ALR Community – Initial Individual Assessment Team Determination

Individual's Name: _____ Date: _____

Based on all assessment information, the Assessment Team has determined:

Moving into the ALR is the individual's choice:	☐ Yes	☐ No	
Community meets individual's independence/community integration needs:	☐ Yes	☐ No	
Individual agrees to the available selection of living arrangement, Room # ____:	☐ Yes	☐ No	
Individual agrees to roommate choice (if applicable):	☐ Yes	☐ No	☐ N/A
Individual is capable of locking and unlocking their living quarters:	☐ Yes	☐ No	
Community is able to meet therapeutic diet needs and/or food preferences:	☐ Yes	☐ No	
Individual is able to safely cook and use food preparation areas/utensils:	☐ Yes	☐ No	
Individual is able to self-manage any injectable medications: (Note: answering "no" does not preclude admission to ALR if the community has a nurse on staff to meet the need for injectable medication administration or if Home Health will administer.)	☐ Yes	☐ No	☐ N/A
Community can meet individual's level of need related to continence:	☐ Yes	☐ No	☐ N/A
Community can meet individual's nighttime needs:	☐ Yes	☐ No	☐ N/A
Community can meet the individual's level of need related to supervision and protective oversight:	☐ Yes	☐ No	
Community's physical plan/layout is able to accommodate the individual's needs related to accessibility:	☐ Yes	☐ No	☐ N/A
Community can support the individual's overall physical, emotional, social and spiritual needs:	☐ Yes	☐ No	
Community's culture is a good fit for the individual:	☐ Yes	☐ No	

Comments and considerations:

Individual's Name: _____ Date of Determination: _____

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.

Signatures:

Signatures and titles of determination team members involved in completion of this form:

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Individual's Signature: _____ Date: _____

INSTRUCTIONS

Initial Individual Assessment Team Determination

Use the Initial Individual Assessment Team Determination to document your Assisted Living Residence (ALR) community's decision regarding its ability to meet a potential resident's needs.

- Enter the individual's full name and enter the date the form is completed.
- Enter the name of the individual and date of determination in the document's header, starting on page 2.
- Answer all questions with a "yes" or "no," as appropriate. If a question is not applicable, mark "n/a".
- Document any other comments or considerations.
- Enter the name and title of all staff members who contributed to the discussion. If the individual receives Medicaid funding (Home and Community Based Services waiver), the Single Entry Point (SEP) Case Manager must be part of the Team Determination Assessment. While there is no requirement for the SEP case manager's signature, it does provide good documentation of the process. Consider faxing the document to the SEP case manager for their signature.
- Request that the individual sign the document.
- Date the document.