FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RESIDENT HEALTH ASSESSMENT for ASSISTED LIVING FACILITIES

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:	

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

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*	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/N0 (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):

TO BE COMPLETED BY FACILITY:
Resident's Name _____ 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 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					
Other					
Other					
Other					

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

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:

	Needs Assistance with Self-Administration of Medications		Needs Medication Administration

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): ☐ MD ☐ DO ☐ ARNP ☐ PA

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, except for residents receiving the following:

(a) Extended congregate care services (ECC) in a facility holding an ECC license; or
(b) Services under a community living support plan in a facility holding a limited mental health license; or
(c) Medicaid assistive care services; or
(d) Medicaid waiver services.

#	(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 ADMINISTRATOR OR DESIGNEE: (Please Print) _____

SIGNATURE OF ADMINISTRATOR OR DESIGNEE: _____

DATE OF SIGNATURE: _____