ASSISTED LIVING RESIDENCE

ALR RESIDENT PERSONAL DATA and ALR RESIDENT EVALUATION INSTRUCTIONS

General Directions

The ALR Resident Personal Data Form DOH 4397 Part A and ALR Resident Evaluation Form DOH 4397 Part B must be completed for all individuals prior to their admission to an Assisted Living Residence (ALR). The ALR Resident Personal Data Form DOH 4397 Part A contains two sections: personal data and personal background and the ALR Resident Evaluation Form DOH 4397 Part B contains six sections: communication/dental/vision/hearing, customary routine, continence status/management, physical function, cognitive impairment screen and admission decision. Both forms are completed in conjunction with the Medical Evaluation Form DOH-3122, which must be completed by the individual's physician prior to the individual's admission.

Information contained in these three forms is used to determine the individual's appropriateness for a particular level of care within the ALR and when developing the initial Individualized Service Plan (ISP). The ALR Resident Personal Data Form DOH 4397 Part A and the Resident Evaluation Form DOH 4397 Part B meet the requirements for the Adult Care Facility (ACF) Personal Data Sheet, the ACF Pre-Admission Interview and the Enriched Housing Program (EHP) Functional Assessment.

The ALR Resident Personal Data Form DOH 4397 Part A will be updated on an on-going basis as information changes for each resident. It is each ALR's responsibility to maintain the most current information in these areas as part of the resident's permanent record in the facility and as part of the facility's ongoing case management responsibilities.

The ALR Resident Evaluation Form DOH 4397 Part B includes six pages. At the top of each page, write the resident's name, facility's name and the date on which the evaluation was conducted in the spaces provided. Then proceed with completing the rest of the form.

Assisted Living Resident Personal Data Form DOH 4397 Part A

Section I: Personal Data

This section includes general information for the resident, such as the **date of birth**, **gender** and **marital status**, as well as emergency contact, attending physician, health insurance and other personal background information. This information should be collected prior to admission and updated immediately as circumstances change. This information should be obtained by an interview with the resident, the resident's family/significant other, if present, and any other persons participating in the interview.

In the **Notify in Case of Emergency** box, include the name, relationship to the resident, and contact information of the individual that will be contacted in the event the resident experiences a medical or other emergency.

In the **Attending Physician/Other Health Care Provider** boxes, include the name and contact information for the resident's attending physician and any other health or mental health providers in the appropriate spaces.

In the **Health Insurance** box, include the name of the resident's primary insurer, the resident's insurance ID number, Medicaid and/or Medicare numbers (if appropriate), the name of any prescription drug plan in which the resident is a member, any associated ID numbers, as well as any other health care insurance coverage that the resident might have. In addition, include the name, phone number, and address of any pharmacy with which the resident does business.

In the **Area Hospital/Clinic of Choice** box, include the name and address of any hospitals or clinics that the resident prefers to use.

Section 2: Personal Background

This section includes information regarding the family, social, residential, occupational/educational, and religious background of the resident, as well as other personal information. This information should be obtained by an interview with the resident and the resident's family/significant other, if present, and any other persons participating in the interviews.

Wishes to be addressed as: enter the name the resident wishes to be used to address him/her (Mr. Smith, Mrs. Smith, Bill, Jane, a nickname, etc.) in the space provided.
Address: enter the address of the resident if the resident maintains an address other than the ALR in the space provided. If the resident's only address is the ALR, leave the space blank.

Resident's Representative(s): Enter the name, relationship (spouse, partner, sibling, child, grandchild, friend, etc.), address, and phone numbers for the representative(s) selected by the resident in the spaces provided.

Significant Others: The resident or resident's representative should be asked to name and provide the addresses and phone information for all family members and significant others (partners, friends, acquaintances). In the spaces provided, enter the names, addresses, phone information and individual's relationship to the resident (partner, son, sister, friend, etc.) in the appropriate space.

Residential Background: The resident or resident's representative should be asked where he/she was born and where he/she has lived most of their life. Enter a brief description of this information in the space provided.

