RESIDENT SERVICE PLAN

RESIDENT'S NAME _____ (First, MI, Last)

DATE OF BIRTH MM DD YY

ADMIT DATE MM DD YY

ADMISSION / DISCHARGE INFORMATION

Facility Name:_____ **County:**_____

Admitted from: ❑ **Own Home** ❑ **Hospital** ❑ **NH** ❑ **OMH** ❑ **Homeless Shelter** ❑ **Other (specify):** _____

Admission Sponsor (if any) _____

Address Admitted from (Street, City, State, Zip): _____

Discharge Date: _____/_____/_____ **Discharge to:** ❑ **Own Home** ❑ **Hospital** ❑ **NH** ❑ **OMH** ❑**Other (Specify):** _____

Address Discharged to (Street, City, State, Zip Code): _____

Reason for Discharge: _____

SECTION 1. PERSONAL DATA

Gender Identity *(Check One)*
❑Male ❑ Female ❑Other

Name/s I prefer:

My legal address (if different from facility):

I have a representative or guardian.
❑YES* (name/contact information)
❑ NO

**Maintain in resident's file.*

My Religion *(Specify Below)*

My Place of Worship (if applicable)

My Residential Background (Born/Raised, lived most of life)

My Occupational Background

My Available Identification (complete all that apply)

❑ Driver License #	
❑ Non-Driver ID #	
❑ Other (identify)	
❑ Other (identify)	

Notify In Case of Emergency

_____
Name

_____
Relationship

_____
Cell/Preferred Contact Number

My Next of Kin/Significant Other

_____
Name

_____
Cell/Preferred Contact Number

My Durable Power of Attorney (if Applicable)

_____
Name

_____
Cell/Preferred Contact Number

My Marital Status *(Check one)*
❑Never Married ❑Separated
❑Married ❑Widowed
❑Partner/Significant Other ❑Divorced
❑Unknown

My Special Orders *(Check all that apply and if checked, maintain in resident's file)*
❑ Do Not Resuscitate ❑Living Will
❑ Health Care Proxy ❑Executed MOLST
❑ Burial Instructions ❑Other (specify)

SECTION 2. My health insurance and preferred service providers (Name, Office and Emergency Number/s, if known and as applicable)

My Health Insurance Information

Insurer Name	ID #

Medicaid ID #	Medicare ID #

Prescription Drug Plan (if any)

Other Health Coverage

My Preferred Pharmacy/ies

Name

Phone	Fax

Address

City, State ZIP

My preferred medical/primary care provider

My preferred dental provider

My preferred mental health provider

My preferred transportation provider

I need assistance to make arrangements. ❑YES ❑ NO

My preferred day program

My preferred clinic/hospital

My known allergies include:

My preferred specialists (check all that apply)

❑Cardiologist

❑Home Care Provider

❑Other Specialist

If this resident is being transferred or discharged, provide a copy of pages 1 and 2 to the resident and the receiving facility as applicable.

SECTION 3. Resident Interview Date Conducted _____/_____/_____ Conducted By:

Those Present:

Below, check as complete.

❑ The resident is sight-impaired or hearing-impaired or otherwise unable to comprehend English or printed matter. The operator conducted the interview and provided the contents of the admission agreement, the statement of rights and responsibilities and facility information in a comprehensible manner.

❑ It has been determined through medical practitioner evaluation, resident interview and other observations that a mental health evaluation:

❑ Is not required. OR ❑Is required, and will be conducted _____/_____/_____.

❑ A determination has been made that the facility program can:

- meet the physical needs and personal care needs of the resident, including dietary needs occasioned by cultural or religious practice or individual preference or medical prescription; and
- meet the psychosocial needs of the resident through available programs and the fostering and maintenance of intellectual, social and recreational interests.

❑ The resident was provided with an explanation of the conditions of residency, including but not limited to the admission agreement, resident rights and responsibilities, facility rules and regulations and the personal allowance protections available to Supplemental Security Income or Safety Net recipients.

The resident received at or prior to the admissions interview:

❑ The admission agreement.
❑ The statement of resident rights.
❑ Grievance process.
❑ Rules relating to resident activities, office and visiting hours and other pertinent information.
❑ A fact sheet about the Long Term Care Ombudsman program and the listing of legal services or advocacy agencies made available by the Department.

