FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RESIDENT HEALTH ASSESSMENT FOR ADULT FAMILY-CARE HOMES (AFCH)

NAME:	D.O.B.	
KNOWN ALLERGIES:	HEIGHT:	WEIGHT:

HEALTH ASSESSMENT

Medical history and diagnoses:
Physical or sensory limitations:
Cognitive or behavioral status:
Nursing/treatment/therapy service requirements:
Special precautions:

A To what extent does the individual need supervision or assistance with the following? Please check appropriate areas below. ↓

AMBULATION:
__Independent
__Needs Supervision
__Needs Assistance
__Needs Total Help

BATHING:
__Independent
__Needs Supervision
__Needs Assistance
__Needs Total Help

DRESSING:
__Independent
__Needs Supervision
__Needs Assistance
__Needs Total Help

TOILETING:
__Independent
__Needs Supervision
__Needs Assistance
__Incontinence
__Catheter Care
__Ostomy Assistance

EATING:
__Independent
__Needs Supervision
__Needs Assistance
__Tube Feeding

GROOMING:
__Independent
__Needs Supervision
__Needs Assistance
__Needs Total Help

TRANSFERRING:
__Independent
__Needs Supervision
__Needs Assistance
__Needs Total Help

Comments (Use additional page if necessary): _____

B To what extent is the individual able to perform other self-care tasks such as preparing meals, shopping, or making phone calls? Please check the appropriate box below. ↓

☐ Independent ☐ Needs Supervision ☐ Needs Assistance ☐ Needs Total Assistance

Comments (Use additional page if necessary): _____

C To what extent does the individual need general oversight such as observing the individual's well-being and whereabouts and reminding the individual of important tasks? Please check the appropriate box below. ↓

☐ Independent ☐ Weekly Oversight ☐ Daily Oversight ☐ Other: Please describe below.

Comments (Use additional page if necessary): _____

D **Does the individual require special diet instructions? Please check the appropriate box below. ↓**

☐ Regular ☐ Diabetic Diet ☐ No Added Salt ☐ Low Fat ☐ Low Cholesterol ☐ Other: Please describe below:

E **Please list all current medications prescribed below (additional pages may be attached). ↓**

	MEDICATION	DOSAGE	DIRECTIONS FOR USE	ROUTE
1.				
2.				
3.				
4.				
5.				
6.				

Does the individual need help with medications? _____YES_____NO. If yes, please describe:

F **Does the individual have any of the following conditions or requirements? Please check appropriate boxes below. ↓**

	YES	NO	COMMENTS
A communicable disease which could be transmitted to other residents or staff?			
Bedridden?			
Any stage 2, 3, or 4 pressure sores?			
Pose a danger to self or others?			
Require 24-hour nursing care?			
Require 24-hour psychiatric supervision?			

G **In your professional opinion, can this individual's needs be met in a residential facility (Adult Family Care Home) that is not a medical, nursing or psychiatric facility? _____YES_____NO Comments (Use additional page if necessary):**

H **In your professional opinion, based on this individual's medical profile, can this individual be left without supervision at the adult family care home for up to two hours per twenty-four (24) hour period without compromising his or her health, safety, security or well-being? _____YES_____NO Comments (Use additional page if necessary):**

NAME OF EXAMINER (Please Print): _____

SIGNATURE OF EXAMINER: _____

MEDICAL LICENSE #: _____

ADDRESS OF EXAMINER: _____

TELEPHONE #: _____

TITLE OF EXAMINER (Please check the appropriate box: ☐ MD ☐ DO ☐ ARNP ☐ PA

DATE OF EXAMINATION: _____

PLEASE RETURN THE COMPLETED FORM TO: ↓

AFCH PROVIDER NAME:	ADDRESS:	TELEPHONE #:	CONTACT PERSON: