ALR Community Pre-Admission Assessment

Date of assessment: _____

Location of assessment: _____

Name: _____

Preferred name: _____

Age: _____

Resident birth date: _____

Gender (identifies as): _____

Relationship status: _____

Reason individual is interested in admission to the ALS community:

Individuals Involved with Pre-Admission Assessment:

Individual	Name(s)	
ALR staff	Name(s)	
Medical Power of Attorney	Name, Address and Phone	☐ In person ☐ By phone
Financial Power of Attorney	Name, Address and Phone	☐ In person ☐ By phone
Representative Payee	Name, Address and Phone	☐ In person ☐ By phone
Single Entry Point or Community Center Board Case Manager	Name and Agency, Phone	☐ In person ☐ By phone
Mental Health Case Manager	Name and Agency, Phone Release of information obtained (date): _____	☐ In person ☐ By phone

Individual Name: _____ Date of Assessment: _____

Other Participants	Name, Agency, Phone	☐ In person ☐ By phone ☐ In person ☐ By phone ☐ In person ☐ By phone ☐ In person ☐ By phone ☐ In person ☐ By phone
Legal Representative: Length of time as representative: _____	Type: ☐ Guardian ☐ Health Care Proxy ☐ Conservatorship Name and Phone:	☐ In person ☐ By phone

Individual's Preferred Support Systems

Significant other:	Phone	Email
Family members:	Phone	Email
Friends:	Phone	Email
Spiritual community:	Phone	Email
Other community resources:	Phone	Email
Primary physician prior to admission:	Phone Fax	Email
Other (e.g., AA meeting, book clubs, day center, mental health center, Veteran's Administration, etc.):	Phone	Email

Individual Name: _____ Date of Assessment: _____

Single Entry Point/Community Center Board (Medicaid clients only)

County:
Case manager name and phone number
How long have they received Home and Community Based Services (HCBS)?

Regional Care Collaborative Organization (RCCO)

Name of RCCO: Phone:

Personal Care (preferences and abilities)

Bathing: Dressing: Toileting: Grooming: Eating: Incontinent/continent (i.e., what level of assistance is needed): Sleep patterns: Living space (e.g., making bed, putting clothing away, clutter, organizing, etc.): Laundry: Cooking: Money Management: Ambulation: REFER TO "ALR COMMUNITY - FALL RISK ASSESSMENT"

Individual Name: _____ Date of Assessment: _____

Medical

Physician(s):

Physician/PA/NPA Evaluation completed and returned: ☐ YES ☐ NO

Date of last physical:

Allergies (medications, food, pets, latex, etc.):

Reactions due to allergies:

Auditory impairment:

Visual impairment:

Wears dentures:

Use of alcohol/tobacco/marijuana:

Seizure Disorder:

If yes, is the seizure disorder controlled by medications? ☐ YES ☐ NO

Diagnoses: (attach if needed)

Diet (e.g., texture, therapeutic, sodium diabetic, etc.):

Medications/dosages (attach if needed):

Recent medication changes:

If the individual requires injectable medication, document if they are able to manage injections independently.

Able to manage own oxygen (if applicable):

Court ordered medications:

Individual Name: _____ Date of Assessment: _____

Overnight continence support:

Other:

External Services

(e.g., Meals on Wheels, PT, OT, Home Health, Day Center, services provided by family members, etc.):

Cognition

Confusion/disorientation (e.g., disoriented to place, person, time, attention span, periods of confusion, etc.):

Dementia diagnosis (if applicable):

SLUMS test results (refer to SLUMS assessment tool):

History of wandering (explain):

Confusion between day and night:

Sundowner's Syndrome behavior:

Able to follow instructions:

Able to communicate needs:

Able to use personal hygiene items safely:

Safety risks (e.g., forgets to use walker, not dressing appropriately for weather, etc.):

Other:

Individual Name: _____ Date of Assessment: _____

Mental Health

Has there been any resistance to care or medication administration?

Examples:

How recent were these incidents?

Redirection strategies:

Has there been any verbal or physically abusive actions towards self or others?

Examples:

How recent were these incidents?

Redirection strategies:

Does the individual spend an unusual amount of time sorting, rummaging or shopping?

Does the individual have hallucinations (visual/auditory), or delusions?

If so, describe them:

Has the individual demonstrated any inappropriate sexual actions?

How recent were these incidents?

History of psychiatric hospitalizations (i.e., date, reason, location, etc.):

Date of last psychiatric hospitalization:

Date of last psychiatric evaluation:

Other mental health information:

Currently receiving treatment (if yes, where)?

Individual Name: _____ Date of Assessment: _____

Substance Use

Alcohol/Drug(s) of choice:

Date of last use:

Substance use history:

How long has the individual been sober/clean?

Is individual currently receiving treatment?

Supportive Treatment Group: ☐ YES ☐ NO

If yes, what support will be needed to maintain participation?

Activities/ Social

What are the individual's hobbies or interests and what assistance is needed to in order to engage in those activities?

Is the individual interested in individual or group activities (review the Community's group activities with the individual)?

What community activities does the individual engage in, and what support will be needed to maintain those activities (e.g., spiritual community, peer support group, volunteer work, visiting friends/family, library use, shopping, etc.)?

What relationships are important to the individual and what support will be needed to maintain those relationships?

Goals/Expectations

What are the individual's goals and expectations related to living in your Community?

Individual Name: _____ Date of Assessment: _____

Employment

Is the individual currently employed? If so, where are they employed? *If so, what support will be needed to maintain employment?* *If not, is there interest in seeking employment, and what support will be needed to assist?*

Criminal/Legal History

Does the individual have a criminal history?: ☐ YES ☐ NO *If yes, describe:* Is the individual involved in any current legal activity (e.g., divorce, probation, etc.)? Are there any parole or probation requirements? Is the individual a registered sex offender? ☐ YES ☐ NO

Other

Other information relevant to pre-admission assessment:

Use of this document does not constitute nor imply compliance with Federal or State rules and regulations. All facilities must follow their own internal guidelines and policies for admission. All facilities are responsible for gathering the appropriate information required to ensure the facility is able to meet the needs of each individual admitted.

Signature of Individual	Printed Name	Date
Signature of Legal Representative	Printed Name	Date
SEP Case Manager (Medicaid only)	Printed Name	Date
Signature of ALR Community Representative	Printed Name	Date

INSTRUCTIONS

Pre-Admission Assessment

This document is to be completed prior to admission. It is important to obtain as much information as possible. It is possible that you or another staff member will complete this document during an interview with the potential resident. Additional Tools/Assessments may/may not be utilized to obtain the information required of this document.

**When performing assessments, it is good practice to: ask the individual questions, speak with family members, and obtain information from their physician (as appropriate). Additionally, whenever possible, it is ideal to observe the individual performing any tasks related to the assessment questions.

1. Enter the name of the individual and date of assessment in the document's header, starting on page 2.
2. On page 1, enter the date of the assessment.
3. Enter the location at which the assessment took place (e.g., individual's home, skilled nursing facility, Assisted Living Residence, etc.).
4. Enter the individual's legal name.
5. If the individual wants to be called by any other name, document that name.
6. Enter the individual's birth date.
7. Enter the individual's current age.
8. Enter the individual's identified gender.
9. Enter the individual's relationship status (e.g., single, married, domestically partnered, divorced, widowed, etc.).
10. Enter the individual's stated reason for interest in admission to the Assisted Living Residence.

Individuals Involved with Pre-Admission Assessment

1. Enter the name of the ALR staff who primarily completed this assessment.
2. Enter the name of any ALR staff who assisted with this assessment.
3. Enter the name and contact information of the Medical Power of Attorney (if applicable). Indicate if they assisted with the assessment in person or by phone.
4. Enter the name and contact information of the Financial Power of Attorney (if applicable). Indicate if they assisted with the assessment in person or by phone.
5. If the individual has a Representative Payee, enter their name and contact information. Indicate if they assisted with the assessment in person or by phone.
6. Enter the name and contact information of the Single Entry Point (SEP) or Community Center Board (CCB) (if applicable). Note: if the individual is funded (in part or in total)

by Medicaid, it is required that the SEP case manager be involved in the assessment process.

