ALP MEDICAL EVALUATION

Check all that apply: ☐ AH ☐ I	EHP 🗆 ALP 🗆	Initial 🛚 Ru	g Category Change 🔲	12 month ☐ Other				
☐ UAS-NY Summary Report is atta	ached for RUG C	ategory Chang	e, 12 month and other a	assessments				
This form may be used to verify that an ind program or residence for adults. It may also medically eligible to reside in a nursing facility be met in an ALP.	be used to verify the	at an applicant/res	ident of an Assisted Living I	Program (ALP) is				
Resident/Patient Name:	dent/Patient Name: Date of Birth:							
Facility Name: Address:								
Sex: Male Female Weight:			Blood Pressure:					
Primary Diagnosis/Prognosis:								
Secondary Diagnoses/Prognosis:								
Significant medical history & current conditions:			ence: r: Yes No Yes No	Allergies: NKA □				
Needs assistance with self-administration of medications? □Yes □No			Type of Diet: Regular □ NSA □ NCS □ Other: (Explain) □					
List all current medications (prescription and OTC, including dosage, type, frequency and method of administration and note special instructions: (attach additional sheets if necessary signed and dated by Physician)								
MEDICATION	DOSAGE	TYPE	FREQUENCY	METHOD				

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Resident/Pat	ient Nan	ne:					
Is the individual free of communicable disease? Yes No If no, describe:							
Does the individual require supervision and/or assistance by aide with:							
bathing:	□No	If yes, is it?:	intermittent:	constant			
grooming:	□No	If yes, is it?:	intermittent:	constant			
dressing:	□No	If yes, is it?:	intermittent:	constant			
eating:	□No	If yes, is it?:	intermittent:	constant			
transferring:	□No	If yes, is it?:	intermittent:	constant			
ambulation:	□No	If yes, is it?:	intermittent:	constant			
toileting:	□No	If yes, is it?:	intermittent:	constant	□ *Such that it requires toileting program		
24 hours/7 da	ys per wo	eek to maintain c	continence?				
Describe any additional activity restrictions/needs:							
Describe Current Treatment Plan (e.g., nursing, therapies, etc.):							
Is Palliative Care appropriate/recommended?: □Yes □ No If yes, describe services:							
Is the individual's condition stable? □Yes □No If no, describe:							
Cognitive Impairment/Memory Loss (including dementia) Does the individual have/show signs of dementia or other cognitive impairment? □Yes □No If yes, describe: If yes, do you recommend testing be performed? □Yes □No If yes, describe: If testing has already been performed, date/place of testing if known: □							
Mental Health Assessment (non-dementia) Does the individual have a history, current condition or recent hospitalization for mental disability?							
□Yes □No If yes, describe:							
Based on your examination, would you recommend the patient seek a mental health evaluation? (If yes, provide referral?							
Date of Today's Examination Recommended frequency of Medical Exams							
I certify that I have accurately described the individual's medical condition, needs, and regimens, including any medication regimens, and that the individual is medically appropriate to be cared for in an Adult Home, Enriched Housing Program or an ALP.							
Physician Sig	sician Signature (required)				Date		

Date

Nurse Practitioner, Physician or Specialist's Assistant Signature