

## RESIDENT APPRAISAL

### Residential Care Facilities For The Elderly

**NOTE:** This information may be obtained from the Prospective Resident, or his/her responsible person. This form is not a substitute for the Physician's Report (LIC 602).

APPLICANT'S NAME

AGE

**HEALTH** (Describe overall health condition including any dietary limitations)

**PHYSICAL DISABILITIES** (Describe any physical limitations including vision, hearing or speech)

**MENTAL CONDITION** (Specify extent of any symptoms of confusion, forgetfulness; participation in social activities (i.e., active or withdrawn))

**HEALTH HISTORY** (List currently prescribed medications and major illnesses, surgery, accidents; specify whether hospitalized and length of hospitalization in last 5 years)

**SOCIAL FACTORS** (Describe likes and dislikes, interests and activities)

**BED STATUS** (An exception must be obtained to admit or retain a resident who will be temporarily bedridden more than 14 days. Permanently bedridden residents are prohibited).

- |  |  |
|--|--|
| <input type="checkbox"/> OUT OF BED ALL DAY      | <input type="checkbox"/> IN BED MOST OF THE TIME |
| <input type="checkbox"/> IN BED PART OF THE TIME | <input type="checkbox"/> IN BED ALL OF THE TIME  |

COMMENT:

#### TUBERCULOSIS INFORMATION

ANY HISTORY OF TUBERCULOSIS IN APPLICANT'S FAMILY?

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|------------------------------|-----------------------------|

DATE OF TB TEST/TYPE OF TEST

- |                                   |
|-----------------------------------|
| <input type="checkbox"/> POSITIVE |
| <input type="checkbox"/> NEGATIVE |

ANY RECENT EXPOSURE TO ANYONE WITH TUBERCULOSIS?

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|------------------------------|-----------------------------|

ACTION TAKEN (IF POSITIVE)

GIVE DETAILS

**AMBULATORY STATUS** (this person is  ambulatory  nonambulatory)

Ambulatory means able to demonstrate the mental and physical ability to leave a building without the assistance of a person or the use of a mechanical device other than a cane. An ambulatory person must be able to do the following:

- | YES                      | NO                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Able to walk without any physical assistance (e.g., walker, crutches, other person), or able to walk with a cane. |
| <input type="checkbox"/> | <input type="checkbox"/> | Mentally and physically able to follow signals and instructions for evacuation.                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Able to use evacuation routes including stairs if necessary.  |
| <input type="checkbox"/> | <input type="checkbox"/> | Able to evacuate reasonably quickly (e.g., walk directly the route without hesitation).                           |

**FUNCTIONAL CAPABILITIES** (Check all items below)

- | YES                      | NO                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Active, requires no personal help of any kind - able to go up and down stairs easily                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Active, but has difficulty climbing or descending stairs   |
| <input type="checkbox"/> | <input type="checkbox"/> | Uses brace or crutch   |
| <input type="checkbox"/> | <input type="checkbox"/> | Frail or slow  |
| <input type="checkbox"/> | <input type="checkbox"/> | Uses walker. If Yes, can get in and out unassisted? <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| <input type="checkbox"/> | <input type="checkbox"/> | Uses wheelchair. If Yes, can get in and out unassisted? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | <input type="checkbox"/> | Requires grab bars in bathroom   |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: (Describe) _____  |

**SERVICES NEEDED** (Check items and explain)

- | YES                      | NO                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Help in transferring in and out of bed/turning in bed or chair (specify) _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Help with bathing _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Help with dressing, hair care, and personal hygiene (specify) _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Does prospective resident desire and is he/she capable of doing own personal laundry and other household tasks? (specify) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Help with moving about the facility _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Help with eating (need for adaptive devices or assistance from another person) _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Special diet/observation of food intake _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Toileting, including assistance equipment, or assistance of another person (specify) _____                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Continence, bowel or bladder control. Are assistive devices such as a catheter required? _____                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Help with medication _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Needs special observation/night supervision (due to confusion, forgetfulness, wandering) _____                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Help in managing own cash resources _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Help in participating in activity programs _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Special medical attention _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Assistance in incidental health and medical care _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Other "Services Needed" not identified above _____  |

Is there any additional information which would assist the facility in determining applicant's suitability for admission?  Yes  No  
If Yes, please attach comments on separate sheet.

**TO THE BEST OF MY KNOWLEDGE, I/THE ABOVE PERSON DO/DOES NOT NEED SKILLED NURSING CARE.**

SIGNATURE OF APPLICANT OR RESPONSIBLE PERSON

DATE COMPLETED

SIGNATURE OF LICENSEE OR DESIGNATED REPRESENTATIVE

DATE COMPLETED