

**Dane County Assisted Living Quality Program
CBRF RESIDENT ASSESSMENT**

NAME: _____

ADMISSION DATE: _____ **DATE OF BIRTH:** _____

FAMILY MEMBER/LEGAL GUARDIAN: _____

Case Manager: _____

Check one:

Initial Assessment _____ **ISP Review** _____ **Change of Condition** _____

Plan Date: _____

PARTICIPANTS IN ASSESSMENT: _____

PREPARED BY: _____

DATE COMPLETED: _____

ASSESSMENT

Date of Assessment: _____

- ✓ **Physical Health**
 - Chronic, short-term or recurring illnesses: _____

- ✓ **Oral health** _____

- ✓ **Physical disabilities** _____

- ✓ **Mobility status** _____
 - Need for restorative or rehabilitative care _____

- ✓ **Medications** (see current MAR for current listing)
 - Resident's ability to control and self-administer medications _____

- ✓ **Presence and intensity of pain** _____

- ✓ **Nursing procedures needed** _____

- ✓ **Number of hours/week of nursing care needed by resident** _____

- ✓ **Mental and emotional health**
 - Self-concept _____
 - Motivation _____
 - Attitudes _____
 - Symptoms of mental illness _____
 - Participation in treatment and programming _____
 - Behavior patterns that may be harmful to resident or others? _____
 - Destructive of property? _____

- ✓ **Risks**
 - Choking _____
 - Falling _____
 - Elopement _____

- ✓ **Capacity for self-care**
 - Need for personal care services _____
 - Adaptive equipment needed _____
 - Training needed _____

- ✓ **Capacity for self-direction**
 - Ability to make decisions _____
 - Ability to act independently _____
 - Ability to communicate wants/needs _____

- ✓ **Social participation**
 - Interpersonal relationships _____
 - Communication skills _____
 - Preferred leisure-time activities _____
 - Family contacts _____
 - Community contacts _____
 - Vocational needs _____

**Dane County Assisted Living Quality Program
CBRF INDIVIDUAL SERVICE PLAN**

RESIDENT: _____

ADMISSION DATE: _____ **DATE OF BIRTH:** _____

FAMILY MEMBER OR LEGAL GUARDIAN: _____

Case Manager: _____

Check one:

Initial ISP _____ **ISP Review** _____ **Change of Condition** _____ **Amended ISP** _____

Plan Date: _____

PARTICIPANTS IN ISP DEVELOPMENT OR REVIEW: _____

PREPARED BY: _____

DATE COMPLETED: _____

Resident signature

Date

Guardian or legal representative

Date

Family member (if applicable)

Date

Case Manager (if applicable)

Date

Assessed Need Resident's Desired Outcome Services provided Who provides Frequency Goals and time limit for attainment

Physical health

Oral health

Physical disabilities

Mobility status

**Medications
(see current MAR)**

**Medication
Administration**

**Presence of pain;
Pain management**

Nursing procedures

**Mental/emotional
Health**

**Harmful
Behaviors**

Choking

Falls risk

Elopement risk

Assessed Need	Resident's Desired Outcome	Services provided	Who provides	Frequency	Goals and time limit for attainment
Personal care					
Bathing					
Dressing					
Grooming					
Oral care					
Toileting					
Incontinence					
Eating					
Adaptive equipment					
Ability to Communicate needs					
Ability to self-Direct					
Social					
Activity preferences					
Family interaction					
Other social contacts					
Preferred outings					
Religious					
Vocational					
Transportation					

Assessed Need Resident's Desired Outcome Services provided Who provides Frequency Goals and time limit for attainment

Need for supervision
