

ASSISTED LIVING PLAN

WITHOUT HEALTH RELATED SERVICES PROVIDED

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

Resident Information

Name _____

Social Security # ____/____/____

Date of Birth ____/____/____

DATE OF THIS PLAN _____

CARE COORDINATOR/CASE MANAGER/PROGRAM SPECIALIST _____

ADDRESS, _____

AGENCY AFFILIATION, (if any) _____

TELEPHONE # _____

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

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

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

2. Training for Independent Living

3. Personal Assistance

4. Health services

5. Health (mental/emotional)

Assessment Areas

Service Needs

Interventions

Provider

Date

6. Legal Situation

7. Financial Situation (income)

8. Transport-

9. Day Care or Day Activities

Blank table with 5 columns: Assessment Areas, Service Needs, Interventions, Provider, Date. Rows are grouped by Assessment Area: 6. Legal Situation (5 rows), 7. Financial Situation (income) (5 rows), 8. Transport- (5 rows), 9. Day Care or Day Activities (5 rows). A large 'SAMPLE' watermark is overlaid diagonally across the table.

<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. _____

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

EVALUATION OF ASSISTED LIVING PLAN

(Must be done at least annually; however;
if Health Related Services are provided,
the evaluation is required every three months (Use ALH Form 5B))

Date Review Required	Date Completed	Signature of Administrator	*Signature of Resident or representative
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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.