❑ The resident was informed of his right to review a copy of the most recent report of inspection issued by the Department to the facility.

Comments

❑ I have received the information above and choose to reside in the facility.

SECTION 4. Enriched Housing Program Functional Assessment **Date Prepared: _____/_____/_____**

This section is only to be completed by enriched housing program (EHP) coordinators, EHP case managers, or the EHP consultant registered nurse.

Prepared By:

_____

Name **Title**

Personal Activities of Daily Living

Instrumental Activities of Daily Living

Sensory Impairments

Behavioral Characteristics

Personality Characteristics

Daily Habits

SECTION 5. My Communication/Vision/Hearing Needs
❑6 Month Review ____/____/____ ❑Annual Review ____/____/____ ❑Change ____/____/____

My Preferred Language *(Specify)* _____

I can speak English. ❑YES ❑ NO I can understand instructions in English. ❑YES ❑ NO
I can read English. ❑YES ❑ NO I can write in English. ❑YES ❑ NO

I can read and write in my preferred language. ❑YES ❑ NO
Interpreter needed. ❑YES ❑ NO

Verbal Expression/Speech (check all that apply):
Easily Understood ❑YES ❑ NO Difficulty finding words or expressing self ❑YES ❑ NO
Slurred or mumbled speech ❑YES ❑ NO Understands directions ❑YES ❑ NO

SPEECH: I have a speech defect/impairment. ❑YES ❑ NO If yes, describe: _____

VISION: Glasses: ❑YES ❑ NO Glaucoma: L ❑ R ❑ Legally Blind: L ❑ R ❑ Contact Lenses: ❑YES ❑ NO
❑Reading Only ❑ Continuously Worn

HEARING: I have a hearing deficit. ❑YES ❑ NO I wear a Hearing Aid: L ❑ R ❑

I require written communication due to hearing deficit. ❑YES ❑ NO

SECTION 6. My Routine
❑6 Month Review ____/____/____ ❑Annual Review ____/____/____ ❑Change ____/____/____

My sleeping routine: Preferred Wake Time: _____ Preferred Bed Time: _____
Napping Routine: _____ Nighttime Sleep Pattern: _____

My bathing routine: Prefer: Bath ❑ Shower ❑ Equipment Specify _____
Frequency: _____

My eating routine: Preferred Meal Times: Breakfast_____Lunch_____Dinner _____Snacks _____

I can access food at my preferred times. ❑YES ❑ NO* ❑ NOT APPLICABLE/NEW ADMIT
*I answered no. Explain below and identify actions taken to address.

Food preferences (religious, cultural, other):

Food dislikes:

Daily Events (check all that apply)
❑Goes out _____ days a week (specify 1-7) ❑Contact with relatives/friends _____ days a week (specify 1-7)
❑Stays busy with hobbies, reading, fixed routine ❑Spends most time watching television
❑Usually attends religious services ❑Prefers large group activities

SECTION 7. My Support Team (Include individuals monitoring this Plan and might include family members, friends, facility staff, etc.)

❑6 Month Review ____/____/____ ❑Annual Review ____/____/____ ❑Change ____/____/____

My Case Manager who helped me complete this Plan:

Name **Phone Number**

In addition to me and my case manager, my Resident Service Plan can be shared with the following:

My Representative (if any), Phone Number (if known)	**Name, Phone Number *(if known)***
Name, Phone Number *(if known)*	**Name, Phone Number *(if known)***
Facility Administrator Name, Phone Number	**EHP Coordinator Name, Phone Number** **N/A ❑**
Facility Nurse Name, Phone Number	**Other Staff Name and title, Phone Number**

If I would like to discuss this Plan or make changes, I will do the following:

Informed Consent: I understand where it states "I have been informed," means that the options, risks and benefits have been explained in a manner that I fully understand and I agree to the plan of action.
❑YES ❑ NO

SECTION 8. My Privacy and Living Space ❑6 Month Review ____/____/____ ❑Annual Review ____/____/____ ❑Change ____/____/____	
I have informed the facility of my desire for a private room. ***(Check one.)*** ❑YES ❑ NO	**I understand I <u>may/will</u> be charged more for a private room.** ***(Circle above to indicate whether there is indeed a charge for a private room. Check below to indicate this individual's understanding.)*** ❑YES ❑ NO
I will accept a semi-private room until an affordable private room becomes available. ***(Check one.)*** ❑YES ❑ NO **Below is my room number.**	**I have the ability to rearrange my room and decorate to my taste.** ***(Check one.)*** ❑YES ❑ NO ***If no, indicate why in the space below.***
I currently have a roommate. ***(Check one.)*** ❑YES ❑ NO ❑ NOT APPLICABLE/NEW ADMIT **Current Roommate's Name:** **I would like to change roommates.** ❑YES ❑ NO ❑ NOT APPLICABLE/NEW ADMIT **If yes, my preferred roommate's name is:**	**I have a key for my bedroom/room.** ***(Check one.)*** ❑YES ❑ NO ***If no, indicate why in the space below.*** **Indicate below by title, the facility staff who have a key to my bedroom/room.** **I understand that, in the event of an emergency, any staff may enter as necessary and appropriate.** ***(Check one.)*** ❑YES ❑ NO
I feel I have privacy in my room. ***(Check one.)*** ❑YES ❑ NO ❑ NOT APPLICABLE/NEW ADMIT ***If no, indicate why in the space below.***	**I am able to make private telephone calls when desired.** ***(Check one.)*** ❑YES ❑ NO ***If no, indicate why in the space below and steps taken to address.***
I feel safe and secure entering/exiting my room. ***(Check one.)*** ❑YES ❑ NO ❑ NOT APPLICABLE/NEW ADMIT ***If no, indicate why in the space below.***	**I feel safe and secure entering/exiting this facility at all times.** ***(Check one.)*** ❑YES ❑ NO ❑ NOT APPLICABLE/NEW ADMIT ***If no, indicate why in the space below.***

SECTION 9. My Rights
❑6 Month Review ____/____/____ ❑Annual Review ____/____/____ ❑Change ____/____/____

I have read and understand the Resident Rights and Responsibilities Statement provided to me. ***(Check one.)***
❑YES ❑ NO

I do not feel I am pressured or limited by facility staff.
❑ Agree ❑ Disagree ❑ NOT APPLICABLE/NEW ADMIT

I disagree. Below, indicate why in the space below and steps taken to address.

The facility supports me in making informed choices.
❑YES ❑ NO ❑ NOT APPLICABLE/NEW ADMIT

If no, indicate why in the space below and steps taken to address.

I feel I have control over my personal belongings.
❑YES ❑ NO ❑ NOT APPLICABLE/NEW ADMIT

If no, indicate why in the space below and steps taken to address.

I feel I can choose with whom I want to interact.
❑YES ❑ NO ❑ NOT APPLICABLE/NEW ADMIT

If no, indicate why in the space below and steps taken to address.

I feel I am treated with dignity and respect.
❑YES ❑ NO ❑ NOT APPLICABLE/NEW ADMIT

If no, indicate why in the space below and steps taken to address.

I can independently choose my activities.
❑YES ❑ NO ❑ NOT APPLICABLE/NEW ADMIT

If no, indicate why in the space below and steps taken to address.

I was able to select my own representative payee.
❑YES ❑ NO ❑ NOT APPLICABLE/NEW ADMIT

I am aware I do not have to choose facility staff as my representative payee.
❑YES ❑ NO ❑ NOT APPLICABLE/NEW ADMIT

I was unaware I do not have to choose facility staff as my representative payee. My case manager discussed this with me and provided education about my representative payee options.
❑YES

While I am able to control my own schedule, I understand there may be consequences to participating outside the timeframes of my fellow residents.

❑YES ❑NO ❑NOT APPLICABLE/NEW ADMIT

Below are the potential negative consequences we discussed.

My money will be managed by:
❑Me.
❑My Representative Payee. _____
❑Me, with help from my family.
❑Me, with case management assistance.
❑The facility.

My case manager discussed with me transportation options (public, facility, etc.) that I can use to access outside banking services.

