

APD & MHA RESIDENT SCREENING SHEET

MCAR 023-080-200 through 023-080-225: To be completed *by the operator before you accept the resident into your home* by interviewing the resident in person, and by interviewing the resident's family, caregivers, case manager, and attending medical personnel. Upon completion of the form, and if the resident is admitted, a copy shall be given to the resident, their legal representative, and a copy shall be placed in the resident record.

Resident Information:

Date of screening:	Date of admission:	<input type="checkbox"/> Initial screening <input type="checkbox"/> Readmission
Resident's name:	Date of birth:	Legal Guardian's Name:
Resident's Primary Contact Person:	Primary contact's relationship:	Primary contact's phone:
Other people important to resident (names & phone numbers)		

Current situation:

Current living situation:	<input type="checkbox"/> nursing home	<input type="checkbox"/> ACH	<input type="checkbox"/> own home	<input type="checkbox"/> with family
Other facility name:	Care facility contact person:	Phone number:		
How long in current situation:	Phone number:			
Why is resident leaving living situation?				

Moving & belongings:

Who will move the resident into the AFH?
Will the resident be bringing in their own furniture and belongings?
Will all these items fit in the room?

Resident history:

Comments:

Does the resident have a criminal history?	<input type="checkbox"/> no	<input type="checkbox"/> yes	
Is the resident a registered sex offender?	<input type="checkbox"/> no	<input type="checkbox"/> yes	
Difficulties/behavioral problems in other placements?	<input type="checkbox"/> no	<input type="checkbox"/> yes	
Does the resident have a good payment history?	<input type="checkbox"/> no	<input type="checkbox"/> yes	
How many times has the resident moved in the last 5 years?			

Medical:

Do you have a release of information signed by the resident? <input type="checkbox"/> yes <input type="checkbox"/> no	
Primary Care Provider:	Primary Care Phone Number:
Specialist:	Specialist Phone Number:
Why is specialist needed?	

Benefits & services:

<input type="checkbox"/> Medicare #:	<input type="checkbox"/> Medicaid #:
<input type="checkbox"/> VA #:	<input type="checkbox"/> Providence Elderplace:
<input type="checkbox"/> Home Health Agency:	Phone:
<input type="checkbox"/> Other Contact:	Will they remain involved? <input type="checkbox"/> yes <input type="checkbox"/> no
Services:	
Funeral plan? <input type="checkbox"/> yes <input type="checkbox"/> no Funeral home:	

Consultation with additional sources: *Remember, it is important to use all resources when evaluating a new resident.* I have consulted with the following sources in making a decision about whether or not to accept this resident into my home.

<input type="checkbox"/> Face to face meeting with the resident	Date:	Where:
<input type="checkbox"/> Reviewed residency agreement and policies on pets, smoking, alcohol, medical/recreational marijuana, intercoms and monitors, limitations on advanced directives, & conscientious objections		
<input type="checkbox"/> Discussion with case manager	Date:	Name:
<input type="checkbox"/> Discussion with hospital discharge planner	Date:	Name:
<input type="checkbox"/> Meeting with family members/legal representatives	Date:	Name:
<input type="checkbox"/> Reviewed SDS001 assessment/care plan form (available through resident's case manager)		
<input type="checkbox"/> Discussion with current provider (ACH, ALF, RCF, Nursing facility)	Date:	
<input type="checkbox"/> Reviewed RN notes/history and physical forms from current facility, if available		
<input type="checkbox"/> PASR II (Available from case manager for Nursing Facility residents with MH/behavior history)		
<input type="checkbox"/> Other:		

Medical diagnoses: *Pay close attention to the following diagnoses which range from mild to severe and can require complex medical management: Diabetes, Heart Disease, Parkinson's, Traumatic Brain Injury, Huntington's, Multiple Sclerosis, Dementia, Alzheimer's, Stroke*

List all diagnoses:
Other medical/physical problems:
Describe resident's mental condition/needs:
Describe resident's substance abuse/addiction needs:
Describe any behaviors:
Are there any behaviors that would endanger the health or safety of any occupants or visitors in the home? <input type="checkbox"/> yes <input type="checkbox"/> no Explain:

