ASSESSMENT PLAN FOR AFC RESIDENTS

Michigan Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems

INSTRUCTIONS:

1. A written assessment plan is required. The licensee is responsible for assuring that a written assessment plan is completed.
2. This form has been approved by the Department of Licensing and Regulatory Affairs and contains the information required by administrative rule and Section 3 (9) of.1979 P.A. 218.
3. This form is to be completed by the licensee and resident, or the resident's designated representative. The responsible agency, if any, may assist in this process.
4. Use additional sheets if necessary and **PRINT CLEARLY.**

Name of Resident	Name of Designated Representative (if applicable)	Date of Birth	Sex ☐ M ☐ F

I. SOCIAL/BEHAVIORAL ASSESSMENT PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)

	Yes	No	IF NO, Describe Needs and How They Will Be Met
A. Moves Independently in Community	☐	☐	
B. Communicates Needs	☐	☐	
C. Understands Verbal Communication	☐	☐	
D. Alert to Surroundings	☐	☐	
E. Reads and Writes	☐	☐	
F. Tells Time	☐	☐	
G. Manages Money	☐	☐	
H. Follows Instructions	☐	☐	
I. Controls Aggressive Behavior	☐	☐	
J. Controls Sexual Behavior	☐	☐	
K. Gets Along With Others	☐	☐	
L. Exhibits Self Injurious Behavior	☐	☐	
M. Participants in Social Activities	☐	☐	
N. Smokes	☐	☐	
O. Appropriately Uses Alcohol/Drugs	☐	☐	

See Page 4 for Non-discrimination and ADA statement

Continued on Next Page

II. SELF CARE SKILL ASSESSMENT **PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)**

	Needs Help		IF YES, Describe Needs and How The Will Be Met
	Yes	No	
A. Eating/Feeding	☐	☐	
B. Toileting	☐	☐	
C. Bathing	☐	☐	
D. Grooming (hair care, teeth, nails, etc.)	☐	☐	
E. Dressing	☐	☐	
F. Personal Hygiene	☐	☐	
G. Walking/Mobility	☐	☐	
H. Stair climbing	☐	☐	
I. Use of Prosthesis (Dentures, Artificial limbs, etc.)	☐	☐	
J. Use of Assistive Devices (explain)	☐	☐	
K. Other (explain)	☐	☐	

III. HEALTH CARE ASSESSMENT **PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)**

	Yes	No	IF YES, Describe Needs and How They Will Be Met
A. Taking medication	☐	☐	
B. Special Diets	☐	☐	
C. Physical Limitations	☐	☐	
D. Special Equipment Used (Wheel chair, Walker, Cane, etc.)	☐	☐	
E. Other Difficulties (Vision, Weight, Allergies, etc.)	☐	☐	
F. Susceptible to Hypothermia or Hyperthermia	☐	☐	

Continued on Next Page

IV. SOCIAL AND PROGRAM ACTIVITIES PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)

	Yes	No	Explain How These Activities Will Be Provided or Encouraged
A. Participates in Religious Practice	☐	☐	
B. Participates in Household Chores	☐	☐	
C. Adult Activity Program	☐	☐	
D. Senior Center	☐	☐	
E. Workshop or job	☐	☐	
F. School	☐	☐	
G. Hobbies/Special Interest	☐	☐	
H. Recreation	☐	☐	
I. Physical Exercise	☐	☐	
J. Family/Friends (Please Address Any Applicable Visitation Prohibitions and/or Other Considerations)	☐	☐	
K. Other (explain)	☐	☐	

V. MEDICAL INFORMATION

Name of Primary Physician/Clinic		Telephone Number ( )	
Primary Physician's Complete Address (Street Number and Name)	City	State	Zip Code

V. MEDICATIONS TAKEN AT TIME OF ASSESSMENT

Name of Medication	Who Prescribed	Dosage

Continued on Next Page

MEDICAL OR DENTAL FOLLOW-UPS NEEDED (i.e., check-ups, regular appointments, etc.)

VI. RELEASE OF INFORMATION – RESIDENT OR LEGAL GUARDIAN SIGNATURE ONLY

"By signing this form, I understand that I am authorizing the release of medical information concerning me, including information regarding Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV), if applicable, to the licensee and licensee's staff, the responsible agency and the Michigan Department of Licensing and Regulatory Affairs, Bureau of Community and Health Systems, for the purpose of providing appropriate care to me and determining compliance with licensing rules."	
Signature of Resident or Legal Guardian	Date

VII. OTHER INFORMATION

Comments/Special Instructions

VIII. ASSESSMENT PLAN COMPLETION

Date Assessment Plan Was Completed	Name(s) and Position(s) of Person(s) Who Completed Assessment

IX. PLACEMENT OBJECTIVE

A. ☐ Delay/prevent deterioration and movement to a more restrictive setting.
B. ☐ Encourage movement to a less restrictive setting.

