FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RESIDENT HEALTH ASSESSMENT for ASSISTED LIVING FACILITIES

❖ This form must be completed annually for residents receiving assistive care services in order to comply with Medicaid

TO BE COMPLETED BY FACILITY:

Resident's Name _____ **DOB:** _____

INSTRUCTIONS TO LICENSED HEALTH CARE PROVIDERS: *AFTER COMPLETION OF ALL ITEMS IN SECTIONS 1 AND 2 OF THIS FORM (pages 1 through 4), PLEASE RETURN TO:*

FACILITY NAME: EMMANUEL CARE ALF INC,

FACILITY ADDRESS: 3628 DAISY AVE., PALM BEACH GARDENS, FL. 33410

TELEPHONE NUMBER: 561-627-3674 CONTACT PERSON: LEITHA SANDERS

SECTION 1: HEALTH ASSESSMENT (*MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.*)

Known Allergies:	**Height:** **Weight:**
Medical history and diagnoses: ,	
Physical or sensory limitations:	
Cognitive or behavioral status:	
Nursing/treatment/therapy service requirements: .	
Special precautions: **Elopement Risk:** **Yes** ☐ **No** ☐	

AHCA Recommended Form 1823
9/2013

TO BE COMPLETED BY FACILITY:

Resident's Name _____DOB: _____

SECTION 1: HEALTH ASSESSMENT (*MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.*)

A. To what extent does the individual need supervision or assistance with the following?

Key	I = Independent	S = Needs Supervision	A = Needs Assistance	T = Total Care

Indicate by a checkmark (✓) in the appropriate column below the extent to which the individuals is able to perform each of the activities of daily living. If "needs supervision" or "needs assistance" is indicated, please explain the extent and type of supervision or assistance needed in the comments column.*

ACTIVITIES OF DAILY LIVING	I	S*	A*	T	COMMENTS*
Ambulation					
Bathing					
Dressing					
Eating					
Self Care (grooming)					
Toileting					
Transferring					

B. Special Diet Instructions

__Regular Calorie Controlled No Added Salt Low Fat/Low Cholesterol

__Other, please describe: _____

C. Does the individual have any of the following conditions/requirements? If yes, please include an explanation in the comments column.

STATUS	YES/N0 (Y/N)	COMMENTS
1. A communicable disease, which could be transmitted to other residents or staff?		
2. Bedridden?		
3. Any stage 2, 3, or 4 pressure sores?		
4. Pose a danger to self or others?		
5. Require 24-hour nursing or psychiatric care?		

D. In your professional opinion, can this individual's needs be met in an assisted living facility, which is not a medical, nursing or psychiatric facility? Yes___No ___

Comments (Use additional page if necessary):

_____

TO BE COMPLETED BY FACILITY:
Resident's Name _____ DOB: _____

SECTION 2-A: SELF-CARE AND GENERAL OVERSIGHT ASSESSMENT (*MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.*)

A. ABILITY TO PERFORM SELF-CARE TASKS:

Indicate by a checkmark (✓) in the appropriate column below the extent to which the individuals is able to perform each of the listed self-care tasks. If "needs supervision" or "needs assistance" is indicated, pleaseexplain the extent and type of supervision or assistance necessary in the comments column.*

KEY:	I = Independent	S = Needs Supervision	A = Needs Assistance

TASKS	I	S*	A*	COMMENTS*
Preparing Meals				
Shopping				
Making Phone Calls				.
Handling Personal Affairs				
Handling Financial Affairs				
Other				

B. GENERAL OVERSIGHT:

Indicate by a checkmark (✓) in the appropriate column below the extent to which the individual needs general oversight. If other, please explain in the comments column*.

KEY	I = Independent	W = Weekly	D = Daily	O* = Other

TASKS	I	W	D	O*	COMMENTS*
Observing Wellbeing					
Observing Whereabouts					
Reminders for Important Tasks					
Other					
Other					
Other					
Other					

C. ADDITIONAL COMMENTS/OBSERVATIONS (Use additional page if necessary): _____

.

