ALR Community – Individual/Family Self-Evaluation

Please print legibly

Individual's Name: _____ **Age:** _____

What is your present living arrangement? _____

What type of assistance do you currently receive?

Why are you considering a move to an Assisted Living Residence?

How soon would you like to move into an Assisted Living Residence? _____

Which areas of assistance would benefit you?

Activity of Daily Living		Type of Assistance
Taking medication Any meds taken via injection (shots)?	☐ Yes ☐ No ☐ Yes ☐ No	
Preparing meals	☐ Yes ☐ No	
Dressing/Undressing	☐ Yes ☐ No	
Grooming	☐ Yes ☐ No	
Showering/Bathing	☐ Yes ☐ No	
Toileting	☐ Yes ☐ No	
Housekeeping	☐ Yes ☐ No	
Laundry	☐ Yes ☐ No	
Transportation	☐ Yes ☐ No	
Accessing Community	☐ Yes ☐ No	
Community Involvement	☐ Yes ☐ No	
Employment	☐ Yes ☐ No	

Individual's Name: _____ Date of Assessment: _____

Physical Health:
Do you have any significant health concerns?

Do you have diet restrictions? ☐ Yes ☐ No
If yes, please explain:

Do you have any difficulty swallowing? ☐ Yes ☐ No
If yes, please explain:

Mobility:
Do you utilize any of the following: ☐ Cane ☐ Scooter ☐ Walker ☐ Wheelchair
Are you able to walk independently 150 feet? ☐ Yes ☐ No
Are you able to transfer independently? ☐ Yes ☐ No
(e.g., move from bed to standing position or from chair to standing position)
Are you able to go up and down stairs independently? ☐ Yes ☐ No

Cognition/Mental Health:

How would you describe your memory? (Check one)

☐ **Good** memory for present-day events – no difficulty remembering names, places, or scheduled appointments. Does not become confused in unfamiliar places.

☐ **Fair** memory for present-day events – little help required for remembering names or appointments. May become confused in unfamiliar places.

☐ **Poor** memory for present-day events – require a lot of reminders with names, scheduling and remembering appointments. Almost always confused in unfamiliar places.

☐ **Extremely Poor** memory – does not remember familiar people or names. Others must schedule and supervise appointments. Always confused in unfamiliar places.

☐ **History of Hoarding** – select this box if you have a history of hoarding.

Do you experience depression? ☐ Yes ☐ No
If yes, is it: ☐ Mild ☐ Moderate ☐ Severe

Do you experience anxiety? ☐ Yes ☐ No
If yes, is it: ☐ Mild ☐ Moderate ☐ Severe

Individual's Name: _____ Date of Assessment: _____

Do you take medications for depression or anxiety? ☐ Yes ☐ No
Comments regarding depression or anxiety:

Do you have a history of any of the following? ☐ Suicidal/self-abuse ☐ Substance abuse

If yes, please explain:

General Information:
Is anyone assisting you with bill paying or managing your finances? ☐ Yes ☐ No
If yes, please provide name and phone number: *(If PoA or Conservator, please provide documentation)*

Name: _____ Phone: _____

Are you receiving any external services such as home care, physical therapy, adult day services, etc.?

Are you currently receiving Medicaid benefits? ☐ Yes ☐ No
If yes, Case Manager name: _____
Case management agency: _____
Contact information: _____

Do you currently use tobacco? ☐ Yes ☐ No

Do you currently use marijuana? ☐ Yes ☐ No

Is there any additional information you would like us to know?

Signature of person completing evaluation: _____

Individual's Signature: _____ Date: _____

INSTRUCTIONS

Individual/Family Self-Evaluation

This document is to be completed prior to admission by the individual and/or their family. This document provides a way to gather preliminary information and have discussion with the individual and/or their family. This document is intended to be used before other Assessments are completed. It is important to obtain as much information directly from the individual as possible. It is possible that you or another staff member will complete this document during an interview with the potential resident.

There is no "right" or "wrong" way for the individual and their family to complete this form or answer these questions. This is a starting point for you, as the potential residential provider, to begin to understand the individual and their needs.

Review this information and begin to form questions and note any areas of concern, so as to understand if this person may or may not be a good fit in your Assisted Living Residence.

If you believe your Assisted Living Residence can meet the needs of this resident, complete the other Assessments.

Note: if the individual reports using injectables (shots) for medications, you will need to determine if the individual is fully capable of independent self-administration (via discussion or demonstration), if you will have appropriate medical staff to administer the medication (nurse), or if the individual will receive Home Health services to administer the injectable medication.