ASSESSMENT PLAN FOR RESIDENTS

St. Elizabeth Briarbank Assisted Living
39315 Woodward Avenue
Bloomfield Hills, MI 48304

Instructions:

1. A written assessment plan is required. This licensee is responsible for assuring that a written assessment plan is completed.
2. This form has been approved by the Department of Consumer and Industry Services and contains the information required by administrative rule and Section 3(9) of At 218, P.a. 1979 as amended.
3. This form is to be completed by the licensee and resident, or the resident's designated representative. The responsible agency, if any, may assist in this process
   Use additional sheets of more information are needed and PRINT CLEARLY.

Name of Resident	Name of Designated Representative (if applicable)	Date of Birth	Sex – circle Female Male

I.SOCIAL/BEHAVIORAL ASSESSMENT **PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)**

Does the person:	YES	NO	If No, Describe Needs and How they Will Be Met
1. Move Independently in Community			
2. Communicate Needs			
3. Understands Verbal Communication			
4. Alert to Surroundings			
5. Read and Writes			
6. Tell Time			
7. Manage Money			
8. Follow Instructions			
9. Control Aggressive Behavior			
10. Control Sexual Behavior			
11. Get Along With Others			
12. Exhibit Self Injurious Behavior			
13. Participate in Social Activities			
14. Smoke			
15. History of alcohol or drug abuse			

II. SELF CARE SKILL ASSESSMENT			**PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)**
Is the person	**YES**	**NO**	**If No, Describe Needs**
1. Independent in eating			
2. Independent in Toileting			
3. Independent in Bathing			
4. Independent in grooming (hair care, teeth, nails, etc)			
5. Independent in Dressing			
6. Independent in Walking/Mobility			
7. Independent in Stair Climbing			
8. Independent in use of Assistive Devices (cane, walker, hearing aid, dentures, etc.)			
9. What have we missed…what other needs do we need to plan for?			

III. HEALTH CARE ASSESSMENT			**PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)**
	YES	**NO**	**If No, Describe Needs and How they Will Be Met**
1. Taking Medication			
2. Special Diet			
3. Physical Limitations			
4. Special Equipment Used (wheelchair/walker/cane, etc)			
5. Impaired vision, allergies, weight, hearing aid, dentures etc.			
6. Susceptible to Hypothermia or Hyperthermia			

IV. SOCIAL AND PROGRAM ACTIVITIES	YES	NO	PLAN OF ACTION (Check Yes or No and Complete Where Appropriate If No, Describe Needs and How they Will Be Met
1. Participates in religious practice			
2. Participates in Household Chores			
3. Participates in Adult Activity Programs			
4. Participates in Senior Center Activities			
5. Participates in Workshop or job			
6. Any hobbies or special interests?			
7. Any recreational interests?			
8. Will join-in physical exercise activities? (chair exercises)			
9. Any applicable visitation prohibitions and/or other considerations?			
10. Other (explain)			

V MEDICAL INFORMATION

Name of Primary Physician/Clinic	Phone # Fax #
Physician Address (street, city, ZIP)	

MEDICATIONS TAKEN AT TIME OF ASSESSMENT

Name of Medication	Who Prescribed This Medication	Dosage

MEDICAL OR DENTAL FOLLOW-UPS NEEDED. Indicate family member(s)who will oversee health care needs. (I.e. checkups, sick visits to physician/dentist, etc)

VI. RELEASE OF INFORMATION – RESIDENT OR LEGAL GUARDIAN SIGNATURE ONLY

By signing this form I understand that I am authorizing the release of medical information concerning me, including information regarding Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV), if applicable, to the licensee and licensee's staff, the responsible agency and the Michigan Department of Consumer and Industry services, Bureau of Regulatory Services, for the purpose of providing appropriate care to me and deterring compliance with licensing rules."

_____
Signature of Resident or Legal Guardian Date _____

_____
Print Name

VII WHAT OTHER INFORMATION WILL HELP US PLAN CARE FOR THIS RESIDENT?

VIII. PLACEMENT OBJECTIVE

	Delay/prevent Deterioration and movement to a more restrictive setting
	Encourage movement to a less restrictive setting.

IX. SIGNATURES

_____ _____ Signature of Resident or Designated Representative Date _____ Print Name	_____ _____ Signature of Licensee Date
_____ _____ Signature of Responsible Agency (if applicable) Date	
AUTHORITY: Act 218. P.A. 1979 as amended COMPLETION: Voluntary PENALTY: Violation of Administrative Rule and Act 218 P.A. 1979, as amended.	The Department of Consumer and Industry Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs.