DSS-4449D (Rev. 4/97)

ASSISTED LIVING PROGRAM
NURSING/FUNCTIONAL/SOCIAL ASSESSMENT

An Assisted Living Program (ALP) provides long-term residential care, room, board, housekeeping, personal care, supervision, and provides or arranges for home health services to eligible residents in an adult care facility (ACF).

Individual's Name: _____ Date of Birth: _____ SSA #: _____

Indicate whether the individual requires assistance with any of the following. Complete all sections:

	YES	NO	DESCRIPTION/LEVEL	FREQUENCY	DURATION
Nursing					
Diet Counseling-Specify Diet					
Dressings					
Vital Sign Monitoring					
Medication Administration					
Tube Feeding*					
Tube Irrigation*					
Suctioning*					
Laboratory Services					
Physical Therapy					
Occupational Therapy					
Speech pathology					
Inhalation Therapy					
Oxygen Therapy					
Medical Social Service					
Counseling					
Transportation Arrangements					
Personal/Financial Errands					
Legal/Protective Services					
Bathing					
Grooming					
Dressing					
Toileting					
Eating					
Exercise/Activity/Walking					
Bedbound Care					
Housekeeping Services					
Laundry Services					
Meal Preparation					
Shopping (food, supplies)					
Transportation Attendant					
Ramps Outside/Inside					
Commode/Special Bed/Wheelchair					
Structural Modifications					
Bed Protector/Diapers					
Cane/Walker/Crutches/Other					
Catheter/Colostomy Supplies					
Eyeglasses/Hearing Aide					
Self-help Devices (specify)					
Other: 1) 2)					

***Please note:** A yes response in any of thee categories may indicate that the individual may be inappropriate for placement or continued stay in the ALP.

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Community Support: Indicate organization serving individual at present or who has provided a service in the past six months (e.g. Home Care Services, Adult Day Health Care, Day Treatment Programs).

		PRESENTLY	RECEIVING		
ORGANIZATION	TYPE OF ERVICE	HRS/DAY	HRS/WK	CONTACT PERSON	TELEPHONE nO

PRI RUG CATEGORY _____ PRI Attached? ____ Yes ____ No

Can the individual's health/safety needs be met through an ALP? ____ Yes ____ No
If yes, specify the reason and indicate appropriate level of care: _____
_____
If yes, can the individual's needs be met in a lower level of care? ____ Yes ____ No
If yes, explain_____

Narrative: Use this space to describe aspects of the individual's care/needs not adequately covered above.
_____
_____
_____
_____
_____
_____

Signature (CHHA/LTHHP RN): _____ Date: _____

CHHA/LTHHCP Name: _____Telephone No: _____

Signature (ALP RN): _____ Date: _____