SECTION 10. My Access to the Facility and Community

❑6 Month Review ____/____/____ ❑Annual Review ____/____/____ ❑Change ____/____/____

I have access to common areas within the facility. ❑YES ❑ NO ❑ NOT APPLICABLE/NEW ADMIT ***If no, indicate why in the space below and steps taken to address.***	**I require assistance or supervision in accessing the facility's common areas. This is how assistance or supervision is provided and by whom.**
The procedure to request visitors outside of facility visiting hours has been discussed with me. I understand the procedure for making these requests. ❑YES ❑ NO ❑ NOT APPLICABLE/NEW ADMIT ***If no, indicate why in the space below and steps taken to address.***	**I have access to public transportation and know how to use it.** ❑YES ❑ NO ❑ NOT APPLICABLE/NEW ADMIT **I have access to public transportation and need help to use it.** ❑YES ❑ NO ❑ NOT APPLICABLE/NEW ADMIT ***If no, indicate why in the space below and steps taken to address.***
I have access to services and activities in the community. ❑YES ❑ NO ❑ NOT APPLICABLE/NEW ADMIT ***If no, indicate why in the space below and steps taken to address.***	**Public transportation is not available in my community. Below are affordable transportation options and how each can be accessed.**
I feel I am provided opportunities to engage in community events/activities outside the facility. ❑YES ❑ NO ❑ NOT APPLICABLE/NEW ADMIT ***If no, indicate why in the space below and steps taken to address.***	**The facility supports access to my off-site services by providing me with information, transportation and making appointments for me when needed.** ❑YES ❑ NO ❑ NOT APPLICABLE/NEW ADMIT ***If no, indicate why in the space below and steps taken to address.***
Identify below where the facility posts or makes available community events information (flyers, announcements, etc.):	**The facility assists me in getting to the events I want to go to.** ❑YES ❑ NO ❑ NOT APPLICABLE/NEW ADMIT ***If no, indicate why in the space below and steps taken to address.***

SECTION 10. My Access to the Facility and Community (continued)
❑6 Month Review ____/____/____ ❑Annual Review ____/____/____ ❑Change ____/____/____

I want to continue my education. ❑ YES ❑ NO ***If yes, specify how below.*** **I want to continue or pursue a new intellectual activity.** ❑ YES ❑ NO ***If yes, specify below.***	**I want to work or volunteer.** ❑ YES ❑ NO ***If yes, specify how below.***
I want to continue or pursue a new recreational activity. ❑ YES ❑ NO ***If yes, specify below.*** **I will need the assistance of another person to achieve this.** ❑ YES ❑ NO	**I want to continue or pursue a new spiritual activity.** ❑ YES ❑ NO ***If yes, specify below.*** **I will need the assistance of another person to achieve this.** ❑ YES ❑ NO
I want to continue or pursue a new cultural activity. ❑ YES ❑ NO ***If yes, specify below.*** **I will need the assistance of another person to achieve this.** ❑ YES ❑ NO	**I want to vote.** ❑ YES ❑ NO **I am currently registered to vote.** ❑ YES ❑ NO **I am not currently registered to vote and will need assistance from my case manager in registering.** ❑ YES ❑ NO **I will need the assistance of another person to access my voting rights.** ❑ YES ❑ NO

I need my case manager's assistance to access the following benefit programs. (Check all that apply.)
❑ None, managed independently.
❑ None, assistance of family or legal representative. Specify. _____
❑ Assistance of staff. Specify. _____
❑ Medicaid
❑ Medicare
❑ Veteran's Administration
❑ Social Security
❑ Pension
❑ Other (Specify)

SECTION 11. Strengths/Weaknesses/Goals

❑6 Month Review ____/____/____ ❑Annual Review ____/____/____ ❑Change ____/____/____

Below are my strengths/weaknesses and goals related to building relationships. **Strengths:** **Weaknesses:** **Goals:**	**Below are my strengths/weaknesses and goals related to my income/finances:** **Strengths:** **Weaknesses:** **Goals:**
Below are my strengths/weaknesses and goals related to my health and wellness. **Strengths:** **Weaknesses:** **Goals:**	**Below are some identified risks I must consider, and my plans to minimize those risks.** **Risk:** **Plan to Minimize:** **Risk:** **Plan to Minimize:** **Risk:** **Plan to Minimize:**

SECTION 12. My Clinical/Non-Clinical Needs
❑6 Month Review ____/____/____ ❑Annual Review ____/____/____ ❑Change ____/____/____

