# Pre-Screening and Assessment for Admission to Assisted Living Facilities

## Part I - Pre-Screening

<table>
<thead>
<tr>
<th>Field</th>
<th>SSN</th>
<th>Address (Street, City, State, ZIP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (First, Middle, Last)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Security Number</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Person Is Currently

- Living Independently
- Living in Residential Care Facility
- Hospitalized
- Other

### Comments

<table>
<thead>
<tr>
<th>Telephone</th>
<th>DOB</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male</td>
</tr>
</tbody>
</table>

### Marital Status

- Single
- Married
- Never Married
- Divorced/Separated
- Widow(er)

### Resident Able to Participate in Providing Above Information?

- Yes
- No

### Resident Bed-Bound or Similarly Immobilized?

- Yes
- No

### Has the Resident Exhibited Behaviors That Present a Reasonable Likelihood of Serious Harm to Self or Others?

- Yes
- No

### Resident Requires a Physical Restraint?

- Yes
- No

### Resident Uses a Medication as a Chemical Restraint? (Medication Not Used to Treat a Medical Condition)

- Yes
- No

### Resident Requires More Than One Person to Simultaneously Physically Assist with Any Activities of Daily Living Other Than Bathing and/or Transferring?

- Yes
- No

### Resident Has a Condition That Requires Skilled Nursing Services? If Yes, Please List:

- Yes
- No

## To Be Determined by Person Doing Resident Assessment

**Yes** resident meets criteria for admission to Assisted Living Facility. Proceed to complete a community based assessment using the attached or a form which has received prior approval from the Section for Long Term Care Regulation.

**Yes** resident meets criteria for admission to Assisted Living Facility which provides services to residents with a physical, cognitive or other impairment that prevents the resident from safely evacuating the facility with minimal assistance. Proceed to complete a community based assessment using the attached or a form which has received prior approval from the Section for Long Term Care Regulation.

**No** resident is not eligible for admission to an Assisted Living Facility.

**Interviewer Name**

**Date**
### PART II - RESIDENT ASSESSMENT (COMPLETED WITHIN 5 DAYS OF ADMISSION TO ASSISTED LIVING FACILITY)

#### PERSONAL CARE - Grooming/Bathing

<table>
<thead>
<tr>
<th></th>
<th>Performs Independently</th>
<th>Some Assistance</th>
<th>Totally Dependent</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental/Mouth Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hair Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shaving</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toe/Fingernail Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### PERSONAL CARE - Toileting

<table>
<thead>
<tr>
<th></th>
<th>Performs Independently</th>
<th>Some Assistance</th>
<th>Totally Dependent</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bladder/Bowel Control</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Special Equipment Required (List: )</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catheter/Ostomy</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

#### DIETARY

<table>
<thead>
<tr>
<th></th>
<th>Performs Independently</th>
<th>Some Assistance</th>
<th>Totally Dependent</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eats Meals Daily</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meal Preparation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chewing/Swallowing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent Weight Loss/Gain</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Uses Feeding Tubes/Devices</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Calculated Diet Prescribed</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Special Diet Followed</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

#### MOBILITY

<table>
<thead>
<tr>
<th></th>
<th>Performs Independently</th>
<th>Some Assistance</th>
<th>Totally Dependent</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory - Able to Get Around</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Transfer To/From Bed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer To/From Chair</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer To/From Wheelchair</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safely evacuates the facility with minimal assistance.</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

#### HOUSEKEEPING

<table>
<thead>
<tr>
<th></th>
<th>Performs Independently</th>
<th>Some Assistance</th>
<th>Totally Dependent</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleans Bedroom, Bathroom, Kitchen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laundry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make/Change Beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empty Trash</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BEHAVIOR/MENTAL CONDITION</td>
<td>WELL ORIENTED</td>
<td>SOME MEMORY</td>
<td>NEEDS ASSISTANCE</td>
<td>COMMENTS</td>
</tr>
<tr>
<td>---------------------------</td>
<td>--------------</td>
<td>-------------</td>
<td>------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Orientation to Date, Day, and Place</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wanders or confusion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Memory/Recall</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Judgment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follows Instructions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sociability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sad or Anxious Mood</td>
<td>□ Yes</td>
<td>□ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Socially Inappropriate/Disruptive Behavior</td>
<td>□ Yes</td>
<td>□ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosed or Treatment History for Mental Illness or Developmental Disability</td>
<td>□ Yes</td>
<td>□ No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TRANSPORTATION</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Can drive self</td>
<td></td>
<td></td>
<td>□ Yes</td>
</tr>
<tr>
<td>Can leave the facility with assistance</td>
<td>□ No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICAL NEEDS/SUPPORTS/MONITORING</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>RESIDENT CAN</td>
<td>Self Administer</td>
<td>Needs Assistance taking meds</td>
<td>Totally dependent</td>
</tr>
<tr>
<td>Health Problems (Check All That Currently Apply)</td>
<td>Prescription Meds</td>
<td>Dosage</td>
<td>Physician/Pharmacy</td>
</tr>
<tr>
<td>Anemia</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis and other joint limitations or injuries</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel/bladder problems</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer, Leukemia or tumor</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia (OBS, Alzheimer’s, Huntington’s, Pick’s)</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Digestive disorders (ulcers, diverticulosis)</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edema</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effects of stroke (CVA, TIA, memory loss)</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effects of osteoporosis or fractures</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hardening of arteries (ASHD, poor circulation)</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing impairment (H.O.H., deafness)</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart trouble (angina, CHF, MI)</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory problems (asthma, emphysema, COPD)</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin problems (decubitus ulcer, lesions, rashes)</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery with residual effects (drainage, amputation, paralysis, pain, fatigue)</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tremors (Parkinson’s)</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visual impairment (cataracts, glaucoma, blindness)</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER (PLEASE LIST:)</td>
<td>□</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NON PRESCRIPTION MEDICATIONS
List all physicians/clinics and other health providers.

State the condition for which the health provider is being seen, the frequency of contact, and describe what is being done (the procedure to monitor the condition.

<table>
<thead>
<tr>
<th>DOCTOR/CLINIC NAME</th>
<th>CONDITION</th>
<th>FREQUENCY</th>
<th>PROCEDURE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOME HEALTH AGENCY NAME</th>
<th>CONDITION</th>
<th>FREQUENCY</th>
<th>PROCEDURE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER HEALTH CARE PROVIDER</th>
<th>CONDITION</th>
<th>FREQUENCY</th>
<th>PROCEDURE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**THIS ASSESSMENT FORM SHOULD BE USED TO DEVELOP THE INDIVIDUAL SERVICE PLAN FOR RESIDENT.**

**COMMENTS**

INTERVIEWER NAME

DATE