New York State Department of Health
Division of Assisted Living

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

ALL SPACES MUST BE FILLED OUT

Resident's Name: _____ **Date of Exam:** _____

Facility Name: _____ Date of Birth:_____ Sex:_____

Present Home Address:_____
Street City State Zip

Reason for evaluation: ☐ Pre-Admission ☐ 12 month ☐ Acute change in condition ☐ Other :_____

MEDICAL REVIEW FINDINGS

Vital Signs: BP: _____ Pulse:_____ Resp: _____ T: _____ Height: _____ft _____in. Weight: _____

Primary Diagnosis(s): _____

_____

Secondary Diagnosis(s): _____

_____

Allergies: ☐ **None** or list **Known Allergies:** _____

Diet: ☐ Regular ☐ No Added Salt ☐ No Concentrated Sweets ☐ Other: _____

Immunizations: ☐ Influenza (Date_____) ☐ Pneumococcal Vaccine (Date_____)

TB SCREENING *(performed* ***within 30 days prior to initial admission*** *unless medically contraindicated)*

☐**Test is contraindicated** **Test:** ☐ TST1 ☐ TST2 ☐TB Blood Test (Type)_____ Date_____ Result_____

TST1: Date placed_____ Date Read_____ mm_____ TST2: Date placed_____ Date Read_____ mm_____

Based on my findings and on my knowledge of this patient, I find that the patient _____ **IS** _____ **IS NOT** exhibiting signs or symptoms suggestive of communicable disease that could be transmitted through casual contact.

CONTINENCE

Bladder: Yes ☐ No ☐ If no, is incontinence managed? Yes ☐ No ☐
Bowel: Yes ☐ No ☐ If no, is incontinence managed? Yes ☐ No ☐

If no, recommendations for management:_____

LABORATORY SERVICES: ☐None

Lab Test	Reason/Frequency	Lab Test	Reason/Frequency
_____	_____	_____	_____
_____	_____	_____	_____

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

Patient/Resident Name: _____ Date: _____

ACTIVITIES OF DAILY LIVING (ADL's)

Activity Restrictions: No ☐ Yes ☐ (describe):_____

Dependent on Medical Equipment: No ☐ Yes ☐ (describe):_____

Level and frequency of assistance required/needed by the resident of another person to perform the following:

1. Ambulate: Independent ☐ Intermittent ☐ Continual ☐
2. Transfer: Independent ☐ Intermittent ☐ Continual ☐
3. Feeding: Independent ☐ Intermittent ☐ Continual ☐
4. Manage Medical Equipment: Manages Independently ☐ Cannot Manage Independently ☐

ADDITIONAL SERVICES IF INDICATED BY RESIDENT NEED:

Pertinent medical/mental findings requiring follow-up by facility (e.g. skin conditions/acute or chronic pain issues) or any additional recommendations for follow-up: None ☐ or if yes, describe_____

Therapies: ☐ None ☐Yes (specify): ☐ Physical Therapy ☐Speech Therapy ☐Occupational Therapy

Home Care: ☐ None ☐Yes (specify):_____ Other (Specify):_____

Is Palliative Care Appropriate/Recommended: ☐No ☐ If yes, describe services: _____

COGNITIVE IMPAIRMENT/MEMORY LOSS (including dementia)

Does the patient have/show signs of dementia or other cognitive impairment? ☐ No ☐ Yes

If yes, do you recommended testing be performed? ☐ No ☐ If yes, referral to:_____

If testing has already been performed, date/place of testing if known:_____

MENTAL HEALTH ASSESSMENT (non-dementia)

Does the patient have a history of or a current mental disability? ☐ No ☐ Yes
Has the patient ever been hospitalized for a mental health condition? ☐ No ☐ Yes

If yes, describe: _____

Based on your examination, would you recommend the patient seek a mental health evaluation? (If yes, provide referral)
☐No ☐Yes Describe: _____

MEDICATIONS

Pursuant to NYCRR Title 18 487.7(f)(2), the patient is **NOT** capable of self-administration of medication if he/she needs assistance to properly carry out **ONE OR MORE** of the following tasks:

- ■ Correctly read the label on a medication container
- ■ Correctly ingest, inject or apply the medication
- ■ Open the container
- ■ Safely store the medication
- ■ Correctly follow instructions as the route, time dosage and frequency
- ■ Measure or prepare medications, including mixing, shaking and filling syringes
- ■ Correctly interpret the label

New York State Department of Health
Division of Assisted Living

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

Patient/Resident Name: _____ **Date:** _____

Resident will receive assistance with <u>all</u> medications <u>unless</u> physician indicates that resident is capable of self-administration.

