**ALR Community – Individual/Family Self-Evaluation**

Please print legibly

**Individual’s Name:**   **Age:**

What is your present living arrangement?

What type of assistance do you currently receive?

 Why are you considering a move to an Assisted Living Residence?

How soon would you like to move into an Assisted Living Residence?

**Which areas of assistance would benefit you?**

| **Activity of Daily Living**  |  | **Type of Assistance** |
| --- | --- | --- |
| Taking medicationAny meds taken via injection (shots)? | [ ]  Yes [ ]  No[ ]  Yes [ ]  No |    |
| Preparing meals | [ ]  Yes [ ]  No |   |
| Dressing/Undressing | [ ]  Yes [ ]  No |   |
| Grooming | [ ]  Yes [ ]  No |   |
| Showering/Bathing | [ ]  Yes [ ]  No |   |
| Toileting | [ ]  Yes [ ]  No |   |
| Housekeeping | [ ]  Yes [ ]  No |   |
| Laundry | [ ]  Yes [ ]  No |   |
| Transportation | [ ]  Yes [ ]  No |   |
| Accessing Community | [ ]  Yes [ ]  No |   |
| Community Involvement | [ ]  Yes [ ]  No |   |
| Employment | [ ]  Yes [ ]  No |   |

Individual’s Name: Date of Assessment:

**Physical Health:**

Do you have any significant health concerns?

Do you have diet restrictions? [ ]  Yes [ ]  No

*If yes, please explain*:

Do you have any difficulty swallowing? [ ]  Yes [ ]  No

*If yes, please explain*:

**Mobility:**

Do you utilize any of the following: [ ]  Cane [ ]  Scooter [ ]  Walker [ ]  Wheelchair

Are you able to walk independently 150 feet? [ ]  Yes [ ]  No

Are you able to transfer independently? [ ]  Yes [ ]  No

(e.g., move from bed to standing position or
from chair to standing position)

Are you able to go up and down stairs independently? [ ]  Yes [ ]  No

**Cognition/Mental Health:**

How would you describe your memory? (Check one)

[ ]  **Good** memory for present-day events – no difficulty remembering names, places, or scheduled appointments. Does not become confused in unfamiliar places.

[ ]  **Fair** memory for present-day events – little help required for remembering names or appointments. May become confused in unfamiliar places.

[ ]  **Poor** memory for present-day events – require a lot of reminders with names, scheduling and remembering appointments. Almost always confused in unfamiliar places.

[ ]  **Extremely Poor** memory – does not remember familiar people or names. Others must schedule and supervise appointments. Always confused in unfamiliar places.

[ ]  **History of Hoarding** – select this box if you have a history of hoarding.

Do you experience depression? [ ]  Yes [ ]  No

*If yes, is it*: [ ]  Mild [ ]  Moderate [ ]  Severe

Do you experience anxiety? [ ]  Yes [ ]  No

*If yes, is it*: [ ]  Mild [ ]  Moderate [ ]  Severe

Individual’s Name: Date of Assessment:

Do you take medications for depression or anxiety? [ ]  Yes [ ]  No

Comments regarding depression or anxiety:

Do you have a history of any of the following? [ ]  Suicidal/self-abuse [ ]  Substance abuse

*If yes, please explain*:

**General Information:**

Is anyone assisting you with bill paying or managing your finances? [ ]  Yes [ ]  No

*If yes, please provide name and phone number*: *(If PoA or Conservator, please provide documentation)*

Name: Phone:

Are you receiving any external services such as home care, physical therapy, adult day services, etc.?

Are you currently receiving Medicaid benefits? [ ]  Yes [ ]  No

*If yes, Case Manager name*:

Case management agency:

Contact information:

Do you currently use tobacco? [ ]  Yes [ ]  No

Do you currently use marijuana? [ ]  Yes [ ]  No

Is there any additional information you would like us to know?

Signature of person completing evaluation:

Individual’s Signature: Date: