**ALR Community – Individual/Family Self-Evaluation**

Please print legibly

**Individual’s Name:**   **Age:**

What is your present living arrangement?

What type of assistance do you currently receive?

Why are you considering a move to an Assisted Living Residence?

How soon would you like to move into an Assisted Living Residence?

**Which areas of assistance would benefit you?**

| **Activity of Daily Living** |  | **Type of Assistance** |
| --- | --- | --- |
| Taking medication  Any meds taken via injection (shots)? | Yes  No  Yes  No |  |
| Preparing meals | Yes  No |  |
| Dressing/Undressing | Yes  No |  |
| Grooming | Yes  No |  |
| Showering/Bathing | Yes  No |  |
| Toileting | Yes  No |  |
| Housekeeping | Yes  No |  |
| Laundry | Yes  No |  |
| Transportation | Yes  No |  |
| Accessing Community | Yes  No |  |
| Community Involvement | Yes  No |  |
| Employment | Yes  No |  |

Individual’s Name: Date of Assessment:

**Physical Health:**

Do you have any significant health concerns?

Do you have diet restrictions?  Yes  No

*If yes, please explain*:

Do you have any difficulty swallowing?  Yes  No

*If yes, please explain*:

**Mobility:**

Do you utilize any of the following:  Cane  Scooter  Walker  Wheelchair

Are you able to walk independently 150 feet?  Yes  No

Are you able to transfer independently?  Yes  No

(e.g., move from bed to standing position or   
from chair to standing position)

Are you able to go up and down stairs independently?  Yes  No

**Cognition/Mental Health:**

How would you describe your memory? (Check one)

**Good** memory for present-day events – no difficulty remembering names, places, or scheduled appointments. Does not become confused in unfamiliar places.

**Fair** memory for present-day events – little help required for remembering names or appointments. May become confused in unfamiliar places.

**Poor** memory for present-day events – require a lot of reminders with names, scheduling and remembering appointments. Almost always confused in unfamiliar places.

**Extremely Poor** memory – does not remember familiar people or names. Others must schedule and supervise appointments. Always confused in unfamiliar places.

**History of Hoarding** – select this box if you have a history of hoarding.

Do you experience depression?  Yes  No

*If yes, is it*:  Mild  Moderate  Severe

Do you experience anxiety?  Yes  No

*If yes, is it*:  Mild  Moderate  Severe

Individual’s Name: Date of Assessment:

Do you take medications for depression or anxiety?  Yes  No

Comments regarding depression or anxiety:

Do you have a history of any of the following?  Suicidal/self-abuse  Substance abuse

*If yes, please explain*:

**General Information:**

Is anyone assisting you with bill paying or managing your finances?  Yes  No

*If yes, please provide name and phone number*: *(If PoA or Conservator, please provide documentation)*

Name: Phone:

Are you receiving any external services such as home care, physical therapy, adult day services, etc.?

Are you currently receiving Medicaid benefits?  Yes  No

*If yes, Case Manager name*:

Case management agency:

Contact information:

Do you currently use tobacco?  Yes  No

Do you currently use marijuana?  Yes  No

Is there any additional information you would like us to know?

Signature of person completing evaluation:

Individual’s Signature: Date: