# APPRAISAL/NEEDS AND SERVICES PLAN

| CLIENT'S/RESIDENT'S NAME | DATE OF BIRTH | AGE | SEX | DATE |
|---|---|---|---|---|
| DOROTHY E. LARSON | 7/25/1921 | 90 | ☐ MALE ☑ FEMALE | 10/01/2011 |

| FACILITY NAME | ADDRESS | CHECK TYPE OF NEEDS AND SERVICES PLAN: |
|---|---|---|
| ELIM ASSISTED LIVING | 3653 WREN AVENUE, CONCORD, CA 94546 | ☑ ADMISSION ☐ UPDATE |

| PERSON(S) OR AGENCY(IES) REFERRING CLIENT/RESIDENT FOR PLACEMENT | FACILITY LICENSE NUMBER | TELEPHONE NUMBER |
|---|---|---|
| N/A | 07560023 | ( 925) 689-8513 |

**Licensing regulations require that an appraisal of needs be completed for specific clients/residents to identify individual needs and develop a service plan for meeting those needs. If the client/resident is accepted for placement the staff person responsible for admission shall jointly develop a needs and services plan with the client/resident and/or client's/resident's authorized representative referral agency/person, physician, social worker or other appropriate consultant. Additionally, the law requires that the referral agency/person inform the licensee of any dangerous tendencies of the client/resident.**

**NOTE:** *For Residential Care Facilities for the Elderly, this form is not required at the time of admission but must be completed if it is determined that an elderly resident's needs have not been met.*

**BACKGROUND INFORMATION:** *Brief description of client's/resident's medical history/ emotional, behavioral, and physical problems; functional limitations; physical and mental; functional capabilities; ability to handle personal cash resources and perform simple homemaking tasks; client's/resident's likes and dislikes.*

HYPERTENSION, METOPROLOL 25MG, ONE TAB TWICE/DAY
HYPERACIDITY (GERD), PROTONIX 40MG, ONE TAB TWICE/DAY
MILD COGNITIVE IMPAIRMENT
VERY LIMITED VISION, MEDS NEED TO BE LAYED OUT AND SUPERVISED

| NEEDS | OBJECTIVE/PLAN | TIME FRAME | PERSON(S) RESPONSIBLE FOR IMPLEMENTATION | METHOD OF EVALUATING PROGRESS |
|---|---|---|---|---|
| **SOCIALIZATION** — Difficulty in adjusting socially and unable to maintain reasonable personal relationships | | | | |
| TRANSITION FROM LIVING AT HOME TO ASSISTED LIVING FACILITY | Keep activities brief, staff will check in periodically to assess transition to facility. Should not be pressured to join activities. | on-going | Elim Staff | Periodic Reappraisals |
| **EMOTIONAL** — Difficulty in adjusting emotionally | | | | |
| No history of emotional difficulty | n/a | | | |



*(Continued on Reverse)*

| NEEDS | OBJECTIVE/PLAN | TIME FRAME | PERSON(S) RESPONSIBLE FOR IMPLEMENTATION | METHOD OF EVALUATING PROGRESS |
|---|---|---|---|---|
| **MENTAL** — Difficulty with intellectual functioning including inability to make decisions regarding daily living. | | | | |
| N/A | N/A | | | |
| **PHYSICAL/HEALTH** — Difficulties with physical development and poor health habits regarding body functions. | | | | |
| HYPERTENSION, (GERD), | Staff will communicate regularly with resident and ensure regular administration of medications. | on-going | Elim Staff | Progress Reports |
| **FUNCTIONING SKILLS** — Difficulty in developing and/or using independent functioning skills. | | | | |
| Resident is non-ambulatory, Arthritis, Uneven gait, Frailty. | Staff is to encourage the use of assistive devices (cane walker, and pick'r up devices), and supervise all activites, including transfering, walking, and toileting. | on-going | Elim Staff | Progress Reports |

We believe this person is compatible with the facility program and with other clients/residents in the facility, and that I/we can provide the care as specified in the above objective(s) and plan(s).

TO THE BEST OF MY KNOWLEDGE THIS CLIENT/RESIDENT DOES NOT NEED SKILLED NURSING CARE.

LICENSEE(S) SIGNATURE ▶ | DATE

I have reviewed and agree with the above assessment and believe the licensee(s) other person(s)/agency can provide the needed services for this client/resident

CLIENT'S/RESIDENT'S AUTHORIZED REPRESENTATIVE(S)/FACILITY SOCIAL WORKER/PHYSICIAN/OTHER APPROPRIATE CONSULTANT SIGNATURE ▶ | DATE

I/We have participated in and agree to release this assessment to the licensee(s) with the condition that it will be held confidential.

CLIENT'S/RESIDENT'S OR CLIENT'S/RESIDENT'S AUTHORIZED REPRESENTATIVE(S) SIGNATURE ▶ | DATE