ASSISTED LIVING PLAN

(Must be completed within 30 days of admission of Resident)

Resident Information

First Name
Last Name
Date of Birth

Date of this Plan

Assisted Living Home Information

Address

Facility Contact
Facility Phone

Resident Contacts

Care Coordinator/Case Manager/Program Specialist

Name
Agency
Address
Telephone
Alt Telephone

Legal Representative

Name
Agency
Address
Telephone Type
Alt Telephone

Resident's Emergency Contact

Name
Agency
Address
Telephone
Alt Telephone

OTHER FORMS MAY BE USED THAT MEET STATUTORY REQUIREMENTS

Section 1: Resident Strengths/Limitations/Conditions/Diagnosis

Primary Diagnosis

Secondary Diagnosis

Hospice/DNR/Comfort One

Wound Care

Physical Disabilities and Impairments that are Relevant to the Resident's Service Needs

Resident's Strengths/Abilities and Limitations in Performing the Activities of Daily Living

Section 2: Resident Preferences

Include information about the resident's preferences

Roommates

Living environment

Food (Likes/dislikes/preferences)

Recreational activities

Religious affiliation

Relationships/visitation with friends, family members, and other

OTHER FORMS MAY BE USED THAT MEET STATUTORY REQUIREMENTS

Section 3: Service Needs

Activities of Daily Living

Activity/Plan for Care	Frequency of Care/Assistance	Expected Outcome
Dressing		
Eating		
Walking/Ambulation/Transfers		
Toileting		
Hygiene/Bathing		

OTHER FORMS MAY BE USED THAT MEET STATUTORY REQUIREMENTS

Medication and Health Services

Applicant requires the following assistance with medication, (check all that apply):

No Assistance

Reminder to take

Reading Label

Opening Bottle

Observing the Self Administration of Medication

Directing or guiding the hand of the resident as the self-administer medication

Administration of Medication

Facility Stores Medication

Resident Stores Medication in Room

If administration of medication is required describe the task:

If administration of medication is provided by staff attach special instructions, resident/representative permission, and delegation

Other Health services provided by the Home (i.e. wound care, limited nursing tasks, etc)

Health Service	How it will be met

If the health service requires a nurses delegation please attach

OTHER FORMS MAY BE USED THAT MEET STATUTORY REQUIREMENTS

Instrumental Activities of Daily Living

Activity/Plan for Care	**Frequency of Care/Assistance**	**Expected Outcome**
Laundry		
Cleaning		
Food/Meals (include diet restrictions/needs)		
In Home Supervision (bed checks, turning schedule, type/frequency of monitoring)		
Wandering or Elopement Risk/Interventions		

Mental/Emotion Health Summary

Behavioral Health Interventions

Use of Restraints (includes bedrails, self-releasing safety belts, lap-top trays, wedge cushions, concave mattress).

Type	Frequency	Use	Safety

If restraints are used attach Physician's recommendations/orders

OTHER FORMS MAY BE USED THAT MEET STATUTORY REQUIREMENTS

Training for Independent Living

Legal Situation

Financial Assistance/Residential Money Management Agreement

If the home is assisting the resident with managing money attach the residential money management agreement.

Transport/Escort Services

Day Care or Day Activities

Ability to Navigate Community Independently

Other Personal Assistance Needs

Risk Assessment

The Resident (or the resident's guardian/representative) and the Home have identified the following risks associated with specific interventions identified in this plan, have evaluated such risks, and have agreed to this plan recognizing these risks.

I have participated in the planning of my own care; and have read, or had read to me, in a language that I can understand the foregoing plan of care; and agree with my plan of care.

Resident or Resident's Representative	Date
Care Coordinator/Case Manager/ Program Coordinator	Date
Service Providers (as appropriate)	Date
Assisted Living Home Representative	Date
Licensed Nurse (If Health Services Provided)	Date

ATTACHMENTS (check all that apply)

Physician's statement

Separate Nurse Review of Health Services

List of Residents Current Medication

DNR/Comfort One/Advanced Health Care Directives

Medication Administrator Permission and Delegations

Other Delegations for Health Services

Physician's Orders/Recommendations for Restraints

Residential Money Management Agreement

Medicaid Waiver Plan of Care

General Relief Records

Other (Please List)

QUARTERLY EVALUATIONs OF ASSISTED LIVING PLAN

(If Health Related Services are provided, an evaluation is required every three months)
(Any changes should be update in the plan and the resident/representative notified)

Date of Review	Summary of Changes	Administrators Signatures	Resident/representatives Signature*

*NOTE: Signature signifies that a copy of any revisions, if any, have been received and a copy is attached to this plan.

OTHER FORMS MAY BE USED THAT MEET STATUTORY REQUIREMENTS