TASK	LEVEL OF ASSISTANCE
Medication ❑***Checked box indicates changes have been made. Document in case management notes.***	❑Self-administering. ❑Needs assistance.
Eating (Ability to feed self meals and snacks) ❑ ***Checked box indicates changes have been made. Document in case management notes.***	❑ **Independent:** Able to feed self independently with or without assistive device. ❑ **Intermittent Assistance:** Requires minimal, intermittent supervision and/or assistance. ❑ **Continual Assistance:** Requires constant assistance and/or supervision throughout meal. ❑ **Total Assistance:** Unable to feed self, needs to be fed. Unable to take nutrients orally, requires enteral nutrition. Diet ❑ Regular ❑NAS ❑ Chopped ❑NCS ❑Dentures Upper ❑ Yes ❑ No Lower ❑ Yes ❑ No ❑Chewing difficulties ❑Difficulty swallowing ❑Modified consistency _____ ❑Fluid Restrictions/Encouragement ❑Dietary Supplements ❑Tremulous ❑Weighted silverware ❑Cups with lids ❑Other_____ ❑Visually impaired ❑Clock method. ❑Other_____
Ambulation (Ability to safely walk and move about once in a standing position) ❑ ***Checked box indicates changes have been made. Document in case management notes.***	❑**Independent:** Walks and climbs and descends stairs independently with or without assistive device. ❑ **Intermittent Assistance:** Walks and climbs and descends stairs with minimal, intermittent assistance and/or supervision. ❑ **Continual Assistance:** Walks and climbs and descends stairs with constant supervision and/or assistance. ❑ **Total Assistance:** Chairfast or bedfast. Requires total assistance for mobility. ❑Wheelchair ❑Walker ❑Quad cane ❑Cane ❑Escort _____ Other_____ ❑ 1+ Assist *(Chronically needs one person to assist to walk or to climb/descend stairs – EALR required.)* ❑Falls within the last 3 months? Frequency #: _____ Injury:_____
Transferring (Moving from bed to chair, on/off toilet, in/out of shower or tub) ❑ ***Checked box indicates changes have been made. Document in case management notes.***	❑ **Independent:** Able to transfer independently with or without assistive device. ❑ **Intermittent Assistance:** Transfers with minimal human assistance and/or supervision. ❑ **Continual Assistance:** Unable to transfer but can bear weight and pivot when transferred by at least one other person. ❑ **Total Assistance:** Chairfast or bedfast, unable to transfer, pivot, bear weight or turn self in bed. ❑**Prosthesis**_____ ❑**Amputation**_____ ❑**Podiatric**_____ ❑**1+ Assist** *(Chronically chairfast and/or chronically needs one person assist to transfer – EALR required.)* ❑**Other Assistive Device/s**_____

SECTION 12. My Clinical/Non-Clinical Needs
❑6 Month Review ____/____/____ ❑Annual Review ____/____/____ ❑Change ____/____/____

TASK	LEVEL OF ASSISTANCE
Toileting (Getting to/from and on/off the toilet, cleansing self after elimination and adjusting clothing) ***See also Section 13.*** ❑ ***Checked box indicates changes have been made. Document in case management notes.***	❑**Independent:** Able to toilet independently with or without assistive device. ❑**Intermittent Assistance:** Able to toilet with minimal intermittent assistance and/or supervision. ❑**Continual Assistance:** Able to toilet with constant assistance and/or supervision. ❑**Total Assistance:** Unable to toilet. Requires total assistance with toileting. ❑**Ostomy Care** Frequency: _____By Whom:_____
Bathing (Getting in and out of tub or shower, washing and drying entire body) ❑ ***Checked box indicates changes have been made. Document in case management notes.***	❑**Independent:** Able to bathe or shower independently with or without assistive device. ❑**Intermittent Assistance:** Able to bathe or shower w/minimal intermittent assistance and/or supervision. ❑**Continual Assistance:** Able to bathe or shower with constant assistance and/or supervision. ❑**Total Assistance:** Unable to use shower or tub. Bathed in bed or at bedside.
Dressing (Getting clothes from closets and drawers, dressing and undressing upper/lower body including buttons, snaps, zippers, socks and shoes) ❑ ***Checked box indicates changes have been made. Document in case management notes.***	❑**Independent:** Able to dress and undress independently with or without assistive device. ❑**Intermittent Assistance:** Able to dress and undress with minimal, intermittent assistance and/or supervision. ❑**Continual Assistance:** Requires assistance throughout the dressing and undressing process. ❑**Coordination required.** ❑Upper ❑Lower By Whom:_____ ❑**Total Assistance:** Requires another person to dress and undress upper and lower body.
Grooming (Washing face, hair care, shaving, teeth/denture, nail care, foot care, eyeglasses care) ❑ ***Checked box indicates changes have been made. Document in case management notes.***	❑**Independent:** Able to groom independently with or without assistive device. ❑**Intermittent Assistance**: Requires grooming utensils to be set up and placed within reach. ❑**Continual Assistance:** Requires assistance throughout the grooming process. ❑**Total Assistance:** Depends entirely upon someone else for grooming. Assistance is required with:

