Resident Health Assessment for Assisted Living Facilities

To Be Completed By Facility:

Resident Information	
Resident Name:	DOB:
Authorized Representative (if applicable):	

Facility Information		
Facility Name:	Telephone Number: ( )	
Street Address:	Fax Number: ( )	
City:	County:	Zip:
Contact Person:		

INSTRUCTIONS TO LICENSED HEALTH CARE PROVIDERS:
After completion of all items in Sections 1 and 2 (pages 1 – 4), return this form to the facility at the address indicated above.

SECTION 1. Health Assessment

NOTE: This section must be completed by a licensed health care provider and must include a face-to-face examination and interview 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:	**Elopement Risk:** Yes: ☐ No: ☐	

To Be Completed By Facility:

Resident Name:	DOB:
Authorized Representative (if applicable):	

SECTION 1. Health Assessment (continued)

NOTE: This section must be completed by a licensed health care provider and must include a face-to-face examination and interview 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 = Total Care

Indicate by a checkmark (✓) in the appropriate column below, the extent to which the individual is able to perform each of the activities of daily living. If "Needs Supervision" or "Needs Assistance" is indicated, 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 ☐ **Calorie Controlled** ☐ **No Added Salt** ☐ **Low Fat/Low Cholesterol** ☐

Other (specify, including consistency changes such as puree): _____

_____

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

STATUS	Yes/No	COMMENTS
A communicable disease, which could be transmitted to other residents or staff?		
Bedridden?		
Any stage 2, 3 or 4 pressure sores?		
Pose a danger to self or others? (Consider any significant history of physically or sexually aggressive behavior.)		
Require 24-hour nursing or psychiatric care?		

D. In your professional opinion, can this individual's needs be met in an assisted living facility, which is not a medical, nursing or psychiatric facility? Yes ☐ No ☐

Comments (use additional paper if necessary): _____

To Be Completed By Facility:

Resident Name:	DOB:
Authorized Representative (if applicable):	

SECTION 2-A. Self-Care and General Oversight Assessment

NOTE: This section must be completed by a licensed health care provider and must include a face-to-face examination and interview with the resident.

A. Ability to Perform Self-Care Tasks:

Key	I = Independent	S = Needs Supervision	A = Needs Assistance

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

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

B. General Oversight:

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

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

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

C. Additional Comments/Observations (use additional paper if necessary):

To Be Completed By Facility:

Resident Name:	DOB:
Authorized Representative (if applicable):	

SECTION 2-B. Self-Care and General Oversight Assessment – Medications

NOTE: This section must be completed by a licensed health care provider and must include a face-to-face examination and interview with the resident.

A. List all current medications prescribed below (attach additional pages if necessary):

	MEDICATION	DOSAGE	DIRECTIONS FOR USE	ROUTE
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

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

☐ **Needs Assistance With Self Administration**
- ❖ This allows unlicensed staff to assist with oral and topical medication

☐ **Needs Medication Administration**
- ❖ Not all assisted living facilities have licensed staff to perform this service

☐ **Able To Administer Without Assistance**

C. Additional Comments/Observations (use additional pages if necessary):

NOTE: MEDICAL CERTIFICATION IS INCOMPLETE WITHOUT THE FOLLOWING INFORMATION

Name of Examiner (please print):	
Medical License #:	
Telephone Number:	
Title of Examiner (check box) ☐ **MD** ☐ **DO** ☐ **ARNP** ☐ **PA**	
Address of Examiner:	
Signature of Examiner:	**Date of Examination:**

To Be Completed By Facility:

Resident Name:	DOB:
Authorized Representative (if applicable):	

SECTION 3. Services Offered or Arranged By The Facility For The Resident

NOTE: This section must be completed by the ALF Administrator or designee.

THIS SECTION MUST BE COMPLETED FOR ALL RESIDENTS and must be based on needs identified in Sections 1 and 2 of this form, or electronic documentation, which at a minimum includes the elements below. The facility may attach resident service plans, care plans, or community living support plans to this form to satisfy this requirement, provided the documentation corresponds with the information listed below.

#	Needs Identified from Sections 1 and 2	Services Needed	Service Frequency & Duration	Service Provider Name	Initial Date of Service
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

Name of Resident or Authorized Representative (print): _____

(By signing this form, I agree to the services identified above to be provided by the assisted living facility to meet identified needs.)

Signature of Resident or Authorized Representative: _____
Date

If Authorized Representative, provide contact # _____

Name of Administrator or Designee (print): _____

Signature of Administrator or Designee: _____
Date