AGE

RESIDENT APPRAISAL

Residential Care Facilities For The Elderly

NOTE: This information may be obtained from the Prospective Resident, or his/her responsible person. This form is not a substitute for the Physician's Report (LIC 602).

APPLICANT'S NAME

HEALTH (Describe overall health condition including any dietary limitations)

PHYSICAL DISABILITIES (Describe any physical limitations including vision, hearing or speech)

MENTAL CONDITION (Specify extent of any symptoms of confusion, forgetfulness: participation in social activities (i.e., active or withdrawn))

HEALTH HISTORY (List currently prescribed medications and major illnesses, surgery, accidents; specify whether hospitalized and length of hospitalization in last 5 years)

SOCIAL FACTORS (Describe likes and dislikes, interests and activities)

BED STATUS (An exception must be obtained to admit or retain a resident who will be temporarily bedridden more than 14 days. Permanently bedridden residents are prohibited).				
OUT OF BED ALL DAY	IN BED MOST OF THE TIME	COMMENT:		
IN BED PART OF THE TIME	IN BED ALL OF THE TIME			
TUBERCULOSIS INFORMATION				
ANY HISTORY OF TUBERCULOSIS IN APPLICAN	NT'S FAMILY?	DATE OF TB TEST/TYPE OF TEST	D POSITIVE	
YES	NO		NEGATIVE	
ANY RECENT EXPOSURE TO ANYONE WITH TU	JBERCULOSIS?	ACTION TAKEN (IF POSITIVE)		
YES	NO			
GIVE DETAILS				

AMBULATORY STATUS	(this person is	ambulator	γL	nonambulatory)
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Ambulatory means able to demonstrate the mental and physical ability to leave a building without the assistance of a person or the use of a mechanical device other than a cane. An ambulatory person must be able to do the following:

YES	NO	
		Able to walk without any physical assistance (e.g., walker, crutches, other person), or able to walk with a cane.
		Mentally and physically able to follow signals and instructions for evacuation.
		Able to use evacuation routes including stairs if necessary.
		Able to evacuate reasonably quickly (e.g., walk directly the route without hesitation).

FUNCTIONAL CAPABILITIES (Check all items below)

YES	NO			
		Active, requires no personal help of any kind - able to go up an	d down stairs easily	
		Active, but has difficulty climbing or descending stairs		
		Uses brace or crutch		
		Frail or slow		
		Uses walker. If Yes, can get in and out unassisted?	Yes	No
		Uses wheelchair. If Yes, can get in and out unassisted?	Yes	🗌 No
		Requires grab bars in bathroom		
		Other: (Describe)		

SERVICES NEEDED (Check items and explain)

VEO			
YES	NO	Help in transferring in and out of bed/turning in bed or chair (specify)	
		Help with bathing	
		Help with dressing, hair care, and personal hygiene (specify)	
		Does prospective resident desire and is he/she capable of doing own personal laundry and other household tasks? (specify)	
		Help with moving about the facility	
		Help with eating (need for adaptive devices or assistance from another person)	
		Special diet/observation of food intake	
		Toileting, including assistance equipment, or assistance of another person (specify)	
		Continence, bowel or bladder control. Are assistive devices such as a catheter required?	
		Help with medication	
		Needs special observation/night supervision (due to confusion, forgetfulness, wandering)	
		Help in managing own cash resources	
		Help in participating in activity programs	
		Special medical attention	
		Assistance in incidental health and medical care	
		Other "Services Needed" not identified above	
Is there any additional information which would assist the facility in determining applicant's suitability for admission? Yes No If Yes, please attach comments on separate sheet.			

TO THE BEST OF MY KNOWLEDGE, I/THE ABOVE PERSON DO/DOES NOT NEED SKILLED NURSING CARE.			
SIGNATURE OF APPLICANT OR RESPONSIBLE PERSON	DATE COMPLETED		
SIGNATURE OF LICENSEE OR DESIGNATED REPRESENTATIVE	DATE COMPLETED		