Task (Check all that apply)	Frequency	By Whom
❑Hair Care		
❑Shampoo		
❑Shaving		
❑Teeth		
❑Denture		
❑Fingernails		
❑Toenails		
❑Foot Care		

SECTION 12. My Clinical/Non-Clinical Needs ❑6 Month Review ____/_____/_____ ❑Annual Review ____/_____/_____ ❑Change ____/_____/_____		
TASK	**LEVEL OF ASSISTANCE**	
Transportation (Physical and mental ability to safely use a car, taxi, or public transportation [bus, train, subway**]**) ❑ ***Checked box indicates changes have been made. Document in case management notes.***	❑**Independent:** Able to independently drive a regular or adapted car; *OR* uses a regular or handicap accessible public bus, train or subway. ❑**Independent:** But requests facility to drive. ❑**Intermittent Assistance:** Able to ride in a car only when driven by another person; *AND/OR* due to physical, cognitive or mental limitations occasionally requires another person to accompany him/her when using a bus, train or subway. ❑**Continual Assistance:** Able to ride in a car only when driven by another person; *OR* able to use a bus or handicap van, train or subway only when assisted or accompanied by another person. ❑**Total Assistance:** Unable to ride in a car, taxi, bus or van, and requires transportation by ambulance.	**Transportation Assistance Level (TAL)** ❑ TAL 1 – Non-ambulatory ❑ TAL 2 – Wheelchair ❑ TAL 3 - Ambulatory
Laundry (Ability to do own laundry – to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand) ❑ ***Checked box indicates changes have been made. Document in case management notes.***	❑**Independent:** ❑ Able to independently take care of all laundry tasks. ❑Requests facility perform task. ❑**Intermittent Assistance:** Able to do only light laundry, such as minor hand wash or light washer loads. Needs assistance with heavy laundry, such as carrying large loads of laundry. ❑**Continual Assistance:** Due to physical, cognitive or mental limitations, needs continual supervision and assistance to do any laundry. ❑**Total Assistance:** Unable to do any laundry.	
Housekeeping (Ability to safely and effectively perform light housekeeping and heavier cleaning tasks) ❑ ***Checked box indicates changes have been made. Document in case management notes.***	❑**Independent:** ❑ Able to independently take care of all housekeeping tasks. ❑Requests facility perform task. ❑**Intermittent Assistance:** Able to perform only light housekeeping (e.g., dusting, wiping kitchen counters) tasks independently; *AND/OR* able to perform housekeeping tasks with intermittent assistance or supervision from another person. ❑**Continual Assistance:** *Unable* to consistently perform any housekeeping tasks unless assisted by another person throughout the process. ❑**Total Assistance:** Unable to effectively participate in any housekeeping tasks.	

SECTION 12. My Clinical/Non-Clinical Needs
❑6 Month Review ____/____/____ ❑Annual Review ____/____/____ ❑Change ____/____/____

