

# ASSISTED LIVING PLAN

## WITH HEALTH RELATED SERVICES PROVIDED

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

Health Related Services may include supervision of self-administration of medications; providing intermittent nursing services; arranging for or providing skilled nursing care; providing or arranging for 24 hour a day skilled nursing; and providing care for terminally ill patient, with restrictions see AS 47.33.020 for details

### Resident Information

Name \_\_\_\_\_

Social Security # \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

DATE OF THIS PLAN \_\_\_\_\_

CARE COORDINATOR/CASE MANAGER/PROGRAM SPECIALIST \_\_\_\_\_

ADDRESS, \_\_\_\_\_

AGENCY AFFILIATION, (if any) \_\_\_\_\_

TELEPHONE # \_\_\_\_\_

### Assisted Living Home Information

Address \_\_\_\_\_

Phone # ( ) \_\_\_\_\_

Contact Person \_\_\_\_\_

### **ANY PHYSICAL DISABILITIES AND IMPAIRMENTS THAT ARE RELEVANT TO THE SERVICES NEEDED BY THE RESIDENT**

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### **RESIDENT'S STRENGTHS/ABILITIES AND LIMITATIONS IN PERFORMING THE ACTIVITIES OF DAILY LIVING**

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### **RESIDENT'S PREFERENCE WANTED IN THE FOLLOWING AREAS:**

a. roommates \_\_\_\_\_

b. living environment \_\_\_\_\_

c. food \_\_\_\_\_

d. recreational activities \_\_\_\_\_

e. religious affiliation \_\_\_\_\_

f. relationships/visitation with friends, family members, and other \_\_\_\_\_

**Assessment Areas**                      **Service Needs**                      **Interventions**                      **Provider**                      **Date**

1. Activities of Daily Living

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2. Training for Independent Living

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3. Personal Assistance

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4. Health services

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5. Health (mental/emotional)

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**Assessment**                      **Service**                      **Interventions**                      **Provider**                      **Date**

**Areas**

**Needs**

6. Legal Situation

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7. Financial situation (income)

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8. Transport-

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9. Day Care or Day Activities

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<u>Assessment Areas</u>	<u>Service Needs</u>	<u>Interventions</u>	<u>Provider</u>	<u>Date</u>
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10. Plan for Community Activities				

11. Other				

**Risks**

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. \_\_\_\_\_

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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	_____ Date

**ATTACHMENT**

Physician's statement about the resident

**EVALUATION OF ASSISTED LIVING PLAN**

(If Health Related Services are provided, an evaluation is required every three months)

<b><u>Date Review Required</u></b>	<b><u>Date Completed</u></b>	<b><u>Signature of Administrator</u></b>	<b><u>*Signature of Resident or representative</u></b>
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_____	_____	_____	_____
_____	_____	_____	_____

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