ASSISTED LIVING RESIDENCE LICENSING
RESIDENT ASSESSMENT FORM
55 Pa.Code § 2800.22(a)(2), 2800.224(a), 2800.225

(To be completed within 30 days prior to admission or within 15 days after admission if certain conditions apply, annually and if significant change in resident needs)

Type of Assessment: ☐ Initial Admission ☐ Annual ☐ Significant Change

Date of Assessment: ______________ Date of Admission __________________

RESIDENT INFORMATION		
Name (First, MI, Last)		Date of Birth (mm/dd/yyyy)
Sex ☐ Male ☐ Female	Marital Status ☐Single ☐Married ☐Divorced/Separated ☐ Widow(er)	Rm/Apt. #
Is Able to Safely Operate Key-Locking Devices ☐ Yes ☐No	Is a Veteran ☐ Yes ☐No	
Is Able to Safely Use Poisonous Personal Care and Toiletry Items ☐ Yes ☐No		
Is Able to Safely Use Other Poisons (such as cleaning supplies) ☐ Yes ☐No		

HEALTH PROBLEMS (Check All That Currently Apply)			
Anemia	☐	Hearing impairment (H.O.H., deafness)	☐
Arthritis and other joint limitations or injuries	☐	Heart trouble (angina, CHF, MI)	☐
Bowel/bladder problems	☐	Hypertension	☐
Brain Injury (stroke, CVA, TIA, memory loss)	☐	Mental Illness	☐
Cancer, Leukemia or tumor	☐	Respiratory problems (asthma, emphysema, COPD)	☐
Dementia (OBS, Alzheimer's, Huntington's, Pick's)	☐	Skin Problems (decubitus ulcer, lesions, rashes)	☐
Developmental Disorder	☐	Surgery with residual effects (drainage, amputation, paralysis, pain, fatigue)	☐
Diabetes	☐	Tremors (Parkinson's)	☐
Digestive disorders (ulcers, diverticulosis)	☐	Visual impairments (cataracts, glaucoma, blindness)	☐
Edema	☐	Other (please list):	☐
Effects of stroke (CVA, TIA, memory loss)	☐		
Effects of osteoporosis or fractures	☐		
Hardening of arteries (ASHD, poor circulation)	☐		

EXCLUDABLE CONDITIONS (Check All That Currently Apply)

A residence may not admit, retain or serve an individual with any of the below excludable conditions. The residence may submit a written request to the Department for an exception related to any of the identified conditions or health care needs to allow the residence to admit, retain or serve an individual with one of those conditions or health care needs.

		Exception request submitted and **approved** by the Department?	Exception request submitted; pending Department approval
Ventilator dependency	☐	☐ Yes ☐ No	☐
Stage III and IV decubiti or vascular ulcers – not in a healing stage	☐	☐ Yes ☐ No	☐
Continuous intravenous fluids	☐	☐ Yes ☐ No	☐
Reportable infectious disease, such as TB, requiring isolation and/or special precautions	☐	☐ Yes ☐ No	☐
Nasogastric tubes	☐	☐ Yes ☐ No	☐
Physical restraints	☐	☐ Yes ☐ No	☐
Continuous skilled nursing care 24 hours a day	☐	☐ Yes ☐ No	☐

The following Excludable Conditions do not require an exceptions request if the individual is capable of self-administration/ self-care or administered by a licensed health professional/other qualified individual: (check all that apply)		Capable of self-administration/ care or administered by licensed health profession/other qualified individual	If no, was exception request submitted and **approved** by the Department?	Exception request submitted; pending Department approval
Gastric tubes	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐
Tracheostomy	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐
Sliding scale insulin administration	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐
Intermittent intravenous therapy	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐
Insertions, sterile irrigation and replacement of a catheter	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐
Oxygen	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐
Inhalation therapy	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐
Skilled nursing care 24 hours a day provided on a temporary or intermittent basis	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐

MEDICATIONS (List All Current Medications at Time of Assessment)				
Prescription Medications	**Dosage**	**Frequency**	**Physician/Pharmacy**	**Reason for Medication/Comments**

Non-prescription/OTC Medications	**Dosage**	**Frequency**	**Reason for Medication/Comments**

MEDICATION ADMINISTRATION
☐Can self-administer medications with no assistance from others
☐Can self-administer medications with assistance to store medications in a secure place
☐Can self-administer medications with assistance in remembering schedule
☐Can self-administer medications with assistance in offering medications at prescribed times
☐Can self-administer medications with assistance opening container or locked storage area
OR
☐Cannot self-administer medications

MOBILITY					
	Independent with or without assistive devices	**Requires prompting or cueing to complete**	**Requires physical assistance to complete**	**Requires full physical assistance**	**N/A**
Ambulatory					
Transfer To/From Bed					
Transfer To/From Chair					
Transfer To/From Wheelchair					
Turning and Positioning in Bed/Chair					

Mobility Aids
☐ None ☐ Wheelchair ☐ Walker ☐ Cane ☐ Braces/Prostheses ☐ Other (specify) _______________

EMERGENCY EVACUATION - Mobility Needs: In the event of an emergency, how much assistance does the applicant require to vacate the building? (Check All Applicable)
☐Unable to move from one location to another without physical assistance from others
☐Unable to move from one location to another without oral prompting from others
☐Difficulty understanding and following oral directions in the event of an emergency
☐Independently mobile with ambulation device
☐Walks without assistance

RESIDENT NEED FOR ASSISTANCE					
	Independent with or without assistive devices	**Requires prompting or cueing to complete**	**Requires physical assistance to complete**	**Requires full physical assistance**	**N/A**
PERSONAL CARE – Grooming/Bathing					
Bathing					
Dental/Mouth Care					
Hair Care					
Shaving					
Toe/Fingernail Care					
PERSONAL CARE - Toileting					
Bladder Control					
Bowel Control					
Special Equipment Required List:					
Catheter/Ostomy					
PERSONAL CARE – Dressing/Undressing					

Undergarments					
Shirts/Blouses/Sweaters					
Pants					
Shoes					
Other (specify)					

	Independent with or without assistive devices	**Requires prompting or cueing to complete**	**Requires physical assistance to complete**	**Requires full physical assistance**	**N/A**
DIETARY					
Eating					
Drinking					
Chewing/Swallowing					
Meal Preparation					
Recent Weight Loss/Gain	☐ Yes ☐ No				
Uses Feeding Tubes/Devices Calculated Diet Prescribed	☐ Yes ☐ No				
Special Diet Followed	☐ Yes ☐ No				
Special Dietary Needs: (specify)					
HEALTHCARE					
Securing Healthcare Services					
Managing Healthcare Needs					
HOUSEKEEPING					
Cleans Bedroom, Bathroom, Kitchen					
Personal Laundry					
Make/Change Bed Linens					
Empty Own Trash					
MISCELLANEOUS					
Shopping					
Securing and Using Transportation					
Managing Finances					
Using the Telephone					
Making and Keeping Appointments					
Caring for Personal Possessions					
Writing Correspondence					
Engaging in Social and Leisure Activities					
Using a Prosthetic Device					
Obtaining Clean, Seasonal Clothing					
Other (specify)					
Other (specify)					

COMMUNICATION

Ability to Hear

☐No impairment
☐Impairment evident but not does not interfere with everyday functioning
☐Impairment interferes with everyday functioning
☐Minimal hearing even with device
☐No hearing even with device
☐Hears with device: Device ________________________

Ability to See
☐No impairment
☐Impairment evident but does not interfere with everyday functioning
☐Impairment interferes with everyday functioning
☐Minimal vision even with device
☐No vision even with device
☐Sees with device: Device ________________________

Understanding Instructions
☐No impairment
☐Impairment evident but not does not interfere with everyday functioning
☐Impairment interferes with everyday communication or is significant enough to require the use of an alternative mode of communication - Alternative mode (specify): __________________________
☐Minimal communication ability with or without the use of an alternative mode of communication
☐No communication ability

Ability to Communicate Needs and Articulate Thoughts
☐No impairment
☐Impairment evident but not does not interfere with everyday functioning
☐Impairment interferes with everyday communication or is significant enough to require the use of an alternative mode of communication - Alternative mode (specify): __________________________
☐Minimal communication ability with or without the use of an alternative mode of communication
☐No communication ability

BEHAVIORAL/COGNITIVE CONDITION

	No Problem	Current problem but does not interfere with every day functioning	Problem interferes with every day functioning	Severe problem that requires intervention
Orientation to Date, Day, and Place				
Memory				
Irritability				
Judgment				
Aggression				
Anxiety				
Depression				
Wandering				
Sociability				
Socially Inappropriate/Disruptive Behavior				
Hallucinations/Delusions/ Paranoia				

RESIDENT PREFERENCES

Leisure Activities and Interests

List all hobbies, interests or leisure activities the resident enjoys:

Does the resident need or use any type of adaptive equipment to participate in hobbies, interests or leisure activities of choice? (specify)
Religious
Resident's religious affiliation, if any:
Does the resident wish to participate in religious practices or services? ☐ Yes ☐ No
Socialization
Does the resident like to go out and do things with other people? ☐ Yes ☐ No
Does the resident belong to or participate in any clubs or organizations? ☐ Yes ☐ No If yes, list:
Pets (If permitted by the facility)
Does the resident have a pet that will reside in the facility/resident's living unit? ☐ Yes ☐ No If yes, type of pet:
Does the pet have a current certificate of rabies vaccination from a licensed veterinarian? ☐ Yes ☐ No
Firearms and Weapons (If permitted by the facility)
Does the resident own firearms, weapons or ammunition that will be stored in a locked cabinet/area of the facility? ☐ Yes ☐ No
Has the resident been made aware and understands the facility's policy regarding the safety, access and use of firearms, weapons and ammunition? ☐ Yes ☐ No
Personal Vehicle/Transportation (If permitted by the facility)
Resident has personal vehicle and can drive self ☐ Yes ☐ No
Resident has a valid driver's license. ☐ Yes ☐ No

FORMAL SUPPORTS			
List all physicians/clinics and other health providers. Provide contact information. State the condition for which the health provider is being seen.			
Doctor/Clinic Name	Address	Phone Number	Condition

INFORMAL SUPPORTS

List Family and Friends. Provide contact information

Name	Address	Phone Number	Relationship

DOCUMENTATION OF PARTICIPATION

Who assisted in completing the assessment (check all that are applicable):

☐ Resident

☐ Resident's family member	Name
	Address:
	Telephone:
	Signature:
	Relationship to resident:
☐ Resident's designated person	Name
	Address:
	Telephone:
	Signature:
	Relationship to resident:
☐ Other	Name

	Address:
	Telephone:
	Signature:
	Relationship to resident:
☐ Other	Name
	Address:
	Telephone:
	Signature:
	Relationship to resident:
☐ Residence	Name
	Title
	Signature
☐ Residence	Name
	Title
	Signature

CERTIFICATION	
Certification shall be made, prior to admission, that the needs of the potential resident can be met by the services provided by the residence. The certification shall be made by the administrator of the residence acting in consultation with the supplemental health care providers; the individual's physician or certified registered nurse practitioner; or the medical director of the residence.	
☐ Yes	Resident meets the criteria for admission to the assisted living residence.
☐ Yes	The assisted living residence certifies that the potential resident's needs can be met by the services provided by the assisted living residence
☐ No	The assisted living residence cannot meet the needs of the potential resident. (A written decision, including the basis for denial of admission, shall be provided to the potential resident or his/her designated person)

Signature:	Title:	Date: (mm/dd/yyyy)