Occupational/Educational Background: The resident or resident's representative should be asked to provide a brief description of his/her educational background and the type of work done he/she has done. Enter this information in the space provided.

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Religious Affiliation (if any): Enter the resident's stated religious affiliation (enter none if none is stated) in the space provided. In addition, enter the location at which the person prefers to attend religious services in the space provided after **Place of Worship**. Enter the **Phone Number** (if the resident knows it) of the named Place of Worship in the space provided.

Health Care Proxy: Check the appropriate box to indicate whether or not the resident has a health care proxy. Identify by name the designated health care proxy in the space provided.

DNR: Check the appropriate box to indicate whether or not the resident has established Do Not Resuscitate orders.

Power of Attorney: Check the appropriate box to indicate whether or not the resident has given power of attorney and identify the individual with power of attorney, by name, in the space provided.

Living Will: Check the appropriate box to indicate whether or not the resident has a living will.

Burial Instructions: Include any burial instructions that the resident may have in the space provided.

Assisted Living Resident Evaluation Form DOH 4397 Part B

Section 1: Communication/Dental/Vision/Hearing

This section contains information regarding the resident's communication, dental, vision and hearing. Complete the items in this section based on the interview with the resident and/or conversations with the resident's family or significant others.

Ability to Speak, Read/Write English: Based on conversation with the resident, indicate whether or not the individual can speak, read/write English. Check the "yes" box only if the individual can speak, read and write English. If the Resident cannot speak, read/write English, indicate the resident's dominant language (or literacy status) in the space provided.

Verbal Expression/Speech: Based on observation and conversation with the resident, and on conversation with the resident's family or significant other, check the appropriate box to indicate the resident's ability to speak and understand other's speech.

Speech: Identify if the resident has a speech defect/impairment.

Other Sensory Impairments Noted: Based on observation and interview of the resident and resident representative, check the appropriate box if the resident has a hearing, vision or dental impairment and provide a brief explanation in the comment section.

Identify whether the resident has dental prosthetics, vision or hearing problems and whether they wear glasses, contact lenses and/or a hearing aide.

Section 2: Customary Routine

This section contains information regarding the resident's preferences in terms of sleeping, bathing, and eating habits as well as other social preferences and activities. Complete the items in this section based on the interview with the resident and/or conversations with the resident's family or significant others.

Sleeping Routine: In the spaces provided, indicate the resident's stated preferences for wake up time, bedtime, napping routine (when, how long, if any), and nighttime sleep pattern. In the space provided for "comments" include any additional information that will be important for facility staff to know regarding the resident's sleeping routine.

Bathing Routine: In the spaces provided, indicate whether the resident expresses any preference for a bath or shower and the frequency that the resident prefers to bathe. In the space provided for "comments" include any additional information that will be important for facility staff to know regarding the resident's bathing routine (for example, the time of day the resident prefers to bathe).

Eating Routine: In the spaces provided, indicate any food preferences and food dislikes as expressed by the resident. In the space provided for "comments" include any additional information that will be important for facility staff to know regarding the resident's eating habits (for example, times the resident prefers to eat, snacking habits, if any).

Daily Events: The intent of these questions is to determine the types of activities in which the resident prefers to engage. This information should be gathered by conversation with the resident or the resident's family or significant others, if present.

Section 3: Continence Status/Management

This section contains information regarding whether the resident is continent of bowel and bladder and, if not, the management techniques that are used. Complete these items based on the most recently completed Medical Evaluation (DOH 3122) of the resident, the interview of the resident and/or on conversations with the resident's family or significant other.

Is the resident continent of urinary function: based on information from the completed Medical Evaluation, check the appropriate box.

Is the resident continent of bowel function: based on information from the completed Medical Evaluation, check the appropriate box.

- If the answer to either of these questions is "no" (the individual is incontinent of bowel and/or bladder), answer any appropriate questions in the subsequent section.
- If the resident is incontinent of both bladder and bowel, answer both the "Urinary" and "Bowel" Incontinence sets of questions.

- If the resident is incontinent of only bladder or only bowel, answer the appropriate set of questions and leave the other set blank.

Urinary Incontinence and Current Management Techniques:
Indicate the frequency of incontinence by checking the appropriate box: "Several times a week", or "Daily".
Indicate the time of day of incontinence by checking the appropriate box: "Day only", "Night only", or "Day and Night".

Indicate which, if any, of the specified management techniques are currently being used by checking the appropriate box: "Prompting/reminding defers incontinence", "Timed voiding defers incontinence", "Uses incontinence pad/adult diapers", or "Catheter" (specify the type of catheter in the space provided).

- If the "incontinence pad/adult diapers" box is checked, indicate whether they are used during the day only, night only, or day and night by checking the appropriate box.
- Include any additional information that may be important for managing the resident's urinary incontinence in the spaces provided after "Comments".
- Indicate whether the resident can self-manage continence problems by checking the appropriate response, "yes" or "no". Assistance includes prompting and reminding. Select "yes" only if the resident requires no assistance of any kind at any time, no matter how infrequently.

Bowel Incontinence and Current Management Techniques:
Indicate the frequency of incontinence by checking the appropriate box: "Several times a week", or "Daily".
Indicate the time of day of incontinence by checking the appropriate box: "Day only", "Night only", or "Day and Night".

- Indicate whether or not "incontinence pads/adult diapers" are used as a management technique by checking the appropriate box. If this technique is used, indicate whether it is used during the "day only", "night only" or "day and night" by checking the appropriate box.
- Include any additional information that may be important for managing the resident's bowel incontinence in the spaces provided after "Comments".
- Indicate whether the resident can self-manage continence problems by checking the appropriate response "yes" or "no". Assistance includes prompting and reminding. Select "yes" only if the resident requires no assistance of any kind at any time, no matter how infrequently.

Section 4: Physical Function:

This section contains questions intended to address the resident's ability to function independently for each of the Activities of Daily Living (ADLs) and instrumental activities of daily living (IADLs). Complete these items based on the interview with the individual and/or discussions with the family and/or significant others. Review the responses with the resident

and/or family and select the one that most closely describes the resident's ability to conduct the activity. In the "Comments" section, include any additional information that describes the resident's ability to conduct the activity that might be important for developing the resident's Individual Service Plan (ISP).

Responses should be based on the resident's ABILITY to perform the activity rather than his/her preference for performing the activity. For example, the resident who is able to shower independently, but chooses to sponge bathe at the sink, should be scored as being able to independently shower even though their preference is not to use the shower. Such PREFERENCES should be noted in the "Comments" section and should be used to develop the resident's ISP. In the case where the resident can independently perform an IADL but chooses to have facility staff perform the task, the appropriate box should be checked for that IADL.

Eating: Refers to the ability to feed self-meals and snacks including chewing and swallowing food. This excludes the ability to prepare meals.

Comments:

- In the "comments" section, indicate whether the resident wears dentures by checking the appropriate box. If the resident does wear dentures, indicate whether the residents wears Upper or Lower (or both) dentures by checking the appropriate box. If the resident does not wear dentures, do not check any boxes.
- Indicate whether the resident has any "Chewing difficulties" or any "Difficulty swallowing" by checking the appropriate box. If the resident requires that the consistency of his/her food be modified in any way before it can be eaten, check the "yes" box. Otherwise, check the "no" box. If the "yes" box is checked, specify the manner in which the food consistency must be modified (pureed, etc.) in the space provided.

Ambulation: Refers to the ability to safely walk once in a standing position.

Comments:

- If the resident uses any mechanical device to ambulate, check the appropriate box in this section. If the resident uses any mechanical device not described, check the "other" box and describe this device in the space provided.
- Indicate whether or not the resident has fallen in the last three months. If the resident indicates that he/she has fallen in the last three months, check the "yes" box; otherwise check the "no" box. If the resident has fallen in the last three months, indicate the number of times he/she has fallen in the space provided.
- If the resident has fallen, indicate whether or not any injury has resulted from the falls. If there have been multiple falls, include injuries that have resulted from all falls.

Transferring: Refers to the ability to safely move from bed to chair, on and off toilet, into and out of tub or shower, and ability to turn and position self in bed if bedfast.

Other: Check if resident has an amputation, prosthesis or podiatric concern.
Toileting: Refers to the ability to use the toilet or commode, including getting to and from the toilet or commode, getting on/off the toilet or commode, adjusting clothes, and the ability to cleanse after use.

Comments: If the resident has had an ostomy, check the "yes" box. Otherwise, check the "no" box.

Bathing: Refers to the ability to get in and out of the tub or shower, and the ability to wash and dry the entire body.

Dressing: Refers to the ability to dress and undress upper and lower body including undergarments, socks or nylons, pullovers, front opening shirts and blouses, managing zippers, buttons, snaps and shoes, and the ability to get clothes from closets and drawers.

Grooming: Refers to the ability to attend to personal hygiene needs such as washing face and hands, hair care, shaving, make-up, teeth or denture care, and fingernail care.

Transportation: Refers to the physical and mental ability to safely use a car, taxi or public transportation (bus, train, subway).

Laundry: Refers to the ability to do his or her own laundry including carrying the laundry to and from the washing machine and dryer, using the washer and dryer, and washing small items by hand.

Housekeeping: Refers to the ability to safely and effectively perform light housekeeping and heavier cleaning tasks.

Shopping: Refers to the ability to plan for, select, and purchase items in a store and carry them home or arrange for delivery.

Ability to use telephone: Refers to the ability to answer the phone, dial/push numbers, and effectively use the telephone to communicate.

Section 5: Cognitive Impairment Screen

The cognitive impairment screen contains a number of questions that are designed to indicate whether or not the individual might need a more extensive cognitive assessment in order to determine the appropriate level of care for the resident and to develop the most appropriate Individualized Service Plan (ISP).

Before asking the first four questions, say: **"Now I want to ask you some questions about your memory."**

"What is today's date?"
If resident only provides a partial date (for example, the 3rd, May, or 2006) prompt for the day, month and year.

Correct answer: day, month, and year, within 2 days

"What day of the week is today?"

Correct answer: must name the correct day, Monday – Tuesday, etc.

"How old are you?"

Correct answer: check resident's records for correct age; must give correct age.

"When were you born?"

Correct answer: check resident's records for day, month, and year of birth; must give correct day, month and year.

Behaviors of Note:

The behaviors listed may sometimes be associated with cognitive impairment. Based on your observation and/or interview with the resident, as well as discussions with the resident's family and/or caregivers, indicate whether any of these behaviors are present. Indicating that any of these conditions are present does not necessarily indicate that a cognitive issue exists. Check as many conditions as may apply.

Overall Cognitive Functioning:

Based on observation and interview of the resident and any discussions with the resident's family and/or representative, check the box that most closely corresponds with the resident's overall level of cognitive function. The answer to these questions are intended to assist the residence in determining if a resident is appropriate and/or if the individual should be referred to his/her physician for consultation or further cognitive evaluation or treatment. In the "comments" space, include any information that would be important or pertinent for the development of the resident's ISP.

Section 6: Admission Decision

Admission Decision: Based on the information obtained in the Medical Evaluation Form, any recommendations by the resident's physician, and the information from the resident and/or the resident's significant others, indicate the level of care to which the person is being admitted by checking the appropriate box: "ALR/AH/EHP", "EALR", or "SNLR" box.

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Documents Provided: Check the information that was provided to resident at or prior to admission.

Signature(s) of Appropriate Staff: All staff who participated in the evaluation of the resident must sign their name in the appropriate space. The title of each staff person as well as the date on which they participated in the evaluation of the resident must be included.

The facility administrator, case manager or ISP planner must sign and date the form as the representative of the facility in the appropriate spaces.

The resident being evaluated and the resident representative, if applicable must sign and date the form in the appropriate spaces.

Include the names of any other individuals who participated in the evaluation. Include their relationship to the resident and the date on which they participated in the evaluation in the appropriate space.