DSS-4569 (Rev. 9/97)

ASSISTED LIVING PROGRAM INTERIM ASSESSMENT

Name of ALP: _____

CHECK ONE: ____ 45 Days ____ Interim six (6) months

Name: _____ SSA#:_____ CIN#: _____

PRI Score: _____ PRI Date: _____ DOB: _____

New Certification from: _____ to _____
Describe change(s) in resident's health or functional status since last medical evaluation:
(Consider: diagnosis, health, mental health, diet, allergies, functional or behavioral status, need for assistance and related information)

Current Medications: (or see initialed and dated attachment) (Consider changes to medication regimen)

Skilled Professional Services:

Physician:
I have examined the above resident and this evaluation describes the resident's medical condition, needs, and regimens. The resident's condition is stable and the individual is medically appropriate to be cared for in an ALP.

Date of examination: _____

Signature (required): _____ Date: _____

Nurses:
We have reviewed the last full assessment that was completed on _____, as well as all subsequent assessment documentation. We have conducted a reassessment of the resident and agree that the previous assessment reflects the resident's current condition and needs, with the above changes **(if any)**. The resident's health/safety needs require more care and services to meet health or functioning needs than can be provided in an AH or EHP but can safely be provided in an ALP. If no, specify the reason and indicate appropriate level of care.
_____
_____
_____

Signature: _____ Date: _____
(CHHA/LTHHCP RN)

Signature: _____ Date: _____
(ALP RN)