X. SIGNATURES

Signature of Resident or Designated Representative Date	Signature of Licensee Date
Signature of Responsible Agency (if applicable) Date	

AUTHORITY: 1979 P.A. 218 COMPLETION: Voluntary PENALTY: Violation of Administrative Rule and 1979 P.A. 218	LARA is an equal opportunity employer/program.

AFC – RESIDENT CARE AGREEMENT

Michigan Department of Licensing and Regulatory Affairs
Adult Foster Care Licensing and Home for the Aged Licensing

Resident Name:	Name of Home:	License Number

This agreement to provide adult foster care for (resident's name) _____ **is made between (licensee name)** _____ **and (resident/resident's designated representative)** _____ .

- This agreement is required to be completed at the time of a resident's admission, reviewed annually, and updated as needed to reflect changes.
- This agreement is to be completed by the licensee in cooperation with the resident or his/her designated representative and the responsible agency, if applicable, **Designated representative means** that person or agency which has been granted written authority, by a resident, to act on behalf of the resident or which is the legal guardian of a resident. **Acceptable written authority includes** orders of guardianship or conservatorship, powers of attorney, durable powers of attorney, or other documents executed by the resident that specify the relevant scope of authority. If a resident's designated representative signs this agreement, a copy of the signer's written authority is to be maintained in the resident's file at the AFC home.
- A resident shall be provided care and services as stated in this resident care agreement and the resident's assessment plan.

This agreement constitutes the fee policy statement required by Family Home Rule 400.1407(11), if applicable.

RESIDENT OR DESIGNATED REPRESENTATIVE CHECK ALL BOXES BELOW THAT APPLY:

☐ I have received a copy of the house rules (if applicable) and agree to follow them.

☐ I agree to provide all required resident information to the licensee, including a current health care appraisal, at the time of admission, annually and as the resident's condition changes.

☐ I agree to participate in all required fire and emergency drills, as determined by BCHS and the licensee.

☐ I have signed and received a copy of the home's refund agreement. (GROUP HOMES ONLY)

☐ I have received a copy of the home's discharge policy and agree to follow those procedures. (GROUP HOMES ONLY)

☐ I agree ☐ I do not agree to receive assistance in bathing, dressing, or personal hygiene by a staff member of the opposite sex, if a member of the same sex is not available.

☐ I agree ☐ I do not agree to entrust the following to the license for safekeeping, if this option is available:
☐ Funds ☐ Valuables (specify) _____

☐ I agree to have the licensee manage funds and account for financial transactions on my behalf. Expenditures of my personal funds over the amount of $ _____ require my prior written approval.

☐ I agree to pay the licensee the agreed upon fees for the services designated.

☐ I agree to pay the basic fee of $ _____ on a _____ basis.
daily, week or monthly

The basic fee includes the following basic services:

_____

_____

_____

and are further described in the resident's assessment plan, and attachment _____ , if applicable.

☐ The basic fees do not include any transportation services.

☐ The basic fees include the following transportation services.

_____

_____

☐ Transportation fees are charged as follows:

_____

and are further explained in attachment _____ , if applicable.

☐ I agree to additional services according to the fee schedule contained in attachment _____ . Such additional services may include but are not limited to: _____

_____

_____

_____

_____

☐ If applicable. I have read the attachments relating to fees and agree with the terms and conditions established therein, I further acknowledge that additional services are available for additional fees as described in attachment _____ .

BY MY SIGNATURE BELOW, I AFFIRM THAT:

This home is licensed by the Department of Licensing and Regulatory Affairs to provide foster care to adults.

I have provided the resident with a copy of the AFC Resident Rights and agree to respect and safeguard these rights.

I have provided the resident with a copy of the home's discharge policy and procedures and agree to follow them. (AFC Group Homes only.)

I have provided the resident with a signed copy of the home's refund agreement. (AFC Group Homes only.)

I agree to provide personal care, supervision, and protection, in addition to room and board, and to assure the availability of transportation services as indicated in this agreement, the resident's written assessment plan, and the resident's health care appraisal, as defined in the act.

