

**MINIMUM DATA SET (MDS)<sup>®</sup>**  
**ASSISTED LIVING SERVICES (ALS)**

FACE SHEET: BACKGROUND INFORMATION ONLY AT ADMISSION

**SECTION AA. IDENTIFICATION INFORMATION**

1. RESIDENT NAME	_____ a. (First)      b. (Middle Initial)      c. (Last)      d. (Jr/Sr)			
2. GENDER	<input type="checkbox"/> 1. Male	<input type="checkbox"/> 2. Female		
3. BIRTHDATE	<input type="text"/>	-	<input type="text"/>	- <input type="text"/>
	Month	Day	Year	
4. RACE/ ETHNICITY (Check only one.)	<input type="checkbox"/> 1. American Indian/Alaskan Native <input type="checkbox"/> 4. Hispanic <input type="checkbox"/> 2. Asian/Pacific Islander <input type="checkbox"/> 5. White, not of Hispanic origin <input type="checkbox"/> 3. Black, not of Hispanic origin <input type="checkbox"/> 6. Other			
5. SOCIAL SECURITY and MEDICARE NUMBERS (C in 1 <sup>st</sup> box if no med. no.)	a. Social Security Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
	b. Medicare number (or comparable railroad insurance number) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
6. FACILITY NAME AND PROVIDER NO.	a. Facility Name _____ b. Provider No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
7. MAINECARE NO.	[Record a "+" if pending, "N" if not a MaineCare recipient] <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			

**SECTION AB. DEMOGRAPHIC INFORMATION**

1. DATE OF ENTRY	Date the stay began. (Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date.) <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
	Month	Day	Year	
2. ADMITTED FROM (AT ENTRY) (Check only one.)	<input type="checkbox"/> 1. Private home/apt. <input type="checkbox"/> 2. Other board and care/assisted living/group home <input type="checkbox"/> 3. Nursing home <input type="checkbox"/> 4. Acute care hospital <input type="checkbox"/> 5. Psychiatric hospital <input type="checkbox"/> 6. MR/DD facility <input type="checkbox"/> 7. Rehabilitation hospital <input type="checkbox"/> 8. Other (specify) _____			
3. LIVED ALONE (PRIOR TO ENTRY) (Check only one.)	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. In other facility			
4. PRIOR PRIMARY RESIDENCE	Provide town, state, zip code for Resident's primary residence prior to admission _____      _____ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
	Town	State	Zip Code	
5. RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above) <input type="checkbox"/> a. Prior stay at this home <input type="checkbox"/> b. Nursing home <input type="checkbox"/> c. Other residential facility—board and care home, assisted living, group home <input type="checkbox"/> d. MH/psychiatric hospital <input type="checkbox"/> e. MR/DD facility <input type="checkbox"/> f. NONE OF ABOVE			
6. LIFETIME OCCUPATION	Put a "/" between two occupations. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			

7. EDUCATION (Highest Level Completed) (Check only one.)	<input type="checkbox"/> 1. No schooling <input type="checkbox"/> 5. Technical or trade school <input type="checkbox"/> 2. 8th grade or less <input type="checkbox"/> 6. Some college <input type="checkbox"/> 3. 9–11 grades <input type="checkbox"/> 7. Bachelor's degree <input type="checkbox"/> 4. High school <input type="checkbox"/> 8. Graduate degree			
8. PRIMARY LANGUAGE (Check only one.)	<input type="checkbox"/> 0. English <input type="checkbox"/> 2. French <input type="checkbox"/> 1. Spanish <input type="checkbox"/> 3. Other (specify) _____			
9. MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of the following? a. Mental retardation <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes b. Mental illness <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes c. Developmental disability <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes			
10. CONDITIONS RELATED TO MR/DD STATUS	(Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely) <input type="checkbox"/> a. Not applicable—no MR/DD (Skip to AB11) <b>MR/DD with organic condition</b> <input type="checkbox"/> b. Down's syndrome <input type="checkbox"/> e. Cerebral palsy <input type="checkbox"/> c. Autism <input type="checkbox"/> f. Other organic condition related to MR/DD <input type="checkbox"/> d. Epilepsy <input type="checkbox"/> g. MR/DD with no organic condition			
11. ALZHEIMER DEMENTIA HISTORY	Does resident's RECORD indicate any history of the following? a. Alzheimer's disease <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes b. Dementia other than Alzheimer's disease <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes			

