**ALR Community Pre-Admission Assessment**

Date of assessment:

Location of assessment:

Name:

Preferred name:

Age:

Resident birth date:

Gender (identifies as):

Relationship status:

Reason individual is interested in admission to the ALS community:

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

|  |  |  |
| --- | --- | --- |
| Individual | Name(s) | |
| ALR staff | Name(s) | |
| Medical Power of Attorney | Name, Address and Phone | In person  By phone |
| Financial Power of Attorney | Name, Address and Phone | In person  By phone |
| Representative Payee | Name, Address and Phone | In person  By phone |
| Single Entry Point or Community Center Board Case Manager | Name and Agency, Phone | In person  By phone |
| Mental Health Case Manager | Name and Agency, Phone    Release of information obtained (date): | In person  By phone |

Individual Name: Date of Assessment:

|  |  |  |
| --- | --- | --- |
| Other Participants | Name, Agency, Phone | In person  By phone  In person  By phone  In person  By phone  In person  By phone  In person  By phone |
| Legal Representative:    Length of time as representative: | Type:  Guardian  Health Care Proxy  Conservatorship  Name and Phone: | In person  By phone |

**Individual’s Preferred Support Systems**

|  |  |  |
| --- | --- | --- |
| Significant other: | Phone | Email |
| Family members: | Phone | Email |
| Friends: | Phone | Email |
| Spiritual community: | Phone | Email |
| Other community resources: | Phone | Email |
| Primary physician prior to admission: | Phone    Fax | Email |
| Other (e.g., AA meeting, book clubs, day center, mental health center, Veteran’s Administration, etc.): | Phone | Email |

Individual Name: Date of Assessment:

**Single Entry Point/Community Center Board (Medicaid clients only)**

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| --- |
| County: |
| Case manager name and phone number |
| How long have they received Home and Community Based Services (HCBS)? |

**Regional Care Collaborative Organization (RCCO)**

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| --- |
| Name of RCCO:    Phone: |

**Personal Care (preferences and abilities)**

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| Bathing:    Dressing:    Toileting:    Grooming:    Eating:    Incontinent/continent (i.e., what level of assistance is needed):    Sleep patterns:    Living space (e.g., making bed, putting clothing away, clutter, organizing, etc.):    Laundry:    Cooking:    Money Management:    Ambulation: REFER TO “ALR COMMUNITY - FALL RISK ASSESSMENT” |

Individual Name: Date of Assessment:

**Medical**

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| --- |
| Physician(s):    Physician/PA/NPA Evaluation completed and returned:  YES  NO    Date of last physical:    Allergies (medications, food, pets, latex, etc.):    Reactions due to allergies:    Auditory impairment:    Visual impairment:    Wears dentures:    Use of alcohol/tobacco/marijuana:    Seizure Disorder:    *If yes, is the seizure disorder controlled by medications?*  YES  NO    Diagnoses: (attach if needed)    Diet (e.g., texture, therapeutic, sodium diabetic, etc.):    Medications/dosages (attach if needed):    Recent medication changes:    If the individual requires injectable medication, document if they are able to manage injections independently.    Able to manage own oxygen (if applicable):    Court ordered medications: |

Individual Name: Date of Assessment:

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| --- |
| Overnight continence support:    Other: |

**External Services**

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| (e.g., Meals on Wheels, PT, OT, Home Health, Day Center, services provided by family members, etc.): |

**Cognition**

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| Confusion/disorientation (e.g., disoriented to place, person, time, attention span, periods of confusion, etc.):    Dementia diagnosis (if applicable):    SLUMS test results (refer to SLUMS assessment tool):    History of wandering (explain):    Confusion between day and night:    Sundowner’s Syndrome behavior:    Able to follow instructions:    Able to communicate needs:    Able to use personal hygiene items safely:    Safety risks (e.g., forgets to use walker, not dressing appropriately for weather, etc.):    Other: |

Individual Name: Date of Assessment:

**Mental Health**

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| --- |
| Has there been any resistance to care or medication administration?    *Examples:*  *How recent were these incidents?*    *Redirection strategies:*    Has there been any verbal or physically abusive actions towards self or others?    *Examples:*    *How recent were these incidents?*    *Redirection strategies:*    Does the individual spend an unusual amount of time sorting, rummaging or shopping?    Does the individual have hallucinations (visual/auditory), or delusions?    *If so, describe them:*    Has the individual demonstrated any inappropriate sexual actions?    *How recent were these incidents?*    History of psychiatric hospitalizations (i.e., date, reason, location, etc.):    Date of last psychiatric hospitalization:    Date of last psychiatric evaluation:    Other mental health information:    Currently receiving treatment (if yes, where)? |

Individual Name: Date of Assessment:

**Substance Use**

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| Alcohol/Drug(s) of choice:    *Date of last use:*    Substance use history:    How long has the individual been sober/clean?    Is individual currently receiving treatment?    Supportive Treatment Group:  YES  NO    *If yes, what support will be needed to maintain participation?* |

**Activities/ Social**

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| What are the individual’s hobbies or interests and what assistance is needed to in order to engage in those activities?    Is the individual interested in individual or group activities (review the Community’s group activities with the individual)?    What community activities does the individual engage in, and what support will be needed to maintain those activities (e.g., spiritual community, peer support group, volunteer work, visiting friends/family, library use, shopping, etc.)?    What relationships are important to the individual and what support will be needed to maintain those relationships? |

**Goals/Expectations**

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| What are the individual’s goals and expectations related to living in your Community? |

Individual Name: Date of Assessment:

**Employment**

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| --- |
| Is the individual currently employed? If so, where are they employed?    *If so, what support will be needed to maintain employment?*    *If not, is there interest in seeking employment, and what support will be needed to assist?* |

**Criminal/Legal History**

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| --- |
| Does the individual have a criminal history?:  YES  NO    *If yes, describe:*    Is the individual involved in any current legal activity (e.g., divorce, probation, etc.)?    Are there any parole or probation requirements?    Is the individual a registered sex offender?  YES  NO |

**Other**

|  |
| --- |
| Other information relevant to pre-admission assessment: |

**Use of this document does not constitute nor imply compliance with Federal or State rules and regulations. All facilities must follow their own internal guidelines and policies for admission. All facilities are responsible for gathering the appropriate information required to ensure the facility is able to meet the needs of each individual admitted.**

Signature of Individual Printed Name Date

Signature of Legal Representative Printed Name Date

SEP Case Manager (Medicaid only) Printed Name Date

Signature of ALR Community Representative Printed Name Date