7. Enter the name and contact information of the Mental Health Case Manager (if applicable). Indicate if they assisted with the assessment in person or by phone. Also note if a release of information was obtained, and if so, enter the date of the release.
8. If anyone else assisted with the assessment, enter their name and contact information in the "Other Participants" section. For each, indicate if they assisted in person or by phone.
9. Enter the name and contact information of the Legal Representative (if applicable). Indicate if they assisted with the assessment in person or by phone. Note the length of time that individual has served as Legal Representative. Legal Representatives may include a Guardian (court appointed), a Health Care Proxy or a Conservatorship (court appointed).

Individual's Preferred Support System

Enter as much information as possible about the individual's preferred support systems, including: names, phone numbers, email addresses, or any other pertinent information.

Single Entry Point (SEP)/Community Center Board (CCB) - (Medicaid Clients only)

If the individual is receiving Medicaid funding and is, therefore, receiving Home and Community Based Services (HCBS), complete this section.

1. Enter the county in which the individual is receiving SEP or CCB services.
2. Enter the case manager's name and phone number.
3. If possible, note how long the individual has received HCBS services.

Regional Care Collaborative Organization (RCCO)

A Regional Care Collaborative Organization (RCCO) connects Medicaid clients to Medicaid providers and helps clients find community and social services in their area. RCCOs help providers communicate with Medicaid clients and with each other, so Medicaid clients receive coordinated care. A RCCO will also help Medicaid clients get the right care when they are returning home from the hospital or a nursing facility, by providing the support needed for a quick recovery. Refer to the following link for information about RCCO service areas and contact numbers: www.colorado.gov/hcpf/regional-care-collaborative-organizations.

If the individual receives Medicaid and is enrolled in a RCCO, enter the name of the RCCO and the RCCO's phone number.

Personal Care (preferences and abilities)

Enter as much information as possible about the individual's preferences and abilities related to the Personal Care elements listed.

Medical

1. Enter the name of any current physicians.
2. Note if the Physician/PA/NPA Evaluation was competed and returned (if utilized as part of the assessment process).
3. Enter the date of the individual's last physical.
4. Enter any of the individual's allergies.
5. Enter any reactions due to the above allergies.
6. Enter information related to any auditory impairment.
7. Enter information related to any visual impairment.
8. Document if the individual wears dentures.
9. Document if the individual uses alcohol, tobacco or marijuana in any form.
10. Document if the individual has a seizure disorder.
11. If the individual does have a seizure disorder, indicate if the disorder is or is not controlled by medications
12. Enter the individual's diagnoses. If preferred, attach a print out of diagnoses.
13. Enter any information about the individual's diet. Examples include, but are not limited to: a calorie counted diet, a specific sodium gram diet, a cardiac diet, any specific texture diet (e.g., puree), or a therapeutic diet.
14. Enter the individual's medications and dosages. If preferred, attach a print out of medications.
15. Note if there are recent medication changes.
16. Document if the individual needs injections to receive medication, and note if they are able to do so independently (i.e., ask individual to verbally walk through each step of the administration process or, ideally, observe them administering the medication). Note: if the individual is not able to independently administer injections, this does not preclude admission to the ALR if the community has a nurse on staff to meet the need for injectable medication administration or if the resident is able to obtain skilled home-health care for this purpose.
17. Document if the individual uses oxygen, and document if they are able to manage their oxygen independently.
18. Document any court ordered medications.
19. Document if there is any nighttime incontinence support needed.
20. Document any "Other" information related to medical issues that will assist the ALR to determine if able to meet the needs of the individual.

External Services

External services providers include, but are not limited to, home health, hospice, private pay caregivers and family members.

