

RESIDENT APPRAISAL

Residential Care Facilities For The Elderly

NOTE: This information may be obtained from the Prospective Resident, or his/her responsible person. This form is not a substitute for the Physician's Report (LIC 602).

APPLICANT'S NAME

AGE

HEALTH (Describe overall health condition including any dietary limitations)

PHYSICAL DISABILITIES (Describe any physical limitations including vision, hearing or speech)

MENTAL CONDITION (Specify extent of any symptoms of confusion, forgetfulness; participation in social activities (i.e., active or withdrawn))

HEALTH HISTORY (List currently prescribed medications and major illnesses, surgery, accidents; specify whether hospitalized and length of hospitalization in last 5 years)

SOCIAL FACTORS (Describe likes and dislikes, interests and activities)

BED STATUS (An exception must be obtained to admit or retain a resident who will be temporarily bedridden more than 14 days. Permanently bedridden residents are prohibited).

OUT OF BED ALL DAY

IN BED MOST OF THE TIME

COMMENT:

IN BED PART OF THE TIME

IN BED ALL OF THE TIME

TUBERCULOSIS INFORMATION

ANY HISTORY OF TUBERCULOSIS IN APPLICANT'S FAMILY?

YES

NO

DATE OF TB TEST/TYPE OF TEST

POSITIVE

NEGATIVE

ANY RECENT EXPOSURE TO ANYONE WITH TUBERCULOSIS?

YES

NO

ACTION TAKEN (IF POSITIVE)

GIVE DETAILS

AMBULATORY STATUS (this person is ambulatory nonambulatory)

Ambulatory means able to demonstrate the mental and physical ability to leave a building without the assistance of a person or the use of a mechanical device other than a cane. An ambulatory person must be able to do the following:

YES NO

- Able to walk without any physical assistance (e.g., walker, crutches, other person), or able to walk with a cane.
- Mentally and physically able to follow signals and instructions for evacuation.
- Able to use evacuation routes including stairs if necessary.
- Able to evacuate reasonably quickly (e.g., walk directly the route without hesitation).

FUNCTIONAL CAPABILITIES (Check all items below)

YES NO

- Active, requires no personal help of any kind - able to go up and down stairs easily
- Active, but has difficulty climbing or descending stairs
- Uses brace or crutch
- Frail or slow
- Uses walker. If Yes, can get in and out unassisted? Yes No
- Uses wheelchair. If Yes, can get in and out unassisted? Yes No
- Requires grab bars in bathroom
- Other: (Describe)

SERVICES NEEDED (Check items and explain)

YES NO

- Help in transferring in and out of bed/turning in bed or chair (specify) _____
- Help with bathing _____
- Help with dressing, hair care, and personal hygiene (specify) _____
- Does prospective resident desire and is he/she capable of doing own personal laundry and other household tasks? (specify) _____
- Help with moving about the facility _____
- Help with eating (need for adaptive devices or assistance from another person) _____
- Special diet/observation of food intake _____
- Toileting, including assistance equipment, or assistance of another person (specify) _____
- Continence, bowel or bladder control. Are assistive devices such as a catheter required? _____
- Help with medication _____
- Needs special observation/night supervision (due to confusion, forgetfulness, wandering) _____
- Help in managing own cash resources _____
- Help in participating in activity programs _____
- Special medical attention _____
- Assistance in incidental health and medical care _____
- Other "Services Needed" not identified above _____

Is there any additional information which would assist the facility in determining applicant's suitability for admission? Yes No
If Yes, please attach comments on separate sheet.

TO THE BEST OF MY KNOWLEDGE, I/THE ABOVE PERSON DO/DOES NOT NEED SKILLED NURSING CARE.

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| SIGNATURE OF APPLICANT OR RESPONSIBLE PERSON | DATE COMPLETED |
| SIGNATURE OF LICENSEE OR DESIGNATED REPRESENTATIVE | DATE COMPLETED |