ASSESSMENT PLAN FOR AFC RESIDENTS

Michigan Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems

INSTRUCTIONS:

1. A written assessment plan is required. The licensee is responsible for assuring that a written assessment plan is completed.
2. This form has been approved by the Department of Licensing and Regulatory Affairs and contains the information required by administrative rule and Section 3 (9) of.1979 P.A. 218.
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.
4. Use additional sheets if necessary and **PRINT CLEARLY.**

Name of Resident	Name of Designated Representative (if applicable)	Date of Birth	Sex ☐ M ☐ F

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

	Yes	No	IF NO, Describe Needs and How They Will Be Met
A. Moves Independently in Community	☐	☐	
B. Communicates Needs	☐	☐	
C. Understands Verbal Communication	☐	☐	
D. Alert to Surroundings	☐	☐	
E. Reads and Writes	☐	☐	
F. Tells Time	☐	☐	
G. Manages Money	☐	☐	
H. Follows Instructions	☐	☐	
I. Controls Aggressive Behavior	☐	☐	
J. Controls Sexual Behavior	☐	☐	
K. Gets Along With Others	☐	☐	
L. Exhibits Self Injurious Behavior	☐	☐	
M. Participants in Social Activities	☐	☐	
N. Smokes	☐	☐	
O. Appropriately Uses Alcohol/Drugs	☐	☐	

See Page 4 for Non-discrimination and ADA statement

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II. SELF CARE SKILL ASSESSMENT **PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)**

	Needs Help		IF YES, Describe Needs and How The Will Be Met
	Yes	No	
A. Eating/Feeding	☐	☐	
B. Toileting	☐	☐	
C. Bathing	☐	☐	
D. Grooming (hair care, teeth, nails, etc.)	☐	☐	
E. Dressing	☐	☐	
F. Personal Hygiene	☐	☐	
G. Walking/Mobility	☐	☐	
H. Stair climbing	☐	☐	
I. Use of Prosthesis (Dentures, Artificial limbs, etc.)	☐	☐	
J. Use of Assistive Devices (explain)	☐	☐	
K. Other (explain)	☐	☐	

III. HEALTH CARE ASSESSMENT **PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)**

	Yes	No	IF YES, Describe Needs and How They Will Be Met
A. Taking medication	☐	☐	
B. Special Diets	☐	☐	
C. Physical Limitations	☐	☐	
D. Special Equipment Used (Wheel chair, Walker, Cane, etc.)	☐	☐	
E. Other Difficulties (Vision, Weight, Allergies, etc.)	☐	☐	
F. Susceptible to Hypothermia or Hyperthermia	☐	☐	

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IV. SOCIAL AND PROGRAM ACTIVITIES PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)

	Yes	No	Explain How These Activities Will Be Provided or Encouraged
A. Participates in Religious Practice	☐	☐	
B. Participates in Household Chores	☐	☐	
C. Adult Activity Program	☐	☐	
D. Senior Center	☐	☐	
E. Workshop or job	☐	☐	
F. School	☐	☐	
G. Hobbies/Special Interest	☐	☐	
H. Recreation	☐	☐	
I. Physical Exercise	☐	☐	
J. Family/Friends (Please Address Any Applicable Visitation Prohibitions and/or Other Considerations)	☐	☐	
K. Other (explain)	☐	☐	

V. MEDICAL INFORMATION

Name of Primary Physician/Clinic		Telephone Number ( )	
Primary Physician's Complete Address (Street Number and Name)	City	State	Zip Code

V. MEDICATIONS TAKEN AT TIME OF ASSESSMENT

Name of Medication	Who Prescribed	Dosage

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MEDICAL OR DENTAL FOLLOW-UPS NEEDED (i.e., check-ups, regular appointments, 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 Licensing and Regulatory Affairs, Bureau of Community and Health Systems, for the purpose of providing appropriate care to me and determining compliance with licensing rules."	
Signature of Resident or Legal Guardian	Date

VII. OTHER INFORMATION

Comments/Special Instructions

VIII. ASSESSMENT PLAN COMPLETION

Date Assessment Plan Was Completed	Name(s) and Position(s) of Person(s) Who Completed Assessment

IX. PLACEMENT OBJECTIVE

A. ☐ Delay/prevent deterioration and movement to a more restrictive setting.
B. ☐ Encourage movement to a less restrictive setting.

X. SIGNATURES

Signature of Resident or Designated Representative Date	Signature of Licensee Date
Signature of Responsible Agency (if applicable) Date	

AUTHORITY: 1979 P.A. 218 COMPLETION: Voluntary PENALTY: Violation of Administrative Rule and 1979 P.A. 218	LARA is an equal opportunity employer/program.