PRE-SCREENING AND ASSESSMENT FOR ADMISSION TO ASSISTED LIVING FACILITIES

PART I - PRE-SCREENING

NAME (FIRST, MIDDLE, LAST)	SOCIAL SECURITY NUMBER

ADDRESS (STREET, CITY, STATE, ZIP)

PERSON IS CURRENTLY

☐ Living Independently ☐ Living in Residential Care Facility ☐ Hospitalized
☐ Other _____

COMMENTS

TELEPHONE	DOB	SEX
		Male Female

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 Disqualify	NO Qualify
Has the resident exhibited behaviors that present a reasonable likelihood of serious harm to self or others?	YES Disqualify	NO Qualify
Resident requires a physical restraint?	YES Disqualify	NO Qualify
Resident uses a medication as a chemical restraint? (medication not used to treat a medical condition)	YES Disqualify	NO Qualify
Resident requires more than one person to simultaneously physically assist with any activities of daily living other than bathing and/or transferring?	YES Disqualify	NO Qualify
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)

RESIDENT NAME

RESPONDENT NAME

	PERFORMS INDEPENDENTLY	SOME ASSISTANCE	TOTALLY DEPENDENT	COMMENTS
PERSONAL CARE - Grooming/Bathing				
Bathing				
Dental/Mouth Care				
Hair Care				
Shaving				
Toe/Fingernail Care				
PERSONAL CARE - Toileting				
Bladder/Bowel Control				☐ Yes ☐ No
Special Equipment Required (List:)				
Catheter/Ostomy				☐ Yes ☐ No
DIETARY				
Eats Meals Daily				
Meal Preparation				
Chewing/Swallowing				
Recent Weight Loss/Gain				☐ Yes ☐ No
Uses Feeding Tubes/Devices Calculated Diet Prescribed				☐ Yes ☐ No
Special Diet Followed				☐ Yes ☐ No
MOBILITY				
Ambulatory - Able to Get Around				
Transfer To/From Bed				
Transfer To/From Chair				
Transfer To/From Wheelchair				
Safely evacuates the facility with minimal assistance.				☐ Yes ☐ No
HOUSEKEEPING				
Cleans Bedroom, Bathroom, Kitchen				
Laundry				
Make/Change Beds				
Empty Trash				

	WELL ORIENTED	SOME MEMORY	NEEDS ASSISTANCE	COMMENTS
BEHAVIOR/MENTAL CONDITION				
Orientation to Date, Day, and Place				
Wanders or confusion				
Memory/Recall				
Judgment				
Follows Instructions				
Sociability				
Sad or Anxious Mood				☐ **Yes** ☐ **No**
Socially Inappropriate/Disruptive Behavior				☐ **Yes** ☐ **No**
Diagnosed or Treatment History for Mental Illness or Developmental Disability				☐ **Yes** ☐ **No**
TRANSPORTATION				
Can drive self				☐ **Yes** ☐ **No**
Can leave the facility with assistance				☐ **Yes** ☐ **No**

MEDICAL NEEDS/SUPPORTS/MONITORING

RESIDENT CAN

☐ Self Administer ☐ Needs Assistance taking meds ☐ Totally dependent

Health Problems (Check All That Currently Apply)	**Prescription Meds**	**Dosage**	**Physician/Pharmacy**
Anemia ☐			
Arthritis and other joint limitations or injuries ☐			
Bowel/bladder problems ☐			
Cancer, Leukemia or tumor ☐			
Dementia (OBS, Alzheimer's, Huntington's, Pick's) ☐			
Diabetes ☐			
Digestive disorders (ulcers, diverticulosis) ☐			
Edema ☐			
Effects of stroke (CVA, TIA, memory loss) ☐			
Effects of osteoporosis or fractures ☐			
Hardening of arteries (ASHD, poor circulation) ☐			
Hearing impairment (H.O.H., deafness) ☐			
Heart trouble (angina, CHF, MI) ☐			
Hypertension ☐			
Respiratory problems (asthma, emphysema, COPD) ☐			
Skin problems (decubitus ulcer, lesions, rashes) ☐	NON PRESCRIPTION MEDICATIONS		
Surgery with residual effects (drainage, amputation, paralysis, pain, fatigue) ☐			
Tremors (Parkinson's) ☐			
Visual impairment (cataracts, glaucoma, blindness) ☐			
OTHER (PLEASE LIST:) ☐			

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.

DOCTOR/CLINIC NAME	CONDITION	FREQUENCY	PROCEDURE
HOME HEALTH AGENCY NAME	**CONDITION**	**FREQUENCY**	**PROCEDURE**
OTHER HEALTH CARE PROVIDER	**CONDITION**	**FREQUENCY**	**PROCEDURE**

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

COMMENTS

INTERVIEWER NAME	DATE