A copy of this resident care agreement is required to be provided to the resident's guardian or resident's designated representative and also be maintained in the resident's file at the AFC home.

Attachments to this Resident Care Agreement and any other agreements or contracts with this licensee may not have been reviewed and/or approved by the department. If any contractual provision contained in an attachment conflicts with the Adult Foster Care Facility Licensing Act and/or administrative rules, the act and rules would prevail and the specific provision is not binding.

SIGNATURES

Resident	Date
Resident's Designated Representative (if applicable)	Date
Licensee/Licensee Designee	Date
Responsible Agency (if applicable)	Date

Compliments, comments and/or complaints about this licensed facility can be made by calling the licensing consultant, or at www.michigan.gov/afchfa. Additional information regarding adult foster care is also available at this website.

Complaints (only) can also be made by calling toll-free: 1-866-856-0126.

AUTHORITY: 1979 PA 218 COMPLETION: Mandatory PENALTY: Violation of Adult Foster Care Administrative Rule	LARA is an equal opportunity employer/program.

RESIDENT FUNDS RECORD
PART I

Michigan Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems

Resident Name	
Facility Name	License Number

INSTRUCTIONS:

1. The licensee is to complete Sections A, B, and C for all residents.
2. A Resident Funds Part II (BCAL-2319) or approved substitute, must be completed for:
   a. All resident payments for adult foster care services as required by R400.14102(1)(v)(I), R 400.15102(1)(0)(I)
   b. Account(s) managed by the licensee for a resident including:

Personal allowance	Work/workshop checks
Other checks or cash such as gifts	Cash
Interest	Dividends
Stocks, bonds or money market funds	Savings, checking accounts
All other applicable funds	

3. The licensee is to keep Resident Funds forms in the resident's record
4. The licensee is to give a copy of the Resident Funds forms to the person(s) responsible for managing the resident's funds.
5. The licensee shall not commingle resident funds with licensee's funds.

SECTION A: The person or persons responsible for the resident's funds is (are):

☐ Resident

☐ Legal Guardian…… Name / Phone Number

☐ Representative Payee……. Name / Phone Number

☐ Adult Foster Care Licensee or Designee……. Name / Phone Number

☐ Other……..……..…. Name / Phone Number

SECTION B: Please indicate below all applicable accounts managed by the licensee or their designee. All transactions regarding these accounts must be recorded on the BCAL-2319. Name the individual managing account: _____

☐ Payment for AFC

☐ Cash

☐ Checking Account – Joint Checking…… Name of Bank / Account Number

☐ Saving Account – Joint Savings……... Name of Bank / Account Number

☐ Other Account..……... Name of Bank / Account Number

Signature of Joint Account Holder	Signature of Joint Account Holder
(1)	(2)

SECTION C: I certify that I have no ownership interest in the resident's account.

Licensee/Designee Signature	Date

THANK YOU FOR YOUR COOPERATION

AUTHORITY: 1979 PA 218 COMPLETION: Mandatory CONSEQUENCE: Adult Foster Care Rule Violation	LARA is an equal opportunity employer/program.

RESIDENT FUNDS
PART II

Michigan Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems
Adult Foster Care and Camp Licensing Division

Resident Name	
Facility Name	License Number
Time Period Covered thru	

This form or an approved substitute is to be used to record all resident care payments for adult foster care services.

INSTRUCTIONS:
Please use a separate BCAL-2319 - Resident Funds - Part II for each savings, checking, or other account. One form may be used to account for cash and for payment of adult foster care services. Please attach additional pages as necessary.

Type of Account

☐ SAVINGS ☐ CHECKING ☐ CASH ☐ PAYMENT FOR ADULT FOSTER CARE SERVICES ☐ OTHER (Specify) ▶

Date	Reason for Transaction	Resident or Designated Representative Signature	License or Designee Signature	Deposit Amount (+)	Withdrawal Amount (-)	Balance Forwarded $

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AUTHORITY: 1979 PA 218 R 400.14315(3) and R 400.153.15(3)
COMPLETION: Mandatory
CONSEQUENCE: Adult Foster Care Rule Violation

DISTRIBUTION: PART 1 - Resident Record
PART 2 - Resident or Designated Representative

HEALTH CARE APPRAISAL

Michigan Department of Licensing and Regulatory Affairs, Bureau of Community and Health Systems

Licensee Name	Resident Name		Case Number
AFC Facility Name	Facility License Number	Worker Name / Load Number	Worker Phone Number

Release of General Medical Information: By signing this form, I understand that I am authorizing the release of medical information concerning me to the licensee and licensee's staff, the responsible agency, and the Michigan Department of Licensing and Regulatory Affairs, Bureau of Community and Health Systems for the purpose of providing appropriate care to me and determining compliance with licensing rules.

