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(Specify extent of any symptoms of confusion, forgetfulness: participation in social activities (i.e., active or withdrawn))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

☐ OUT OF BED ALL DAY	☐ IN BED MOST OF THE TIME	COMMENT:
☐ IN BED PART OF THE TIME	☐ IN BED ALL OF THE TIME	

TUBERCULOSIS INFORMATION

ANY HISTORY OF TUBERCULOSIS IN APPLICANT'S FAMILY? ☐ YES ☐ NO	DATE OF TB TEST/TYPE OF TEST	☐ POSITIVE ☐ NEGATIVE
ANY RECENT EXPOSURE TO ANYONE WITH TUBERCULOSIS? ☐ YES ☐ NO	ACTION TAKEN (IF POSITIVE)	

GIVE DETAILS

(Over)

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	
☐	☐	Able to walk without any physical assistance (e.g., walker, crutches, other person), or able to walk with a cane.
☐	☐	Mentally and physically able to follow signals and instructions for evacuation.
☐	☐	Able to use evacuation routes including stairs if necessary.
☐	☐	Able to evacuate reasonably quickly (e.g., walk directly the route without hesitation).

FUNCTIONAL CAPABILITIES (Check all items below)

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

SERVICES NEEDED (Check items and explain)

YES	NO	
☐	☐	Help in transferring in and out of bed/turning in bed or chair (specify)
☐	☐	Help with bathing_____

☐ ☐ Help with dressing, hair care, and personal hygiene (specify) _____

☐ ☐ Does prospective resident desire and is he/she capable of doing own personal laundry and other household tasks? (specify)

☐ ☐ Help with moving about the facility

☐ ☐ Help with eating (need for adaptive devices or assistance from another person)

☐ ☐ Special diet/observation of food intake

☐ ☐ Toileting, including assistance equipment, or assistance of another person (specify) _____

☐ ☐ Continence, bowel or bladder control. Are assistive devices such as a catheter required? _____

☐ ☐ Help with medication

☐ ☐ Needs special observation/night supervision (due to confusion, forgetfulness, wandering) _____

☐ ☐ Help in managing own cash resources _____

☐ ☐ Help in participating in activity programs

☐ ☐ Special medical attention

☐ ☐ Assistance in incidental health and medical care

☐ ☐ 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