SERVICE	SERVICES TO BE PROVIDED
Shopping (Ability to plan form, select and purchase items in a store and to carry them home or arrange delivery) ❑ ***Checked box indicates changes have been made. Document in case management notes.***	❑ **Independent:** ❑Able to plan for shopping needs and independently perform shopping tasks, including carrying package. ❑Requests facility perform task. ❑**Intermittent Assistance:** Able to do only light shopping and carry small packages, but needs someone to do occasional major shopping. ❑**Continual Assistance:** *Unable* to go shopping alone, but can go with someone to assist; *OR* unable to go shopping but is able to identify items needed, place orders, and arrange for home delivery. ❑ **Total Assistance:** Needs someone to do all shopping and errands.
Ability to use a Telephone (Ability to answer the telephone, dial numbers, and *effectively* use the telephone to communicate) ❑ ***Checked box indicates changes have been made. Document in case management notes.***	❑ **Independent:** Able to dial numbers and answers calls appropriately and as desired. ❑ **Independent:** But requests facility perform task. ❑ **Intermittent Assistance:** Able to use a specially adapted telephone (i.e., large numbers on the dial pad, teletype phone for the deaf) and call essential numbers; able to answer the telephone and carry on a normal conversation but has difficulty with placing calls; able to answer the telephone only some of the time or is able to carry on only a limited conversation. ❑ **Continual Assistance:** Unable to make calls or answer the telephone at all, but can listen if assisted with equipment. ❑ **Total Assistance:** Totally unable to use the telephone. Requires someone else to make calls.
MEDICAL SERVICE	**SERVICES TO BE PROVIDED**
Mental Health ❑ ***Checked box indicates changes have been made. Document in case management notes.***	Diagnosis _____ ❑Treatment Required Frequency: _____ By Whom: _____ ❑Substance Abuse ❑Coordination with substance abuse provider Frequency: _____ By Whom: _____
Rehabilitation ❑ ***Checked box indicates changes have been made. Document in case management notes.***	❑Occupational Therapy Frequency: _____ By Whom: _____ ❑Physical Therapy Frequency: _____ By Whom: _____ ❑Speech Therapy Frequency: _____ By Whom: _____ ❑Other _____ Frequency: _____ By Whom: _____

SECTION 12. My Clinical/Non-Clinical Needs
❑6 Month Review ____/_____/_____ ❑Annual Review ____/_____/_____ ❑Change ____/_____/_____

MEDICAL SERVICE	SERVICES TO BE PROVIDED
Other ❑ ***Checked box indicates changes have been made. Document in case management notes.***	❑Pain Management Frequency: _____ By Whom: _____ ❑Health Prevention Frequency: _____ By Whom: _____ ❑Aide-level Health Related Activities Frequency: _____ By Whom: _____ ❑Lab Test Frequency: _____ By Whom: _____ ❑Pacemaker Frequency: _____ By Whom: _____ ❑Dialysis Frequency: _____ By Whom: _____ ❑Skilled Nursing Treatments and/or Education Frequency: _____ By Whom: _____ ❑Medical Equipment _____ ❑Skin Care Frequency: _____ By Whom: _____ ❑Respiratory Therapy and Oxygen Frequency: _____ By Whom: _____ ❑Other Frequency: _____ By Whom: _____ ❑Other Frequency: _____ By Whom: _____ ❑Other Frequency: _____ By Whom: _____

SECTION 13. CONTINENCE STATUS/MANAGEMENT

❑6 Month Review ____/____/____ ❑Annual Review ____/____/____ ❑Change ____/____/____

I have control over my urination. ❑ Yes ❑ No ***If the answer is 'no', complete this section as appropriate.***		**I have control over my bowels.** ❑ Yes ❑ No ***If the answer is 'no', complete this section as appropriate.***	
Urinary Incontinence		**Bowel Incontinence**	
❑ Several times a week ❑ Daily	❑ Daytime Only ❑ Nighttime Only ❑ Day and Night	❑ Several times a week ❑ Daily	❑ Daytime Only ❑ Nighttime Only ❑ Day and Night
Current Management Techniques		**Current Management Techniques**	
❑ Prompting/reminding defers incontinence ❑ Timed voiding defers incontinence ❑ Uses incontinence pads/adult diapers ❑ Daytime Only ❑ Nighttime Only ❑ Day and Night ❑ Catheter (specify type) _____ Self-manage incontinence? ❑ Yes ❑ No Chronic unmanaged incontinence. ❑ Yes ❑ No *(Chronically unwilling or unable to participate, with help from staff, so that cleanliness and sanitation can be maintained – EARL required.)* ❑*Changes have been made. See Case Management Notes*.		❑ Uses incontinence pads/adult diapers ❑ Daytime Only ❑ Nighttime Only ❑ Day and Night Self-manage incontinence? ❑ Yes ❑ No Chronic unmanaged incontinence. ❑ Yes ❑ No ❑*Changes have been made. See Case Management Notes*.	