Signature of Resident / Legal Guardian	Title	Date

Release of HIV/AIDS Information: By signing this form, I understand that I am authorizing the release of medical information concerning me, including information regarding Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), if applicable, to the licensee and licensee's staff, the responsible agency, and the Michigan Department of Licensing and Regulatory Affairs, Bureau of Community and Health Systems, for the purpose of providing appropriate care to me and determining compliance with licensing rules.

Signature of Resident / Legal Guardian	Title	Date

1. Height	2. Weight	3. Ideal Weight Range	4. Blood Pressure	5. Age	6. Sex
					☐ MALE ☐ FEMALE

7. Diagnoses

8. Current Medications and Instructions

9. Allergies

10. General Appearance

11. Mental / Physical Status and Limitations

12. Mobility / Ambulatory Status:

☐ Fully Ambulatory ☐ Uses Walker
☐ Uses Cane ☐ Uses Wheelchair

13. Susceptibility to Hyper / Hypothermia and Related Limitations

14. Special Dietary Instructions and Recommended Caloric Intake

15. Physical Exam:

TYPE	NORM	ABN	** DEFERRED
1. Skin			
2. Ears			
3. Nose			
4. Throat			
5. Mouth			
6. Neck			
7. Breasts			
8. Chest			
9. Lungs			
10. Heart			
11. Abdomen			
12. Extremities Upper			
Lower			
13. Feet / Toes			
14. Lymph Nodes			
15. Genitalia			
16. Testes			
17. Spine			
18. Reflexes			
19. Neurological			
20. Rectal			
21. Sexually Transmitted Diseases	☐ YES	☐ NO	
22. Other:			

**Deferred, as used here, means examination considered but postponed

Explanation of Abnormalities/Treatment Ordered

16. Other Health-Related Information or Concerns

M.D./D.O./P.A. or R.N. (Please Print Name)

Signature	City	State	Zip Code

Address	Title	Date of Signature	Date of Exam

AUTHORITY: 1979 PA 218 R 400.14301(10) and R 400.15301(10)
COMPLETION: Required. R 400.14310 and R 400.15310
CONSEQUENCE: Violation of AFC Licensing Rules. R 400.14313(3) and R 400.15313(3)

LARA is an equal opportunity employer/program.

AFC-RESIDENT INFORMATIONAND IDENTIFICATION RECORD

Michigan Department of Licensing and Regulatory Affairs
Division of Adult Foster Care Licensing

Instructions:

1. **Please complete all applicable information on form at the time of the resident's admission.**
2. **Please complete the resident valuables inventory as required on page 2 of the form.**

License Number

Name	Social Security	Case Number	
Veteran Status and Number (If applicable)		Marital Status	
Home Address (Street, City, Zip Code)		Date of Birth	Sex
Next of Kin/Guardian/Designated Representative		Telephone Number	
Address (Street, City, Zip Code)			
Placing Agency/Person (Name)		Telephone Number	
Address (Street, City, Zip Code)			
Date of Admission	Date of Discharge		
Name of Physician		Telephone Number	
Address (Street, City, Zip Code)			
Name of Preferred Hospital			
Address (Street, City, Zip Code)			
Religious Preference			
Insurance Information			
Burial Provisions			

LARA is an equal opportunity employer/program.	Authorized by 1979 PA 218. Completion is voluntary. However, it is required that resident identifying information be maintained either on this or an equivalent form.

INVENTORY OF VALUABLES

Name	Social Security	License number

ITEM	DATE RECEIVED	DATE RETURNED

RESIDENT WEIGHT RECORD

Michigan Department of Licensing and Regulatory Affairs
Adult Foster Care Licensing Division

License Number

INSTRUCTIONS:

1. The resident's weight is to be recorded at the time of admission and once per month thereafter.
2. Unusual or significant weight gain or loss may be explained in the comments section.

Resident Name (Last, First, Middle)		
Facility Name and Address		
Weight at Admission	Height (Optional)	Physician's Name

Date Month/Day/Yr.	Weight	Comments	Date Month/Day/Yr.	Weight	Comments

AUTHORITY: 1979 PA 218

COMPLETION: Voluntary, however, Rule 310(3) requires that a resident's weight be recorded at admission and monthly thereafter.

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