Cognition

1. Enter any information related to confusion or disorientation. For example, note if the individual experiences any disorientation to place, person or time. Does the individual have any issues with attention span or do they experience any periods of confusion.
2. If there is a current diagnosis for dementia, enter that information.
3. Administer the Saint Louis University Mental Status (SLUMS) Exam. The SLUMS is a brief oral/written exam to determine if the individual may have dementia or Alzheimer's disease.
4. Document if the individual has any history of getting lost, and enter details about when it occurred, what the situation was, how frequently it occurs, or any other relevant information.
5. Document if the individual experiences any confusion between day and night, as this may signal a need for more support during nighttime hours.
6. Document if the individual experiences any Sundowner's Syndrome behavior.
7. Document if the individual is able to follow instructions.
8. Document if the individual is able to communicate their needs, verbally or otherwise.
9. Document if the individual is at risk if they are allowed to directly use personal grooming and/or hygiene items (e.g., shavers, razors, nail clippers, etc.)
10. Document any Safety Risks, such as forgetting to use a walker, not dressing appropriately for the weather, inability to set water temperature, forgetting to turn off stove, putting inappropriate items on stove, etc.
11. If there is any "Other" information related to the individuals cognition, enter it here.

Mental Health

1. Document if there has been any resistance to care or medication administration. Include examples, information about how recent any incidents were, and any successful redirection strategies.
2. Document if there has been any verbal or physically abusive actions towards self or others. Include examples, information about how recent any incidents were, and any successful redirection strategies.
3. Document if the individual spends an unusual amount of time sorting, rummaging or shopping.
4. Document if the individual has hallucinations, delusions or illusions. If so, provide detail sufficient to describe them.
5. Document if the individual has a history of inappropriate sexual actions (e.g., touching others inappropriately). Include information about when any incidents occurred.
6. Document any history of psychiatric hospitalization, including information about date, reason, location, etc.
7. Document the date of the last psychiatric hospitalization, if applicable.
8. Document the date of the last psychiatric evaluation, if applicable.

9. Document any other mental health information.
10. Document if the individual is currently receiving mental health treatment; if so, where that treatment is being received.

Substance Use

1. Document information about the individual's alcohol or drug(s) of choice.
2. Document reported last usage of each drug noted above.
3. Document information about substance use history.
4. Document how long the individual has been sober or clean of drug usage.
5. Document if the individual is currently receiving treatment for substance use.
6. Document if the individual is in a supportive treatment group, and if so, document what kind of support the ALR will need to provide to maintain their participation.

Activities/Social

1. Document what the individual's hobbies or interests are and what assistance will be needed for the individual to engage in those hobbies or interests.
2. Review the Community's activities with the individual and document if they are interested in individual or group activities.
3. Document any information about community activities the individual engages in and what level of support will be needed to maintain that engagement.
4. Document any relationships that are important to the individual and the level of support that will be needed to maintain those relationships.

Goals/Expectations

Document information about the individual's goals and expectations related to living in your Community. This will enable you to determine if your Community can meet those goals and expectations.

Employment

1. Document if the individual is currently employed and, if so, where.
2. If employed, document the level of support that will be needed to maintain that employment.
3. If the individual is not employed, do they have interest in seeking employment? If so, document the level of support they will need to do so.

Criminal/Legal History

1. Document if the individual does or does not have a criminal history.
2. If they have a criminal or legal history, describe.

3. Document if the individual is involved in any current legal activity (e.g., divorce, probation, etc.).
4. Document if there are any current probationary requirements.
5. Document if the individual is or is not a registered sex offender.

Other

If there is any other information relevant to making a decision about admitting the individual to the Community, document it here.

It is the provider's responsibility to gather the appropriate information required to ensure the Community is able to meet the needs of each individual admitted.

Signatures

1. Have the individual sign their name, print their name and date the document.
2. Have the Legal Representative sign their name, print their name and date the document.
3. If the individual receives Medicaid, consider faxing the document to the SEP or CCB case manager for their signature. While this is not required, doing so provides documentation that the case manager was involved in the assessment process, which is a requirement.
4. Have the ALR Community representative sign their name, print their name and date the document.