SECTION 14. COGNITIVE FUNCTIONING

❑6 Month Review ____/____/____ ❑Annual Review ____/____/____ ❑Change ____/____/____

Current level of alertness, orientation, comprehension, concentration and immediate memory.

Response:

What is today's date? ❑Correct ❑Incorrect

What day of the week is today? ❑Correct ❑Incorrect (correct, if within 2 days)

How old are you? ❑Correct ❑Incorrect

When were you born? ❑Correct ❑Incorrect

Behaviors of Note: (check all that apply)

❑Wanders day/night ❑Sleep Disturbance ❑Confused ❑Depressive Feelings ❑Anxious
❑Withdrawn/Refuses to Socialize ❑Agitated (repeated vocalizations, screaming, shouting, moaning, cursing, etc.)
❑Other (describe)

Overall Cognitive Functioning: (check all that apply)

❑Is alert and oriented, comprehends verbal questions and commands and has accurate recall.
❑Requires prompting and redirection, on occasion, to complete tasks.
❑Has occasional fluctuation in orientation, memory/alertness.
Check One: ❑Short-term memory impairment ❑Long-Term memory impairment
❑Has significant memory loss and is disoriented to person, place and/or time.
❑Specialized Services (Check one)
Check One: ❑Dementia Care, Secured Unit *(requires SNALR)*
❑Environmental Modifications
❑Supervision and monitoring

This screen includes indicators, which are often related to cognitive impairment. This is a screen ONLY and is intended to assist the residence in determining if an individual is appropriate for care in an ALR and/or if the individual should be referred to his/her physician for consultation and/or further evaluation or treatment.

If the resident resides in an ALR, SNALR or EALR, then the ISP Addendum is required. Proceed to Page 19.

SECTION 15. Affirmation/Attestation and Plan Distribution

My Case Manager will contact me routinely to ensure that my goals, preferences, and needs are being met. I may call my Case Manager at any time to initiate changes or discuss the quality of care of the services listed in this Plan.

My signature below affirms that I have been informed of the benefits of receiving supports, as documented in this Plan, and indicates that I understand and agree that:

1. I have been informed that I am eligible to receive services.
2. I may choose to receive the services as designated in this Plan.
3. I have the choice among qualified providers and have been notified of the providers available.
4. I have the right to be free of abuse, neglect and exploitation and to report abuses at any time.
5. I may request to revisit this Plan at any time.

Printed Name	Signature/Date

Individual/Resident

Commitment to Confidentiality and Support
By signing this form:

1. I agree to maintain this Resident's confidentiality.
2. I affirm that I participated in the development of this Service Plan.
3. I affirm that the Resident was given choices in selecting providers.
4. I support the Resident's goals.
5. I understand and approve the content of this Service Plan.
6. I received a copy of this Plan.

Printed Name	Signature/Date
Resident's Representative	
Resident's Legal Representative (if applicable)	
Case Manager	

Plan Distribution *(Check all that apply.)*

❑ Resident ❑ Resident's Representative (if any) ❑ Case Manager ❑ Other (specify)

Plan Cycle *(Check One)*

❑ Initial ❑ 6 months ❑ Annual ❑ Modification* ❑ Change in Condition* ❑ Resident Request*

Indicate change in applicable section, and document all changes in case management notes.

Plan Date _____ MM _____ DD _____ YYYY

Next Plan Review _____ MM _____ DD _____ YYYY

Attach documentation of additional reviews as necessary.

Individualized Service Plan (ISP) Addendum

Was the resident's primary physician consulted?

❑ NO
❑YES _____

Physician's Name Date

_____

Home Care Services Agency Rep. Signature Date

_____

ALR Provider's Representative Signature Date

Documentation of ISP Review: For 6-month ISP reviews, please consider and review any changes in the following areas: Communication/Dental/Vision/Hearing; Customary Routine; Continence Status/Management; Physical Function; Cognitive Impairment Screen; and Admission Decision.

❑ My signature below affirms that I am confirming the services listed in this document, including any changes made since the last review.

❑ I have reviewed the services listed in this document and recommend the following change(s) in service:

_____

Printed Name Signature

_____

Title Date