

# INSTRUCTIONS

## Pre-Admission Assessment

This document is to be completed prior to admission. It is important to obtain as much information as possible. It is possible that you or another staff member will complete this document during an interview with the potential resident. Additional Tools/Assessments may/may not be utilized to obtain the information required of this document.

\*\*When performing assessments, it is good practice to: ask the individual questions, speak with family members, and obtain information from their physician (as appropriate). Additionally, whenever possible, it is ideal to observe the individual performing any tasks related to the assessment questions.

1. Enter the name of the individual and date of assessment in the document's header, starting on page 2.
2. On page 1, enter the date of the assessment.
3. Enter the location at which the assessment took place (e.g., individual's home, skilled nursing facility, Assisted Living Residence, etc.).
4. Enter the individual's legal name.
5. If the individual wants to be called by any other name, document that name.
6. Enter the individual's birth date.
7. Enter the individual's current age.
8. Enter the individual's identified gender.
9. Enter the individual's relationship status (e.g., single, married, domestically partnered, divorced, widowed, etc.).
10. Enter the individual's stated reason for interest in admission to the Assisted Living Residence.

### **Individuals Involved with Pre-Admission Assessment**

1. Enter the name of the ALR staff who primarily completed this assessment.
2. Enter the name of any ALR staff who assisted with this assessment.
3. Enter the name and contact information of the Medical Power of Attorney (if applicable). Indicate if they assisted with the assessment in person or by phone.
4. Enter the name and contact information of the Financial Power of Attorney (if applicable). Indicate if they assisted with the assessment in person or by phone.
5. If the individual has a Representative Payee, enter their name and contact information. Indicate if they assisted with the assessment in person or by phone.
6. Enter the name and contact information of the Single Entry Point (SEP) or Community Center Board (CCB) (if applicable). Note: if the individual is funded (in part or in total)

by Medicaid, it is required that the SEP case manager be involved in the assessment process.

7. Enter the name and contact information of the Mental Health Case Manager (if applicable). Indicate if they assisted with the assessment in person or by phone. Also note if a release of information was obtained, and if so, enter the date of the release.
8. If anyone else assisted with the assessment, enter their name and contact information in the “Other Participants” section. For each, indicate if they assisted in person or by phone.
9. Enter the name and contact information of the Legal Representative (if applicable). Indicate if they assisted with the assessment in person or by phone. Note the length of time that individual has served as Legal Representative. Legal Representatives may include a Guardian (court appointed), a Health Care Proxy or a Conservatorship (court appointed).

### **Individual’s Preferred Support System**

Enter as much information as possible about the individual’s preferred support systems, including: names, phone numbers, email addresses, or any other pertinent information.

### **Single Entry Point (SEP)/Community Center Board (CCB) - (Medicaid Clients only)**

If the individual is receiving Medicaid funding and is, therefore, receiving Home and Community Based Services (HCBS), complete this section.

1. Enter the county in which the individual is receiving SEP or CCB services.
2. Enter the case manager’s name and phone number.
3. If possible, note how long the individual has received HCBS services.

### **Regional Care Collaborative Organization (RCCO)**

A Regional Care Collaborative Organization (RCCO) connects Medicaid clients to Medicaid providers and helps clients find community and social services in their area. RCCOs help providers communicate with Medicaid clients and with each other, so Medicaid clients receive coordinated care. A RCCO will also help Medicaid clients get the right care when they are returning home from the hospital or a nursing facility, by providing the support needed for a quick recovery. Refer to the following link for information about RCCO service areas and contact numbers: [www.colorado.gov/hcpf/regional-care-collaborative-organizations](http://www.colorado.gov/hcpf/regional-care-collaborative-organizations).

If the individual receives Medicaid and is enrolled in a RCCO, enter the name of the RCCO and the RCCO’s phone number.

### **Personal Care (preferences and abilities)**

Enter as much information as possible about the individual’s preferences and abilities related to the Personal Care elements listed.

## **Medical**

1. Enter the name of any current physicians.
2. Note if the Physician/PA/NPA Evaluation was completed and returned (if utilized as part of the assessment process).
3. Enter the date of the individual's last physical.
4. Enter any of the individual's allergies.
5. Enter any reactions due to the above allergies.
6. Enter information related to any auditory impairment.
7. Enter information related to any visual impairment.
8. Document if the individual wears dentures.
9. Document if the individual uses alcohol, tobacco or marijuana in any form.
10. Document if the individual has a seizure disorder.
11. If the individual does have a seizure disorder, indicate if the disorder is or is not controlled by medications
12. Enter the individual's diagnoses. If preferred, attach a print out of diagnoses.
13. Enter any information about the individual's diet. Examples include, but are not limited to: a calorie counted diet, a specific sodium gram diet, a cardiac diet, any specific texture diet (e.g., puree), or a therapeutic diet.
14. Enter the individual's medications and dosages. If preferred, attach a print out of medications.
15. Note if there are recent medication changes.
16. Document if the individual needs injections to receive medication, and note if they are able to do so independently (i.e., ask individual to verbally walk through each step of the administration process or, ideally, observe them administering the medication). Note: if the individual is not able to independently administer injections, this does not preclude admission to the ALR if the community has a nurse on staff to meet the need for injectable medication administration or if the resident is able to obtain skilled home-health care for this purpose.
17. Document if the individual uses oxygen, and document if they are able to manage their oxygen independently.
18. Document any court ordered medications.
19. Document if there is any nighttime incontinence support needed.
20. Document any "Other" information related to medical issues that will assist the ALR to determine if able to meet the needs of the individual.

## **External Services**

External services providers include, but are not limited to, home health, hospice, private pay caregivers and family members.

## **Cognition**

1. Enter any information related to confusion or disorientation. For example, note if the individual experiences any disorientation to place, person or time. Does the individual have any issues with attention span or do they experience any periods of confusion.
2. If there is a current diagnosis for dementia, enter that information.
3. Administer the Saint Louis University Mental Status (SLUMS) Exam. The SLUMS is a brief oral/written exam to determine if the individual may have dementia or Alzheimer's disease.
4. Document if the individual has any history of getting lost, and enter details about when it occurred, what the situation was, how frequently it occurs, or any other relevant information.
5. Document if the individual experiences any confusion between day and night, as this may signal a need for more support during nighttime hours.
6. Document if the individual experiences any Sundowner's Syndrome behavior.
7. Document if the individual is able to follow instructions.
8. Document if the individual is able to communicate their needs, verbally or otherwise.
9. Document if the individual is at risk if they are allowed to directly use personal grooming and/or hygiene items (e.g., shavers, razors, nail clippers, etc.)
10. Document any Safety Risks, such as forgetting to use a walker, not dressing appropriately for the weather, inability to set water temperature, forgetting to turn off stove, putting inappropriate items on stove, etc.
11. If there is any "Other" information related to the individuals cognition, enter it here.

## **Mental Health**

1. Document if there has been any resistance to care or medication administration. Include examples, information about how recent any incidents were, and any successful redirection strategies.
2. Document if there has been any verbal or physically abusive actions towards self or others. Include examples, information about how recent any incidents were, and any successful redirection strategies.
3. Document if the individual spends an unusual amount of time sorting, rummaging or shopping.
4. Document if the individual has hallucinations, delusions or illusions. If so, provide detail sufficient to describe them.
5. Document if the individual has a history of inappropriate sexual actions (e.g., touching others inappropriately). Include information about when any incidents occurred.
6. Document any history of psychiatric hospitalization, including information about date, reason, location, etc.
7. Document the date of the last psychiatric hospitalization, if applicable.
8. Document the date of the last psychiatric evaluation, if applicable.

9. Document any other mental health information.
10. Document if the individual is currently receiving mental health treatment; if so, where that treatment is being received.

### **Substance Use**

1. Document information about the individual's alcohol or drug(s) of choice.
2. Document reported last usage of each drug noted above.
3. Document information about substance use history.
4. Document how long the individual has been sober or clean of drug usage.
5. Document if the individual is currently receiving treatment for substance use.
6. Document if the individual is in a supportive treatment group, and if so, document what kind of support the ALR will need to provide to maintain their participation.

### **Activities/Social**

1. Document what the individual's hobbies or interests are and what assistance will be needed for the individual to engage in those hobbies or interests.
2. Review the Community's activities with the individual and document if they are interested in individual or group activities.
3. Document any information about community activities the individual engages in and what level of support will be needed to maintain that engagement.
4. Document any relationships that are important to the individual and the level of support that will be needed to maintain those relationships.

### **Goals/Expectations**

Document information about the individual's goals and expectations related to living in your Community. This will enable you to determine if your Community can meet those goals and expectations.

### **Employment**

1. Document if the individual is currently employed and, if so, where.
2. If employed, document the level of support that will be needed to maintain that employment.
3. If the individual is not employed, do they have interest in seeking employment? If so, document the level of support they will need to do so.

### **Criminal/Legal History**

1. Document if the individual does or does not have a criminal history.
2. If they have a criminal or legal history, describe.

3. Document if the individual is involved in any current legal activity (e.g., divorce, probation, etc.).
4. Document if there are any current probationary requirements.
5. Document if the individual is or is not a registered sex offender.

### **Other**

If there is any other information relevant to making a decision about admitting the individual to the Community, document it here.

It is the provider's responsibility to gather the appropriate information required to ensure the Community is able to meet the needs of each individual admitted.

### **Signatures**

1. Have the individual sign their name, print their name and date the document.
2. Have the Legal Representative sign their name, print their name and date the document.
3. If the individual receives Medicaid, consider faxing the document to the SEP or CCB case manager for their signature. While this is not required, doing so provides documentation that the case manager was involved in the assessment process, which is a requirement.
4. Have the ALR Community representative sign their name, print their name and date the document.