities for referrals, placements, leads, rankings, tours, move-ins, occupancy, preferred status, or favorable scores. A facility cannot buy visibility in the safety ranking.

- NO FACILITY REFERRAL FEES. The facility does not become the economic client.
- NO PAY-TO-RANK. A community cannot purchase a higher position.
- NO SPONSORED SAFETY SCORE. Advertising and safety analysis cannot be merged.
- NO CONTRACTED-NETWORK FILTER. The search should not exclude a legitimate option simply because it refuses to pay Autilogix.
- SAFETY BEFORE AMENITIES. Clinical and operational capability gates come before pool, dining, apartment size, activities, or sales presentation.
- PATIENT FIRST. The resident's needs define the required capability. The building's marketing language does not define the resident's acuity.
- PUBLIC EVIDENCE FIRST. Regulator-published records, official datasets, dated facility documents, and verified facts carry more weight than reviews or sales claims.
- UNKNOWN STAYS UNKNOWN. Missing staffing, enforcement, complaint, or capability information is surfaced as a verification requirement.
- POSITIVE RESULTS ARE ALLOWED. A clean, capable facility should be identified as such. The system is not designed to manufacture failure.
- CORRECTIONS ARE PART OF THE PRODUCT. Facilities should have a documented way to challenge inaccurate public facts and supply verifiable corrections.
- NO ABSOLUTE 'SAFE' BADGE. The output is evidence and patient-fit risk, not a lifetime warranty.

Senior Care Remedy is not valuable because it has a nicer list of buildings. It is valuable because its revenue cannot increase when a particular facility wins the placement. That removes the most obvious commercial conflict before the analysis starts.

This design also changes the order of operations. Traditional placement begins with the available community list and asks which one feels best. Senior Care Remedy begins with the resident and asks what capabilities are required. Only then does it ask which facilities can meet them.

SENIOR CARE REMEDY

11. PATIENT-TO-FACILITY CAPABILITY MATCHING

The right question is not 'Is this a good building?' It is 'Can this building safely manage this person?'

Autilogix's existing Facility Grades / AcuityFit design provides the clinical logic for this distinction. Its governing concept is that a patient may face a capability deficit when the care a person requires exceeds what a facility can actually deliver. The model explicitly rejects the assumption that a building category determines patient acuity. [13]

Layer	Question	What it measures
PALS	Patient-required capability	Clinical instability, cognition/self-report, functional dependency, medication complexity, deterioration risk, wounds/skin, infection recognition, falls/neuro risk, hydration/nutrition/swallowing, diabetes, RN assessment frequency, response time, night/weekend need.
OperationalBanding	Facility-available capability	Credential mix, direct-care RN presence, surveillance, response delay, escalation reliability, medication surveillance, wound/skin capability, infection recognition, night/weekend coverage, workforce stability.
AcuityFit	Mismatch analysis	Compares what the person needs with what the facility can actually provide and surfaces domain deficits.
Facility Grades	Public accountability layer	Uses public/regulator-published facts, source dates, confidence/evidence tiers, limitations, and a correction process.

THE SHIFT IN THINKING

A resident does not become less medically complex because the family moved them from a hospital or home into assisted living. Lower staffing changes the facility's detection and response capability; it does not change the resident's underlying vulnerability.

The exact historical AcuityFit scoring weights were not fully recovered in the existing canonical, so this report does not present a numerical score as validated or production-ready. The architecture is the useful part: resident need and facility capability must be measured separately before any match is called acceptable. [13]

SENIOR CARE REMEDY

12. WHAT FAMILIES SHOULD DEMAND FROM ANY REFERRAL SERVICE

Twelve questions that reveal whether the service is an advocate, a lead source, or both.

1. **Who pays your company if we choose one of the facilities you recommend?**
2. **How is the referral fee calculated, and will you disclose the amount or good-faith estimate?**
3. **Do you consider every appropriate facility in this area, or only facilities in your contracted/participating network?**
4. **Give me the names of appropriate facilities you excluded because they do not pay or contract with you.**
5. **What exact safety checks did you perform on each recommended facility, and on what date?**
6. **Did you review the latest standard inspections, complaint inspections, deficiencies, enforcement actions, and legal orders where available?**
7. **Have you or your company physically toured this facility? When was the most recent tour?**
8. **What staff and licensed clinicians are physically present on nights, weekends, and holidays?**
9. **How did you determine this facility can manage the resident's actual medications, dementia, falls, wounds, diabetes, swallowing, behavior, or other foreseeable risks?**
10. **What condition or change would exceed the facility's capability and require transfer or discharge?**
11. **What happens to your fee if the resident leaves, is hospitalized, dies, or requires a more appropriate placement shortly after admission?**
12. **Will you refrain from sending our name, phone number, health information, or other personal information to any facility until we specifically authorize it?**

IF THEY REFUSE THE MONEY QUESTION

That is not a minor detail. Arizona law requires facility-payment disclosure and the amount or good-faith estimate for covered referral agencies. Washington requires fee-method disclosure. Texas requires disclosure of who pays the referral fee. Disclosure is a recognized consumer-protection issue, not an impolite question. [4][5][7]

SENIOR CARE REMEDY

13. RED FLAGS: VERIFY, STOP, OR WALK

A short list for families who do not have time to become long-term-care investigators.

Action	Red flag	Response
VERIFY	The service checks only that the license is active.	Ask for inspection, complaint, enforcement, staffing, and capability evidence.
VERIFY	Advisor has never toured the facility or cannot say when anyone from the company last did.	Treat descriptions as secondhand until confirmed.
VERIFY	Only a small list is offered.	Ask whether the list is limited by contracts, referral fees, availability, or actual fit.
STOP	The family is told a facility is a 'perfect fit' before meaningful medical/cognitive/medication needs are collected.	Do not tour or place until patient requirements are documented.
STOP	The service will not disclose who pays it.	Do not assume independence.
STOP	The facility's sales team contacts the family before the family knowingly authorized sharing.	Clarify consent and data-sharing immediately.
STOP	The answer to staffing is 'we have staff 24/7' with no credential mix or night/weekend detail.	That phrase does not answer clinical capability.
WALK	A service claims an active license proves the facility is safe.	A license is a minimum status check, not a resident-specific safety conclusion.
WALK	A service guarantees safety, guarantees no falls/hospitalizations, or guarantees that the placement cannot fail.	No honest placement system can promise that.
WALK	The service pressures immediate commitment while material safety or contract questions remain unanswered.	Urgency should not erase due diligence.

SENIOR CARE REMEDY

14. EXACT SCRIPTS FAMILIES CAN USE

Plain sentences. No industry vocabulary required.

PAYMENT DISCLOSURE

“Before you recommend a facility, tell me who pays your company, how the fee is calculated, and whether your company gets paid only if we move in or if our contact information is sent to a provider.”

NETWORK LIMIT

“Are you showing me every appropriate facility in the area, or only facilities that contract with or pay your company? Tell me which otherwise-qualified options are missing and why.”

SAFETY EVIDENCE

“A current license is not enough. Show me the inspection, complaint, enforcement, staffing, and care-capability information you reviewed for this exact facility, and tell me when you reviewed it.”

PATIENT FIT

“Explain exactly why this facility can manage these specific needs: medications, dementia, falls, wounds, diabetes, swallowing, behavior, and night or weekend deterioration.”

TOUR CLAIM

“Have you or someone from your company physically toured this facility? Give me the most recent date. If you have not, say that clearly.”

DATA SHARING

“Do not send our name, phone number, email, health information, or other personal information to any facility until I approve that facility in writing.”

ROLE CLARITY

“If your compensation depends on a referral, lead, or move-in, I will treat your company as a commissioned sales channel unless you can show me an independent safety process.”

NO-COMMISSION COMPARISON

“I want to compare your recommendations with options from a source that is not paid by the facility. Please give me the full list and your evidence so I can do that.”

SENIOR CARE REMEDY

15. WHAT NO PLACEMENT TOOL CAN HONESTLY PROMISE

Senior Care Remedy should be stricter with itself than the industry it criticizes.

- No database can prove a facility will remain safe tomorrow.
- An inspection is a snapshot, not continuous surveillance.
- A complaint can be serious without being substantiated, and a complaint count alone can be misleading.
- A clean inspection does not prove perfect care.
- Staffing can change between the date of review and move-in.
- A facility can be appropriate for one resident and unsafe for another.
- A high-performing facility can experience an adverse event.
- A transfer to the hospital can be the correct response once instability is recognized; the relevant question may be whether deterioration was recognized early enough.
- Missing data must never be converted into reassurance.
- Reviews are experience data, not clinical or regulatory evidence.
- A referral engine should not accuse a named facility of negligence, fraud, abuse, or illegality unless the facts and controlling legal standard support that conclusion.
- The final placement decision still belongs to the resident and family, informed by clinicians, regulators, ombudsman resources, direct facility interviews, tours, contracts, and current evidence.

SENIOR CARE REMEDY'S PROMISE

Not: 'We guarantee this facility is safe.'

Instead: 'We do not take facility money. We show you what we can verify, what we cannot verify, what this person needs, what the facility appears able to provide, and what still has to be checked before you place someone you love.'

SENIOR CARE REMEDY

THE VERDICT

The real consumer-protection question is not whether the referral is free. It is whether the recommendation is independent, evidence-based, and safety-first.

Commercial senior-care referral can provide convenience, local knowledge, scheduling help, and a useful starting point. None of that is the issue.

The issue is that a family in crisis can reasonably mistake a facility-funded transaction channel for a buyer-side safety advisor.

The industry itself discloses the economic model. A Place for Mom says participating communities pay when referred families move in. Caring.com says providers may pay for referrals or leads. CALA warns that community-paid referral agencies may limit referrals to communities that do business with them. Arizona, Washington, and Texas all treat payment and referral-process disclosures as consumer-protection issues. Florida expressly permits certain facility-paid referral services for non-Medicaid residents, demonstrating that the commission model can be lawful. [1][2][3][4][5][6][7]

The correct conclusion is therefore not 'every referral agency is fraudulent.'