1. Does the patient/resident require assistance with medications (see criteria on page 2)? Yes ☐ No ☐
2. List all prescription, OTC medications, supplements and vitamins. Attach additional sheets if necessary or attach current discharge note, signed by the physician, listing ALL medications.

Medication	Dosage	Type	Frequency	Route	Diagnosis/Indication	Prescriber (name of MD/NP)

STATEMENT OF PURPOSE

Adult Homes (AH), Enriched Housing Programs (EHP), Residences for Adults (RFA), Assisted Living Residences (ALR), Enhanced Assisted Living Residences (EALR) and Special Needs Assisted Living Residences (SNALR):

- provide 24-hour residential care for dependent adults
- are not medical facilities
- are not appropriate for persons in need of constant medical care and medical supervision and these persons should not be admitted or retained in these settings because the facility lacks the staff and expertise to provide needed services.
- Persons who, by reason of age and/or physical and/or mental limitations who are in need of assistance with activities of daily living, can be cared for in adult residential care settings listed above, or if applicable, an EALR or SNALR.

<u>PHYSICIAN CERTIFICATION</u>

I certify that I have physically examined this patient and have accurately described the individual's medical condition, medication regimen and need for skilled and/or personal care services. Based on this examination and my knowledge of the patient, this individual (see Statement of Purpose):

☐**Yes** ☐ **No** **Is** mentally **suited** for care in an Adult Home/Enriched Housing Program/Assisted Living Residence/ Enhanced Assisted Living Residence (EALR)/Special Needs Assisted Living Residence (SNALR).

☐**Yes** ☐ **No** **Is** medically **suited** for care in an Adult Home or Enriched Housing Program/Assisted Living Residence / Enhanced Assisted Living Residence (EALR)/Special Needs Assisted Living Residence (SNALR).

☐**Yes** ☐ **No** **Is not** in need of continual acute or long term medical or nursing care, including 24-hour skilled nursing care or supervision, which would require placement in a hospital or nursing home.

Name/Title of individual completing form: _____ **Date:** _____

Physician Signature: _____ **Date** _____

The Massry Residence
Gracious Assisted Living
Daughters of Sarah

Resident Diagnoses and Allergies

Resident Name: _____ Date: _____

Apartment Number: _____ Physician: _____

Allergies: _____

_____

Diagnoses:

Date	Diagnosis

Reviewed by: _____ **Date:** _____

MD Signature for Approval: _____ **Date:** _____

DEV – 11/08 – PJR
RES – 12/08 - PJR

The Massry Residence
Gracious Assisted Living
Daughters of Sarah

EQUIPMENT STATEMENT

Dear Doctor: _____:

_____, a resident at The Massry Residence, needs the following equipment for health reasons:

_____ Lift Chair

_____ Lift bed without bedrails

_____ Oxygen Enricher - _____ Liters per minute

_____ Oxygen Concentrator - _____ Liters per minute

_____ Oxygen (pressurized) _____ Liters per minute via _____

Other (please specify): _____

He/She is:

[ ] able to use and maintain the equipment without staff supervision

Physician to Complete:
Additional Orders/Comments related to Use of Equipment:

_____
_____
_____
_____
_____
_____

_____ _____
Physician Signature Date

The Massry Residence
Gracious Assisted Living
Daughters of Sarah

The Massry Residence

Equipment Statement

_____, a resident at The Massry Residence would like to have the following equipment in his/her kitchen:

_____Microwave oven

_____Toaster

_____Coffee Pot

_____Electric Tea Pot

_____He/she is able to use and maintain the equipment without staff supervision.

_____ _____

Signature Date

The Massry Residence
Gracious Assisted Living
Daughters of Sarah

Dear Doctor

To comply with New York State Department of Health regulations, the Massry will honor the following diet orders:

Regular
Regular with half portions of dessert

The following definitions will apply:

REGULAR: Diet includes a wide variety of foods to meet requirements of healthy adults. Used to promote health and reduce the risks of developing major, chronic or nutrition-related disease.

REGULAR WITH HALF PORTIONS OF DESSERT: Regular diet with half portions of the dessert to assist with blood glucose and weight management.

The dining services department will assist residents in meal planning and will make accommodations to individual needs as able. Staff members are alerted to diet restrictions/needs by the use of the "I'm OK" list which has each resident's individual needs listed. This is updated monthly and as needed. Compliance to diet orders is encouraged while respecting individual rights and preferences. **(It is ultimately the resident's choice to follow any restrictions. If a resident consistently is noted to be noncompliant, the dining services supervisor will be notified so that nursing can notify physician and arrange nutritional consult).**

To assist residents with individual needs and preferences, there are low calorie, low sugar items available daily and are posted on menus. Low calorie and low sugar condiments as well as sugar and salt alternatives are available upon request.

Menus are reviewed at least monthly by the Director of Dining Services and Registered Dietitian.

Thank you,

Wellness Departmentt

The Massry Residence
Gracious Assisted Living
Daughters of Sarah

Resident Name_____ Date of Birth_____

In order to maintain compliance with facility policy on diet orders, please sign and return with the proper diet checked.

( ) REGULAR: Diet includes a wide variety of foods to meet requirements of healthy adults. Used to promote health and reduce the risks of developing major, chronic or nutrition-related disease.

( ) REGULAR WITH HALF PORTIONS OF DESSERT: Regular diet with half portions of dessert with blood glucose and weight management.

COMMENTS/CONCERNS: _____

_____

_____

_____

Physician Signature: _____

Date: _____

The Massry Residence
Gracious Assisted Living
Daughters of Sarah

Physician PRN Medication Approval Form

Date:_____

According to the New York State Department of Health:
"Any medication, prescription, controlled or over-the-counter may be prescribed as a PRN medication"

However, the prescriber should be made aware that facility staff are **NOT** authorized to determine whether a resident is able to receive PRN medications.

A resident that a PRN medication is appropriate and can be prescribed for is:

A resident who, in the medical opinion of the prescriber, is **capable of determining** his/her won need for the prescribed medication.

The order must be specific as to why the medication is ordered (e.g. Tylenol for pain and it must include the dosage and the frequency).

Name of Resident: _____

I believe that this resident is capable of determining the need for PRN medications including:

Correctly read the label on the medication container; correctly interpret the label; correctly ingest, inject, or apply the medication; correctly follow directions as to the route, time, dosage and frequency; open the container; and measure or prepare medication; including mixing, shaking, safely store medication and filling syringes.

PRN Medication Only (Prescriptions still need to be written)

Medication	Dosage	Frequency	Method	Reason

NOTE: All information must be entered in order to be in compliance with DOH regulations.

Signature of the Prescriber: _____
Print Name and Address: _____

_____

License Number: _____

The Massry Residence
Gracious Assisted Living
Daughters of Sarah

Immunization Record

Name	DOB	Admission Date	Physician

Mantoux – TB Test	Admission Step 1	Admission Step 2
Date Placed		
Date Read		
Results in mm		

Influenza Vaccine					
Date given					

Pneumococcal Vaccine						
Date	Res age @ time of vaccination					

COVID-19 Vaccine	Product Name/ Manufacturer	Date	Location		
1ST Dose					
2nd Dose					

Comments: _____

_____

The Massry Residence
Gracious Assisted Living
Daughters of Sarah

Date: _____

RE:

Dear Doctor,

Please sign the statement below attesting the ability that the named resident being seen in your office can safely consume meals without continuous supervision.

If you have any questions please feel free to contact the Wellness Office at (518) 724-3485. Please fax back the signed copy to 724-3497. Thank you.

This is a statement attesting to the ability that _____ can safely consume meals without continuous supervision.

_____ _____

Physician Signature Date

Daughters of Sarah
Community for Seniors
182 Washington Ave Ext., Albany, NY 12203 I ph: 518.689.0453 I fx:518.689.0454
daughtersofsarah.org

New York State Department of Health
Adult Care Facility Mental Health Evaluation

Directions

In accordance with 18 NYCRR § 487.4(i) and § 488.4(e)(3), each mental health evaluation shall be a written and signed report from a psychiatrist or other licensed physician, a nurse practitioner or other registered nurse, a certified psychologist, or a certified social worker who has experience in the assessment and treatment of mental illness. This form must be completed prior to admission for any proposed adult care facility resident who has a known history of chronic mental disability or for whom the medical evaluation or resident interview suggests such disability; for annual evaluations thereafter; and for any change in condition of a resident that would warrant such evaluation.

I. Identifying Data

Individual's Name (Print Name) _____ Date of Birth _____

Current Address _____ Phone Number _____

II. Type/Date of Evaluation (check one):

- ☐ An initial evaluation conducted prior to a prospective resident's admission
- ☐ An annual evaluation conducted each year following a resident's admission
- ☐ An evaluation following a resident's change in condition

III. Serious Mental Illness

A person with serious mental illness means an individual who meets criteria established by the Commissioner of Mental Health, which shall be persons: (1) who have a diagnosis of mental illness designated under the Diagnostic and Statistical Manual of Mental Disorders (excluding neurocognitive, substance use, and neurodevelopmental disorders); and (2) whose severity and duration of mental illness results in substantial functional disability. See 18 NYCRR § 487.2(c).

A. Diagnosis of Mental Illness

1. Based upon your examination and/or review of available records, conducted within the scope of your professional practice, does this person have a diagnosis or diagnoses of mental illness designated under the Diagnostic and Statistical Manual of Mental Disorders?

☐ Yes ☐ No

2. If your answer to Question #1 above is "Yes," list the diagnosis or diagnoses:

_____

_____

_____

_____

3. If your answer to Question # 1 above is "Yes," explain whether this conclusion is based on:

- ☐ Yes ☐ No Your examination
- ☐ Yes ☐ No A review of records
- ☐ Yes ☐ No Both your examination and a review of records

4. If your answer to Question # 3(b) or (c) is yes, identify the records reviewed:

_____

_____

_____

_____

New York State Department of Health
Adult Care Facility Mental Health Evaluation

B. Substantial Functional Disability

1. Does the individual meet ALL THREE of the following?

☐ Yes ☐ No ☐ Unknown • The individual is less than 65 years old; and

☐ Yes ☐ No ☐ Unknown • The individual is a recipient of Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)

***If yes, is the SSI or SSDI due to mental illness (excluding neurocognitive, substance use, and neurodevelopmental disorders);* and

☐ Yes ☐ No ☐ Unknown

☐ Yes ☐ No ☐ Unknown • During the year preceding the date of this report, the individual received one or more services from a provider licensed by the New York State Office of Mental Health (OMH) under Article 31 of the Mental Hygiene Law.

2. Does the individual meet BOTH of the following?

☐ Yes ☐ No ☐ Unknown • The individual is NOT a recipient of SSI; and

• During the year preceding the date of this report, the individual received three or more months of Health Home services, Assertive Community Treatment (ACT) services, or Personalized Recovery Oriented Services (PROS) services.

3. Does the individual meet EITHER of the following?

☐ Yes ☐ No ☐ Unknown • During the three years preceding the date of this report, the individual had three or more psychiatric inpatient admissions; or

• During the three years preceding the date of this report, the individual had more than 30 days of psychiatric inpatient services (regardless of number of hospitalizations).

4. During the year preceding the date of this report, was the individual discharged from an OMH Psychiatric Center after an inpatient stay that lasted 60 days or more?

☐ Yes ☐ No ☐ Unknown

5. At any point during the five years preceding the date of this report, did the individual have a current or expired Assisted Outpatient Treatment (AOT) order?

☐ Yes ☐ No ☐ Unknown

6. During the five years preceding the date of this report, was the individual discharged from a correctional facility with a history of inpatient or outpatient behavioral health treatment?

☐ Yes ☐ No ☐ Unknown

7. At any point during the three years preceding this report, was the individual a resident in OMH-funded housing for persons with mental illness?

☐ Yes ☐ No ☐ Unknown

8. a. If you checked "Yes" to Question # 1, 2, 3, 4, 5, 6 or 7, then the individual should be considered to have a substantial functional disability as a result of mental illness (check "Yes" below), unless there is some information obtained from your face-to-face examination or your review of records that indicates the individual currently does not have a substantial functional disability (check "No" below).

