



**RESIDENT HEALTH ASSESSMENT for ASSISTED LIVING FACILITIES**

❖ This form must be completed annually for residents receiving assistive care services in order to comply with Medicaid

TO BE COMPLETED BY FACILITY:

Resident's Name \_\_\_\_\_ DOB: \_\_\_\_\_

**INSTRUCTIONS TO LICENSED HEALTH CARE PROVIDERS: *AFTER COMPLETION OF ALL ITEMS IN SECTIONS 1 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 BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.*)**

Known Allergies:	Height:	Weight:
Medical history and diagnoses:		
Physical or sensory limitations:		
Cognitive or behavioral status:		
Nursing/treatment/therapy service requirements:		
Special precautions:		
Elopement Risk: Yes <input type="checkbox"/> No <input type="checkbox"/>		

TO BE COMPLETED BY FACILITY:

Resident's Name \_\_\_\_\_ DOB: \_\_\_\_\_

**SECTION 1: HEALTH ASSESSMENT (MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.)**

A. To what extent does the individual need supervision or assistance with the following?

Key	I = Independent	S = Needs Supervision	A = Needs Assistance	T = Total Care
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Indicate by a checkmark (✓) in the appropriate column below the extent to which the individuals is able to perform each of the activities of daily living. If "needs supervision" or "needs assistance" is indicated, please 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

Regular       Calorie Controlled       No Added Salt       Low Fat/Low Cholesterol

Other, please describe: \_\_\_\_\_

C. Does the individual have any of the following conditions/requirements? If yes, please include an explanation in the comments column.

STATUS	YES/NO (Y/N)	COMMENTS
1. A communicable disease, which could be transmitted to other residents or staff?		
2. Bedridden?		
3. Any stage 2, 3, or 4 pressure sores?		
4. Pose a danger to self or others?		
5. Require 24-hour nursing or psychiatric care?		

D. In your professional opinion, can this individual's needs be met in an assisted living facility, which is not a medical, nursing or psychiatric facility? Yes \_\_\_ No \_\_\_

Comments (Use additional page if necessary):

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<b>TO BE COMPLETED BY FACILITY:</b> Resident's Name _____ DOB: _____
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**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 SELF-CARE TASKS:**

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 = Needs Supervision | A = Needs Assistance

TASKS	I	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	I	W	D	O*	COMMENTS*
Observing Wellbeing					
Observing Whereabouts					
Reminders for Important Tasks					
Other					

**C. ADDITIONAL COMMENTS/OBSERVATIONS** (Use additional page if necessary):

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TO BE 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.				
11.				
12.				

B. Does the individual need help with taking his or her medications (meds)? Yes \_\_\_ No \_\_\_. If yes, please place a checkmark (✓) in front of the appropriate box below:

<input type="checkbox"/>	<b>Needs Assistance with Self-Administration of Medications</b> ❖ This allows unlicensed staff to assist with orals and topical medication.	<input type="checkbox"/>	<b>Needs Medication Administration</b> ❖ Not all ALFs have licensed staff to provide this service.
<input type="checkbox"/>	<b>Able to Administer w/o Assistance</b>	<input type="checkbox"/>	

C. ADDITIONAL COMMENTS/OBSERVATIONS (Use additional page if necessary): \_\_\_\_\_

**NOTE: MEDICAL CERTIFICATION IS INCOMPLETE WITHOUT THE FOLLOWING INFORMATION:**

NAME OF EXAMINER (Please Print): \_\_\_\_\_  
 SIGNATURE OF EXAMINER: \_\_\_\_\_  
 MEDICAL LICENSE #: \_\_\_\_\_  
 ADDRESS OF EXAMINER: \_\_\_\_\_  
 TELEPHONE #: \_\_\_\_\_  
 TITLE OF EXAMINER (Please check the appropriate box):

<input type="checkbox"/>	<b>MD</b>	<input type="checkbox"/>	<b>DO</b>	<input type="checkbox"/>	<b>ARNP</b>	<input type="checkbox"/>	<b>PA</b>
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DATE OF EXAMINATION: \_\_\_\_\_

TO BE COMPLETED BY FACILITY:  
 Resident's Name \_\_\_\_\_ DOB: \_\_\_\_\_

**SECTION 3: SERVICES OFFERED OR ARRANGED BY THE FACILITY FOR THE RESIDENT (*MUST BE COMPLETED BY THE ALF ADMINISTRATOR OR DESIGNEE.*)**

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.					
12.					
13.					
14.					
15.					

**NAME OF RECIPIENT OR GUARDIAN:**  
 (Please Print) \_\_\_\_\_

**SIGNATURE OF RECIPIENT OR GUARDIAN:** \_\_\_\_\_

**NAME OF ADMINISTRATOR OR DESIGNEE:**  
 (Please Print) \_\_\_\_\_

**SIGNATURE OF ADMINISTRATOR OR DESIGNEE:** \_\_\_\_\_

Does the facility intend to use this form to satisfy the Medicaid assessment for assistive care services? Yes  No   
 If yes, page 6 is required to be completed. If no, Stop.

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

Resident Name \_\_\_\_\_ DOB \_\_\_\_\_

This is to certify that this recipient is in need of an integrated set of assistive care services on a 24-hour basis, including at least two of the following four service components on a daily basis (check as applicable):

\_\_\_\_ Assistance with activities of daily living, which is defined as individual assistance with ambulating, transferring, bathing, dressing, eating, grooming, and/or toileting.

\_\_\_\_ Assistance with instrumental activities of daily living, which is defined as individual assistance with shopping for personal items, making telephone calls, managing money, etc.

\_\_\_\_ Health support, which is defined as observing the resident's whereabouts and well-being; reminding the resident of any important tasks; and recording and reporting any significant changes in appearance, behavior, or state of health to the health care provider, designated representative, or case manager.

\_\_\_\_ Assistance with self-administration of medication, which is defined as assistance with or supervision of self-administration of medication as permitted by law.

**HEALTH CARE PROVIDER**

Facility Name: \_\_\_\_\_

License Number: \_\_\_\_\_

Administrators' Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

**CERTIFICATION OF MEDICAL NECESSITY:**

Physician/Physician Assistant/  
Advanced Registered Nurse Practitioner/  
Registered Nurse: \_\_\_\_\_

Date: \_\_\_\_\_

The resident service log is still required for Medicaid residents.