The correct conclusion is: facility-paid placement is a conflicted sales model unless the family can see exactly who pays, which facilities were excluded, what safety work was performed, and what evidence supports the match.

Senior Care Remedy removes the easiest conflict to remove: the facility never pays us. Then it applies the harder standard the market should have used all along - patient need first, facility capability second, evidence before marketing, and uncertainty stated plainly.

THE LINE WE WILL NOT CROSS

Most commercial referral services are paid by providers or communities rather than directly by the family. Senior Care Remedy never will be. The facility does not buy the referral, the ranking, or the answer.

SENIOR CARE REMEDY

16. SOURCES AND VERIFICATION NOTES

Primary and industry sources used in this consumer-protection brief.

The factual discussion above deliberately distinguishes company disclosures, statutes, regulator data, historical oversight findings, and Autilogix's internal product architecture. Current law and provider records can change. Verify the live source before using any legal or facility-specific conclusion.

[1] A Place for Mom, “How Our Service Works,” accessed August 2026. The company states that participating communities pay when a referred family moves in; advisors are not compensated based on which community in the network is chosen; the company reviews its network twice yearly to verify valid licenses. https://www.aplaceformom.com/eldercare-advisors

[2] Caring.com, “How We Make Money,” accessed August 2026. Caring states that revenue includes senior-care referrals; some providers pay after a hire or move-in, others for contact information; Caring says the referral service is informational and tells families to do their own homework. https://www.caring.com/about/how-we-make-money

[3] California Assisted Living Association, “Referral Agency Guide,” accessed August 2026. CALA advises consumers to ask how agencies are paid, whether payment limits referrals to contracting communities, whether the agency visits communities, and how matching occurs. https://www.caassistedliving.org/CALA/Residents___Families/Tools_for_Shopping/Referral_Agency_Guide.aspx

[4] Arizona Revised Statutes § 36-446.14, current official text accessed August 2026. Requires covered referral agencies to disclose facility-paid referral fees and the amount or good-faith estimate, among other requirements. https://www.azleg.gov/ars/36/00446-14.htm

[5] Washington Revised Code Chapter 18.330, current official text accessed August 2026. Includes fee disclosure, standardized intake, provider information, tour disclosure, and regulator enforcement-status search requirements for covered elder/vulnerable-adult referral agencies. https://app.leg.wa.gov/rcw/default.aspx?cite=18.330&full=true

[6] Florida Statutes § 429.195, 2025 Florida Statutes accessed August 2026. The ALF rebate prohibition contains an exception for payments by an ALF to a referral service assisting consumers in finding senior/disabled care or housing when referred consumers are not Medicaid recipients. https://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0429/Sections/0429.195.html

[7] Texas Business & Commerce Code Chapter 121, enacted by S.B. 1383 (2025), current codified chapter accessed August 2026. Includes referral-fee disclosure, notice that a list may not include all matching communities, prohibited conduct, license-audit and training duties. https://tcss.legis.texas.gov/resources/BC/htm/BC.121.htm

[8] Florida Agency for Health Care Administration, “Inspection Reports for Health Care Providers” and Public Record Search, accessed August 2026. AHCA publishes inspection/investigation deficiency records and cautions that findings may be contested and should be interpreted with other information. https://ahca.myflorida.com/health-quality-assurance/inspection-reports-for-health-care-providers.html

[9] Centers for Medicare & Medicaid Services, Five-Star Quality Rating System / Medicare Care Compare, current 2026 materials. Nursing homes receive overall and separate ratings for health inspections, staffing, and quality measures. https://www.cms.gov/medicare/health-safety-standards/certification-compliance/five-star-quality-rating-system

[10] U.S. Government Accountability Office, GAO-26-107884, “Assisted Living Facilities: Information on Federal Spending and Medicaid Coverage,” published June 2026 / public release July 2026. Notes that assisted living is not a uniformly defined provider type and is not consistently identified in federal data. https://www.gao.gov/products/gao-26-107884

[11] U.S. Government Accountability Office, GAO-18-179, “Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare is Needed,” January 2018. Historical evidence of state critical-incident reporting gaps; figures are not presented here as a current 2026 nationwide scorecard. https://www.gao.gov/products/gao-18-179

[12] U.S. Administration for Community Living, Long-Term Care Ombudsman Program, current program page accessed August 2026. Ombudsman programs address health, safety, welfare, and rights issues in nursing homes, board-and-care homes, assisted living, and related settings. https://acl.gov/programs/Protecting-Rights-and-Preventing-Abuse/Long-term-Care-Ombudsman-Program

[13] Autilogix / Thalamus LLC, Facility Grades / AcuityFit Master Canonical Recovery, version FG-RECOVERY-2026-06-29. Internal product architecture: resident-required capability, facility-available capability, patient/facility mismatch, public evidence layer. Exact historical weights/calibration are identified in that source as not fully recovered.

SOURCE DISCIPLINE

A regulator complaint, deficiency, inspection finding, lawsuit allegation, or enforcement action must be described for what it is. It is evidence to evaluate, not automatic proof that an unrelated facility or company is unsafe or fraudulent.