☐ Yes ☐ No

If you have checked no, explain the basis of your finding.

_____

_____

_____

New York State Department of Health
Adult Care Facility Mental Health Evaluation

b. If you checked "No" for all seven questions (Question # 1, 2, 3, 4, 5, 6 and 7), state whether the individual has a substantial functional disability as a result of mental illness and explain the basis for this conclusion.

☐ Yes ☐ No

Explain your finding:

_____

_____

_____

IV. Current Psychiatric Status and Substance Use Disorder Treatment

Is the individual currently hospitalized? ☐ Yes ☐ No

If yes, name of facility _____ Admission Date ____/____/____

Reason for Admission _____

Clinical Course _____

Describe any functional impairment _____

V. Psychiatric, Substance Abuse and Treatment History

Psychiatric Diagnosis: List primary diagnosis first followed by remaining disorders in order of focus and attention and treatment.

Primary Diagnosis: _____

Other Diagnosis: _____

Other Diagnosis: _____

Other Diagnosis: _____

Other Diagnosis: _____

Include onset of illness, in-patient and outpatient treatment, history of suicidal/homicidal behavior or ideation, violence, criminal activity and substance use:

_____

_____

_____

Date and location of last in-patient psychiatric hospitalization (if applicable): ____/____/____

VI. Mental Status Exam

Describe the individual in terms of the following characteristics:

Appearance _____

Orientation _____

Speech _____

New York State Department of Health
Adult Care Facility Mental Health Evaluation

VI. Mental Status Exam (continued)

Affect _____

Memory _____

Intelligence _____

Cognition _____

Perception _____

Suicidal/Homicidal (Ideation & Potential) _____

Judgment _____

Insight _____

Impulse Control _____

VII. Summary of Current Medication Regimen and Adherence

1. Describe current treatment plan and medication, including the individual's current adherence to medication, based on records reviewed:

_____

_____

2. Describe the frequency of treatment sessions such as therapy or counseling:

_____

_____

VIII. Determination (check one):

☐ The individual's mental health needs can be adequately met in an Adult Care Facility and the individual does not evidence need for placement in a residential treatment facility licensed or operated pursuant to Article 19, 23, 29, or 31 of the Mental Hygiene Law.

☐ The individual is mentally unsuited for an adult care facility due to the following:

_____

_____

_____

IX. Attestation by Practitioner

I, the undersigned, attest to the fact that I have conducted a face-to-face examination of the above mentioned individual on ____/____/_____ (enter date of face-to-face examination) and that such face-to-face examination, if conducted for an annual evaluation or due to a change in condition, was conducted no more than 30 days prior to the date of this report, which is set forth below. I further attest that the contents of this report are true and accurate to the best of my knowledge.

_____

Practitioner's Name (printed):

_____

Practitioner's Signature:

_____

New York State Department of Health
Adult Care Facility Mental Health Evaluation

IX. Attestation by Practitioner (continued)

Title: _____ NYS License #: _____

Employer: _____

Employment Address: _____

Telephone Number: _____

Email Address: _____

Date of Report: ____/____/____

X. Attestation by Adult Care Facility for Initial Evaluations

Directions: This section must be signed by the Adult Care Facility operator, approved administrator, or case manager.

I, the undersigned, attest that I have reviewed the information in Sections I through IX completed by the practitioner whose signature appears in Section IX above. If conducted for the purpose of an initial evaluation, I attest that the date of the face-to-face examination conducted by the practitioner whose signature appears in Section IX above occurred no more than 30 days prior to the resident's admission, which occurred on ____/____/____ (enter date on which resident was admitted).

If the examination was conducted for the purpose of an initial evaluation, I attest to my understanding that the practitioner has determined that (check one as applicable):

☐ The individual is a person with serious mental illness because the practitioner determined that the individual has both a diagnosis or diagnoses of mental illness and a substantial functional disability as a result of mental illness.

☐ The individual is not a person with serious mental illness because the practitioner did not determine that the individual has both a diagnosis or diagnoses of mental illness and a substantial functional disability as a result of mental illness.

Name (printed): _____

Signature: _____

Title: _____

Adult Care Facility: _____

Telephone Number: _____

Email Address: _____

Date Signed: ____/____/____