TO BE COMPLETED BY FACILITY:
Resident's Name _____ DOB: _____

SECTION 2-B: SELF-CARE AND GENERAL OVERSIGHT ASSESSMENT—MEDICATIONS (*MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.*)

A. Please list all current medications prescribed below (additional pages may be attached):

	MEDICATION	DOSAGE	DIRECTIONS FOR USE	ROUTE
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.			PRN	

B. Does the individual need help with taking his or her medications (meds)? Yes___ No_____. If yes, please place a checkmark (✓) in front of the appropriate box below:

✓	**Needs Assistance with Self-Administration of Medications** ❖ This allows unlicensed staff to assist with orals and topical medication.		**Needs Medication Administration** ❖ Not all ALFs have licensed staff to provide this service.
	Able to Administer w/o Assistance		

C. ADDITIONAL COMMENTS/OBSERVATIONS (Use additional page if necessary): _____

_____

_____

NOTE: MEDICAL CERTIFICATION IS INCOMPLETE WITHOUT THE FOLLOWING INFORMATION:

NAME OF EXAMINER (Please Print): _____

SIGNATURE OF EXAMINER: _____

MEDICAL LICENSE #: _____

ADDRESS OF EXAMINER: _____

TELEPHONE #: _____

TITLE OF EXAMINER (Please check the appropriate box): | | MD | | DO | | ARNP | | PA |

DATE OF EXAMINATION: _____

TO BE COMPLETED BY FACILITY:
Resident's Name_____DOB: _____

SECTION 3: SERVICES OFFERED OR ARRANGED BY THE FACILITY FOR THE RESIDENT (*MUST BE COMPLETED BY THE ALF ADMINISTRATOR OR DESIGNEE.*)

Note: This section must be completed for all residents based on needs identified in Sections 1 and 2 of this form, or electronic documentation, which at a minimum includes the elements below. The facility may attach the resident's service plan, care plan, or community living support plan to this document to satisfy this requirement provided the documentation captures the information listed below.

#	(Column 1) Needs Identified from Sections 1 &	(Column 2) Service Needed	(Column 3) Service Frequency & Duration	(Column 4) Service Provider Name	(Column 5) Date Service Began
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

NAME OF RECIPIENT OR GUARDIAN:
(Please Print)_____

SIGNATURE OF RECIPIENT OR GUARDIAN: _____

NAME OF ADMINISTRATOR OR DESIGNEE:
(Please Print) LEITHA SANDERS

SIGNATURE OF ADMINISTRATOR OR DESIGNEE: _____

Does the facility intend to use this form to satisfy the Medicaid assessment for assistive care services? Yes ☐ No
If yes, page 6 is required to be completed. If no, Stop.

CERTICATE OF MEDICAID NECESSITY
THIS PAGE MUST ALSO BE FILLED OUT FOR RESIDENTS THAT RECEIVE MEDICAID ASSISTIVE CARE SERVICES

Resident Name_____DOB _____

This is to certify that this recipient is in need of an integrated set of assistive care services on a 24-hour basis, including at least two of the following four service components on a daily basis (check as applicable):

_____Assistance with activities of daily living, which is defined as individual assistance with ambulating, transferring, bathing, dressing, eating, grooming, and/or toileting.

_____Assistance with instrumental activities of daily living, which is defined as individual assistance with shopping for personal items, making telephone calls, managing money, etc.

_____Health support, which is defined as observing the resident's whereabouts and well-being; reminding the resident of any important tasks; and recording and reporting any significant changes in appearance, behavior, or state of health to the health care provider, designated representative, or case manager.

_____Assistance with self-administration of medication, which is defined as assistance with or supervision of self-administration of medication as permitted by law.

HEALTH CARE PROVIDER

Facility Name: EMMANUEL CARE, ASSISTED LIVING FACILITY

License Number: AL11412

Administrators' Signature: _____

Date Signed: _____

CERTIFICATION OF MEDICAL NECESSITY:

Physician/Physician Assistant/
Advanced Registered Nurse Practitioner/
Registered Nurse: _____

Date: _____

The resident service log is still required for Medicaid residents.