Resident's ability to communicate

<input type="checkbox"/> speak	<input type="checkbox"/> write	<input type="checkbox"/> cue	<input type="checkbox"/> sign language	<input type="checkbox"/> Non-verbal	<input type="checkbox"/> Speaks English
<input type="checkbox"/> Other:			<input type="checkbox"/> Primary Language:		
Hearing needs: <input type="checkbox"/> yes <input type="checkbox"/> no		Specify:			
Vision needs: <input type="checkbox"/> yes <input type="checkbox"/> no		Specify:			

Night needs: wanders cueing toileting medication repositioning
 other: _____

Medications: insulin Coumadin medical marijuana controlled substances PRN's
List all others: _____

Current pharmacy: _____

Delivery and payment arrangements for meds: _____

Does resident self-administer any meds, treatments, or skilled tasks? (doctor's order required)
 no yes list: _____

Do any tasks require delegation? no yes specify tasks: _____

Which RN will I contact for consultations and delegations? _____

RN who will delegate: _____

RN consultation tasks: _____

Special medical instructions or health care directives: _____

Does the resident have any allergies? no yes If yes, what is the resident allergic to?
 medications (list) _____
 foods (list) _____
 chemicals/perfumes (list) _____
 pets: specify which: _____
 other: _____

Medical equipment /supplies resident has and uses (H) or needs (N):
 Incontinency supplies – type: _____
 Pressure relief devices – type: _____
 bed pan commode urinal crutches cane walker wheelchair power chair
 oxygen trapeze hospital bed protective pads other: _____
Medical equipment supplier(s): _____
Delivery and payment arrangements for supplies: _____

Transportation needs: Public transit family cab medical transport Tri-Met Lift
other: _____ Who will be responsible for setting up transportation? _____

Financial: Medicaid Private Pay Who manages the resident's PIF? _____
Who will be responsible for making payment to the ACH operator? _____

Dietary Needs: diabetic low sodium lactose intolerant low sugar renal low fat
 vegetarian vegan gluten free kosher food allergies: _____
other: _____

Personal & life style preferences: sleeps late stays up late early riser prefers privacy
 smoker very social enjoys alcohol other: _____

Personal preferences for activities: gardening attends job arts enjoys music
 reads cooking/baking crafts attends church wants to be out in the community
 attends day program plays musical instrument /sings enjoys outings cards/board games
other: _____

Does resident have a pet to bring? no yes Is resident able to care for the pet? no yes
Are pet vaccinations current? no yes Who will pay for food, supplies, vet? _____
other: _____

Evacuation: Can be evacuated, along with other residents, in 3 minutes or less: no yes
 Evacuation needs: cueing wheelchair transfer walker Other: _____

ACHP Classification Level Worksheet for Adult Care Home Operators

Resident's Name: _____

Definition	Independent	Assist	Full Assist
<p>Eating Feeding and eating; may include using assistive devices.</p>	<p>Needs no assistance</p> <p>Considered independent even if set-up, cutting up food, or special diet needed.</p> <p><input type="checkbox"/></p>	<p>Requires another person to be immediately available and within sight. Requires hands-on feeding or assistance with special utensils, cueing while eating, or monitoring to prevent choking or aspiration.</p> <p><input type="checkbox"/></p>	<p>Requires one-on-one assist for direct feeding, constant cueing, or to prevent choking or aspiration. Includes nutritional IV or feeding tube set-up by another person. <i>Needs assistance through all phases, every time.</i></p> <p><input type="checkbox"/></p>
<p>Dressing and Grooming Dressing and undressing; grooming includes nail care, brushing and combing hair.</p>	<p>Needs no assistance</p> <p><input type="checkbox"/></p>	<p>Needs minimal assistance:</p> <p>Needs assist in dressing, or full assist in grooming (cannot perform any task of grooming without the assistance of another person.)</p> <p><input type="checkbox"/></p>	<p>Unable to do any activity</p> <p>Needs full assist in dressing. (cannot perform any task of dressing without the assistance of another person.)</p> <p><input type="checkbox"/></p>
<p>Bathing/Personal Hygiene Bathing includes washing hair, and getting in and out of tub or shower. Personal hygiene includes shaving, and caring for the mouth.</p>	<p>Needs no assistance</p> <p>Unable to do Any Activity</p> <p><input type="checkbox"/></p>	<p>Needs minimal assistance:</p> <p>Requires assist in bathing, or full assist in hygiene. (needs hands-on assist through all phases of hygiene, every time, even with assistive devices.)</p> <p><input type="checkbox"/></p>	<p>Unable to do any activity</p> <p>Requires full assistance in bathing. (needs hands-on assist through all phases of bathing, every time, even with assistive devices.)</p> <p><input type="checkbox"/></p>

