

RESIDENT HEALTH ASSESSMENT for ASSISTED LIVING FACILITIES

This form must be completed annually fo	or residents receiving assistive care services in order to comply with Medicaid
TO BE COMPLETED BY FACILITY: Resident's Name	DOB:
	SED HEALTH CARE PROVIDERS: AFTER AND 2 OF THIS FORM (pages 1 through 4), PLEASE RETURN TO:
FACILITY NAME:	
FACILITY ADDRESS:	
TELEPHONE NUMBER:	CONTACT PERSON:
SECTION 1: HEALTH ASSESSMENT (MUST MEANS OF A FACE-TO-FACE EXAMINAT	TT BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY TION WITH THE RESIDENT.)
Known Allergies:	Height: Weight:
Medical history and diagnoses:	
Physical or sensory limitations:	
Cognitive or behavioral status:	
Nursing/treatment/therapy service requirer	ments:
Special precautions:	
Elopement Risk:	

Indicate by a checkmark (*) in the appropriate column below the extent to which the individuals is perform each of the activities of daily living. If "needs supervision" or "needs assistance" is indicate 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									FACILITY:	ETED BY FA	COMPLE	TO BE
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						5. Require 24-hour nursing or psychiatric care?						
medical, nursing or psychiatric facility? Yes No	which is not a	ed living facility, which is	t in an assisted livin									
Comments (Use additional page if necessary):					N		-					

TO BE COMPLETED BY FACILITY Resident's Na						DOB:
Resident 5 Na	е					DOB.
SECTION 2-A: 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 SE	LF-C	ARE 1	TASKS	i :		
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 =	Ne	eds S	upervi	sion	A = Needs Assistance
TASKS	ı	S*	A*			COMMENTS*
Preparing Meals						
Shopping						
Making Phone Calls						
Handling Personal Affairs						
Handling Financial Affairs						
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		ı	w	D	0*	COMMENTS*
Observing Wellbeing				_	-	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
Observing Whereabouts						
Reminders for Important Tasks	5					
Other						
Other						
Other						
Other						
C. ADDITIONAL COMMENTS/OBSERVATIONS (Use additional page if necessary):						

ТО ВЕ	COMPLETED BY FACILITY: Resident's Name			DOB:		
SECTION 2-B: SELF-CARE AND GENERAL OVERSIGHT ASSESSMENT—MEDICATIONS (MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.) A. 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.						
12.					+	
	es the individual need help with taking his o a checkmark () in front of the appropriate			eds)? Yes No	If yes, please	
	Needs Assistance with Self-Administration of Me This allows unlicensed staff to assist with orals and topi		Needs Medication Administration Not all ALFs have licensed staff to provide this service.			
	Able to Administer w/o Assistance					
C. ADDITIONAL COMMENTS/OBSERVATIONS (Use additional page if necessary):						
AME OF	MEDICAL CERTIFICATION IS INCOMPLETE V EXAMINER (Please Print): GIGNATURE OF EXAMINER: MEDICAL LICENSE #:					
	MEDICAL LICENSE #: ADDRESS OF EXAMINER: TELEPHONE #:					
	EXAMINER (Please check the appropriate box): EXAMINATION:	MD	DO	ARNP PA		

TO BE COMPLETED BY FACILITY: Resident's Name DOB:						
CEC	TION 2. CERVICES OFFE		D DV THE EACH IT	EOD THE DECIDENT / **	ICT DE	
	MPLETED BY THE ALF AL			FOR THE RESIDENT (MU	SI BE	
Note: 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. The facility may attach the resident's service plan, care plan, or community living support plan to this document to satisfy this requirement provided the documentation captures the information listed below.						
#	(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	
1.						
2.						
3. 4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
13.						
14.						
15.						
NAME	OF RECIPIENT OR GUARDIAI (Please Pri				-	
SIGNA	TURE OF RECIPIENT OR GUA	ARDIAN:			-	
NAME OF ADMINISTRATOR OR DESIGNEE: (Please Print)						
SIGNA	TURE OF ADMINISTRATOR O	R DESIGNEE:			-	
Does If yes	the facility intend to use this f , page 6 is required to be com	orm to satisfy the Med pleted. If no, Stop.	licaid assessment for ass	istive care services? Yes	No	
۸۵۲	N Pacammandad Form 1822		5			

CERTICATE OF MEDICAID NECESSITY THIS PAGE MUST ALSO BE FILLED OUT FOR RESIDENTS THAT RECEIVE MEDICAID ASSISTIVE CARE SERVICES

Resident Name	DOB
• •	of an integrated set of assistive care services on a 24-hour basis, service components on a daily basis (check as applicable):
Assistance with activities of daily livitransferring, bathing, dressing, eating, groom	ng, which is defined as individual assistance with ambulating, ming, and/or toileting.
Assistance with instrumental activities shopping for personal items, making telephoral	s of daily living, which is defined as individual assistance with one calls, managing money, etc.
the resident of any important tasks; and re-	oserving the resident's whereabouts and well-being; reminding cording and reporting any significant changes in appearance, e provider, designated representative, or case manager.
Assistance with self-administration of supervision of self-administration of medical	Emedication, which is defined as assistance with or ation as permitted by law.
HEALTH CARE PROVIDER	
Facility Name:	
License Number:	
Administrators' Signature:	
Date Signed:	
CERTIFICATION OF MEDICAL NEC	ESSITY:
Physician/Physician Assistant/ Advanced Registered Nurse Practitioner/ Registered Nurse:	
Date:	

The resident service log is still required for Medicaid residents.