RESIDENT HEALTH ASSESSMENT for ASSISTED LIVING FACILITIES and ADULT FAMILY-CARE HOMES

TO BE COMPLETED BY FACILITY:

Resident's Name ______________________________ DOB: ____________

Please place a checkmark (✓) in front of type of facility: [ ] AFCH [ ] ALF

INSTRUCTIONS TO HEALTH CARE PROVIDER: *AFTER COMPLETION OF ALL ITEMS IN SECTIONS1 AND 2 OF THIS FORM, PLEASE RETURN TO:*

PROVIDER NAME: ______________________________

PROVIDER ADDRESS: ______________________________

TELEPHONE NUMBER: ______________ **CONTACT PERSON:** ______________

SECTION 1: HEALTH ASSESSMENT—MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.

Known Allergies:	Height: Weight:
Medical history and diagnoses:	
Physical or sensory limitations:	
Cognitive or behavioral status:	
Nursing/treatment/therapy service requirements:	
Special precautions:	

TO BE COMPLETED BY FACILITY:				
Resident's Name ______			DOB: ______	
Please place a checkmark (✓) in front of type of facility:		AFCH		ALF

SECTION 1: HEALTH ASSESSMENT—MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.

A. To what extent does the individual need supervision or assistance with the following?

Key

I	=	Independent	S	=	Needs Supervision	A	=	Needs Assistance	T	=	Needs Total Help

Indicate by a checkmark (✓) in the appropriate column below the extent to which the individuals is able to perform each of the activities of daily living. If "needs supervision" or "needs assistance" is indicated, please explain the extent and type of supervision or assistance needed in the comments column.*

ACTIVITIES OF DAILY LIVING	I	S*	A*	T	COMMENTS*
Ambulation					
Bathing					
Dressing					
Eating					
Self Care (grooming)					
Toileting					
Transferring					

B. Special Diet Instructions

___ Regular ___ Diabetic Diet ___ No Added Salt ___ Low Fat/Low Cholesterol

_____ Other, please describe: ______________________________

C. Please list all current medications prescribed below (additional pages may be attached):

	MEDICATION	DOSAGE	DIRECTIONS FOR USE	ROUTE
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

TO BE COMPLETED BY FACILITY:				
Resident's Name ______________________________				DOB: ____________
Please place a checkmark (✓) in front of type of facility:		AFCH		ALF

SECTION 1: HEALTH ASSESSMENT—MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.

Does the individual need help with taking his or her medications (meds)? Yes ____ No ____. If yes, please place a checkmark (✓) in front of the appropriate box below:

	Needs Assistance with Self-Administration of Meds		Needs Total Assistance with Administration of Meds

D. Does the individual have any of the following conditions/requirements? If yes, please include an explanation in the comments column.

STATUS	YES/N0 (Y/N)	COMMENTS
1. A communicable disease, which could be transmitted to other residents or staff?		
2. Bedridden?		
3. Any stage 2, 3, or 4 pressure sores?		
4. Pose a danger to self or others?		
5. Require 24-hour nursing or psychiatric care?		

E. In your professional opinion, can this individual's needs be met in an assisted living facility or adult family-care home, which is not a medical, nursing or psychiatric facility? Yes ___ No ___

Comments for Section E (Use additional page if necessary): ______________________________

____

____

F. ***COMPLETE FOR AFCHs ONLY:*** **In your professional opinion, based on this individual's medical profile, can he or she be left without supervision at the adult family-care home for up to two hours per 24 hour period without compromising his or her health, safety, security or well being? Yes____ No_____**

Comments for Section F (Use additional page if necessary): ______________________________

____

____

G. ADDITIONAL COMMENTS/OBSERVATIONS (Use additional page if necessary): ______________________

____

____

____

TO BE COMPLETED BY FACILITY:				
Resident's Name ______________________				DOB: __________
Please place a checkmark (✓) in front of type of facility:		AFCH		ALF

SECTION 2: SELF-CARE AND GENERAL OVERSIGHT ASSESSMENT—MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.

A. ABILITY TO PERFORM SELF-CARE TASKS

Indicate by a checkmark (✓) in the appropriate column below the extent to which the individuals is able to perform each of the listed self-care tasks. If "needs supervision" or "needs assistance" is indicated, please explain the extent and type of supervision or assistance necessary in the comments column.*

Key

I	=	Independent	S	=	Needs Supervision	A	=	Needs Assistance	T	=	Needs Total Help

TASKS	I	S*	A*	T	COMMENTS*
Preparing Meals					
Shopping					
Making Phone Calls					
Handling Personal Affairs					
Handling Financial Affairs					
Other					
Other					

B. GENERAL OVERSIGHT

Indicate by a checkmark (✓) in the appropriate column below the extent to which the individual needs general oversight. If other, please explain in the comments column*.

Key

I	=	Independent	W	=	Weekly	D	=	Daily	O*	=	Other

TASKS	I	W	D	O*	COMMENTS*
Observing Wellbeing					
Observing Whereabouts					
Reminders for Important Tasks					
Other					
Other					
Other					

NOTE: MEDICAL CERTIFICATION IS INCOMPLETE WITHOUT THE FOLLOWING INFORMATION:

NAME OF EXAMINER (Please Print): ______________________________

SIGNATURE OF EXAMINER: ______________________________

MEDICAL LICENSE #: ______________________________

ADDRESS OF EXAMINER: ______________________________

TELEPHONE #: ______________________________

TITLE OF EXAMINER (Please check the appropriate box):

	MD		DO		ARNP		PA

DATE OF EXAMINATION: ______________

TO BE COMPLETED BY FACILITY:				
Resident's Name ______________________				DOB: __________
Please place a checkmark (✓) in front of type of facility:		AFCH		ALF

SECTION 3: SERVICES PROVIDED TO RESIDENT—MUST BE COMPLETED BY THE ALF ADMINISTRATOR/ AFCH PROVIDER OR DESIGNEE FOR THE RESIDENT.

Note: For AFCHs, this section must be completed for all residents based on needs identified in Sections 1 and 2 of this form , except for residents receiving the following:
(a) Medicaid assistive care services; or
(b) Medicaid waiver services.
Note: For ALFs, this section must be completed for all residents based on needs identified in Sections 1 and 2 of this form, or electronic documentation, which at a minimum includes the elements below, except for residents receiving the following:
(a) Extended congregate care services (ECC) in a facility holding an ECC license; or
(b) Services under a community living support plan in a facility holding a limited mental health license; or
(c) Medicaid assistive care services; or
(d) Medicaid waiver services.

#	(Column 1) Needs Identified from Sections 1 & 2	(Column 2) Service Needed	(Column 3) Service Frequency & Duration	(Column 4) Service Provider Name	(Column 5) Date Service Began	(Column 6) Date Service Ended
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						

NAME OF ADMINISTRATOR OR DESIGNEE: (Please Print) ______________________

SIGNATURE OF ADMINISTRATOR OR DESIGNEE: ______________________

DATE OF SIGNATURE: ______________________