<p>Mobility Includes ambulation and transfer. Does NOT include getting to/from toilet or in/out of shower/tub or motor vehicle.</p>	<p>Needs no assistance</p> <p><input type="checkbox"/></p>	<p>Must require assistance of another person with ambulation, OR with transfers, OR with both.</p> <p><input type="checkbox"/></p>	<p>Must need full assist with mobility OR with transfers OR both. Unable to ambulate or transfer without the assistance of another person throughout the activity, every time, even with assistive devices.</p> <p><input type="checkbox"/></p>
<p>Elimination Toileting, bowel & bladder management includes getting on/off toilet, cleansing after elimination, and clothing adjustment; catheter and ostomy care, toileting schedule, changing incontinence supplies, digital stimulation.</p>	<p>Needs no assistance. Continent, or manages own incontinence.</p> <p><input type="checkbox"/></p>	<p>Requires assist with bladder care OR bowel care OR toileting. Even with assistive devices, the individual is unable to accomplish some tasks of bladder care, bowel care, or toileting without the assistance of another person.</p> <p><input type="checkbox"/></p>	<p>Requires full assist with bladder care OR bowel care OR toileting. Full assist means that the individual is unable to accomplish any part of the task and assistance of another person is required throughout the activity, every time.</p> <p><input type="checkbox"/></p>
<p>Cognition/Behavior (8 components: Functions of the brain: adaptation, awareness, judgment/decision-making, memory, orientation. Behavioral symptoms: demands on others, danger to self, wandering)</p>	<p>Needs no assistance</p> <p><input type="checkbox"/></p>	<p>Needs assist in at least 3 of the 8 components of cognition and behavior.</p> <p>Assist implies that the need is less than daily.</p> <p><input type="checkbox"/></p>	<p>Needs full assist in at least 3 of the 8 components of cognition and behavior.</p> <p>Full assist implies that the need is ongoing and daily. The level of impairment must be severe.</p> <p><input type="checkbox"/></p>

Independent

Assist

Full Assist

Total: _____

- Class I = Assist with 4 or fewer ADL
- Class II = Assist with all ADL, full assist in no more than 3.
- Class III = Full assist (dependent) with 4 or more ADL.

After reviewing each category above, determine classification level of this resident.

Class Level: _____

RN or Physician responsible for monitoring client care in the home:

Name: _____ Phone: _____

Frequency of visits: _____

Case manager has approved this placement _____

Determination:

After taking everything listed above into consideration:

I have determined that this resident's needs are within the classification of this adult care home and that I can meet the needs of this resident.

I have determined that I cannot meet the needs of this resident and I am unable to accept placement.

I have determined that the resident's needs are outside of the classification of this adult care home. But that I can meet there needs, and I have requested an exception to serve the resident.

I have determined that I could meet this resident's needs with these additional resources (equipment, training, additional staffing, environmental modifications) and I have requested these resources:

If declining placement, please explain why:

Signature of operator: _____ Date: _____

Signature of Resident or Resident Representative acknowledging receipt of a copy of this screening.

Resident/Resident's Representative _____ Date: _____

Resident or Resident's Representative: If you disagree with the screening determination, you may request an administrative conference by contacting the Adult Care Home Program by phone at **503-988-3000**, by email at advsd.adult.carehomeprogram@multco.us, or by mail at 209 SW 4th Avenue Suite 650, Portland OR 97204.