**SECTION AC. CUSTOMARY ROUTINE**

1. CUSTOMARY ROUTINE (In year prior to DATE OF ENTRY to this home, or year last in community if now being admitted from another home, nursing home, or hospital)	(Check all that apply. If all information UNKNOWN, check last box [z] only) <b>CYCLE OF DAILY EVENTS</b> <input type="checkbox"/> a. Stayed up late at night (e.g., after 9 pm) <input type="checkbox"/> b. Napped regularly during day (at least 1 hour) <input type="checkbox"/> c. Went out 1+ days a week <input type="checkbox"/> d. Stayed busy with hobbies, reading, or a fixed daily routine <input type="checkbox"/> e. Spent most of time alone or watching TV <input type="checkbox"/> f. Moved independently indoors (with appliances, if used) <input type="checkbox"/> g. Used tobacco products at least daily <input type="checkbox"/> h. NONE OF ABOVE		
	<b>EATING PATTERNS</b> <input type="checkbox"/> i. Distinct food preferences <input type="checkbox"/> j. Ate between meals all or most days <input type="checkbox"/> k. Used alcoholic beverage(s) at least weekly <input type="checkbox"/> l. NONE OF ABOVE		
	<b>ADL PATTERNS</b> <input type="checkbox"/> m. In bedclothes much of day <input type="checkbox"/> n. Wakened to toilet all or most nights <input type="checkbox"/> o. Had irregular bowel movement pattern <input type="checkbox"/> p. Shower for bathing <input type="checkbox"/> q. Sponge bath <input type="checkbox"/> r. Bathed in PM <input type="checkbox"/> s. NONE OF ABOVE		
	<b>INVOLVEMENT PATTERNS</b> <input type="checkbox"/> t. Daily contact with relatives/close friends <input type="checkbox"/> u. Usually attended church, temple, synagogue (etc.) <input type="checkbox"/> v. Found strength in faith <input type="checkbox"/> w. Daily animal companion/presence <input type="checkbox"/> x. Involved in group activities <input type="checkbox"/> y. NONE OF ABOVE <input type="checkbox"/> z. UNKNOWN—Resident/family unable to provide information		

END

**SECTION AD. FACE SHEET SIGNATURES and DATES**

1. SIGNATURE(S) OF PERSON(S) COMPLETING FACE SHEET:			
a. Signatures	Title	Sections	Date
			Date
2.	DATE COMPLETED	Record date background information was completed. <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
		Month	Day
		Year	

**MINIMUM DATA SET (MDS)®**  
**ASSISTED LIVING SERVICES (ALS)**

(STATUS IN LAST 7 DAYS UNLESS OTHERWISE NOTED)

**SECTION A. IDENTIFICATION and BACKGROUND INFORMATION**

1. RESIDENT NAME	a. (First)      b. (Middle Initial)      c. (Last)      d. (Jr/Sr)
2. SOCIAL SECURITY and MEDICARE NUMBERS <i>(C in 1st box if no med. no.)</i>	a. Social Security Number <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> b. Medicare number (or comparable railroad insurance number) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>
3. FACILITY NAME AND PROVIDER NO.	a. Facility Name _____ b. Provider No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4. MAINECARE NO.	<i>[Record a "+" if pending, "N" if not a MaineCare recipient]</i> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
5. ASSESSMENT DATE	<i>Last day of observation period</i> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month      Day      Year
6. REASON FOR ASSESSMENT	<i>(Check primary reason for assessment)</i> <input type="checkbox"/> 1. Admission assessment <input type="checkbox"/> 4. Semi-Annual <input type="checkbox"/> 2. Annual assessment <input type="checkbox"/> 5. Other (specify) _____ <input type="checkbox"/> 3. Significant change in status assessment _____
7. MARITAL STATUS <i>(Check only one.)</i>	<input type="checkbox"/> 1. Never married <input type="checkbox"/> 3. Widowed <input type="checkbox"/> 5. Divorced <input type="checkbox"/> 2. Married <input type="checkbox"/> 4. Separated
8. CURRENT PAYMENT SOURCES FOR STAY	<i>(Billing Office to indicate; check all that apply in last 30 days or since last admission if less than 30 days)</i> <input type="checkbox"/> a. MaineCare <input type="checkbox"/> e. Private pay <input type="checkbox"/> b. SSI <input type="checkbox"/> f. Private insurance (including co-payment) <input type="checkbox"/> c. VA <input type="checkbox"/> g. SSDI <input type="checkbox"/> d. Social Security <input type="checkbox"/> h. Other (specify) _____
9. RESPONSIBILITY/LEGAL GUARDIAN	<i>(Check all that apply.)</i> <input type="checkbox"/> a. Legal guardian <input type="checkbox"/> e. Family member responsible <input type="checkbox"/> b. Other legal oversight <input type="checkbox"/> f. Self <input type="checkbox"/> c. Durable power of attorney/health care <input type="checkbox"/> g. Legal Conservator <input type="checkbox"/> d. Durable power of attorney/financial <input type="checkbox"/> h. Representative Payee <input type="checkbox"/> i. NONE OF ABOVE
10. ADVANCED DIRECTIVES	<i>Does resident have any of the following advanced directives in place?</i> a. Living Will <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes b. Do not resuscitate (DNR) <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes c. Do not hospitalize <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes d. Organ donation <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes e. Other <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes (If "yes," specify) _____

**SECTION B. COGNITIVE PATTERNS**

1. MEMORY	<i>(Recall of what was learned or known)</i> a. Short-term memory OK—seems/appears to recall after 5 minutes <input type="checkbox"/> 0. Memory OK <input type="checkbox"/> 1. Memory problem b. Long-term memory OK—seems/appears to recall long past <input type="checkbox"/> 0. Memory OK <input type="checkbox"/> 1. Memory problem
2. MEMORY/RECALL ABILITY	<i>(Check all that resident was normally able to recall during last 7 days)</i> <input type="checkbox"/> a. Current season <input type="checkbox"/> d. That he/she is in a facility/home <input type="checkbox"/> b. Location of own room <input type="checkbox"/> e. NONE OF ABOVE are recalled <input type="checkbox"/> c. Staff names/faces
3. COGNITIVE SKILLS FOR DAILY DECISION-MAKING <i>(Check only one.)</i>	<i>(Made decisions regarding tasks of daily life)</i> <input type="checkbox"/> 0. INDEPENDENT—decisions consistent/reasonable <input type="checkbox"/> 1. MODIFIED INDEPENDENCE—some difficulty in new situations only <input type="checkbox"/> 2. MODERATELY IMPAIRED—decisions poor; cues/supervision required <input type="checkbox"/> 3. SEVERELY IMPAIRED—never/rarely made decisions
4. COGNITIVE STATUS <i>(Check only one.)</i>	Resident's cognitive status or abilities now compared to resident's status 180 days ago (or since admission if less than 180 days). <input type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined

**SECTION C. COMMUNICATION/HEARING PATTERNS**

1. HEARING <i>(Check only one.)</i>	<i>(With hearing appliance, if used)</i> <input type="checkbox"/> 0. HEARS ADEQUATELY—normal talk, TV, phone <input type="checkbox"/> 1. MINIMAL DIFFICULTY when not in quiet setting <input type="checkbox"/> 2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly <input type="checkbox"/> 3. HIGHLY IMPAIRED—absence of useful hearing
2. COMMUNICATION DEVICES/TECHNIQUES	<i>(Check all that apply during last 7 days.)</i> <input type="checkbox"/> a. Hearing aid, present and used <input type="checkbox"/> b. Hearing aid, present and not used regularly <input type="checkbox"/> c. Other receptive communication techniques used (e.g., lip reading) <input type="checkbox"/> d. NONE OF ABOVE
3. MAKING SELF UNDERSTOOD <i>(Check only one.)</i>	<i>(Expressing information content—however able)</i> <input type="checkbox"/> 0. UNDERSTOOD <input type="checkbox"/> 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts <input type="checkbox"/> 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests <input type="checkbox"/> 3. RARELY/NEVER UNDERSTOOD
4. ABILITY TO UNDERSTAND OTHERS <i>(Check only one.)</i>	<i>(Understanding information content—however able)</i> <input type="checkbox"/> 0. UNDERSTANDS <input type="checkbox"/> 1. USUALLY UNDERSTANDS—may miss some part / intent of message <input type="checkbox"/> 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication <input type="checkbox"/> 3. RARELY/NEVER UNDERSTANDS
5. COMMUNICATION <i>(Check only one.)</i>	Resident's current ability to express him/herself or understand others compared to resident's status 180 days ago (or since admission if less than 180 days). <input type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined

**SECTION D. VISION PATTERNS**

1. VISION <i>(Check only one.)</i>	<i>(Ability to see in adequate light and with glasses if used)</i> <input type="checkbox"/> 0. ADEQUATE—sees fine detail, including regular print in newspapers/books <input type="checkbox"/> 1. IMPAIRED—sees large print, but not regular print in newspapers/books <input type="checkbox"/> 2. MODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify objects <input type="checkbox"/> 3. HIGHLY IMPAIRED—object identification in question, but eyes appear to follow objects <input type="checkbox"/> 4. SEVERELY IMPAIRED—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects
2. VISUAL APPLIANCES	a. Glasses, contact lenses <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes b. Artificial eye <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes

**SECTION E. MOOD and BEHAVIOR PATTERNS**

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	<i>(CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause)</i> <input type="checkbox"/> 0. Not exhibited in last 30 days <input type="checkbox"/> 1. This type exhibited up to 5 days a week <input type="checkbox"/> 2. This type exhibited daily or almost daily (6, 7 days/week)
<b>VERBAL EXPRESSIONS OF DISTRESS</b>	
_____ a.	Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die."
_____ b.	Repetitive questions—e.g., "Where do I go; What do I do?"
_____ c.	Repetitive verbalizations—e.g., calling out for help, ("God help me")
_____ d.	Persistent anger with self or others—e.g., easily annoyed, anger at placement in facility; anger at care received
_____ e.	Self deprecation—e.g., "I am nothing; I am of no use to anyone"
_____ f.	Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others
_____ g.	Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack
_____ h.	Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions
_____ i.	Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues <i>(continued next page)</i>

**SECTION E. MOOD and BEHAVIOR PATTERNS (cont.)**

1.	<b>INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD</b>	<i>(CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause)</i>		
		0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week)		
		<b>SLEEP-CYCLE ISSUES</b>		
		___ j. Unpleasant mood in morning ___ k. Insomnia/change in usual sleep pattern		
		<b>SAD, APATHETIC, ANXIOUS APPEARANCE</b>		
		___ l. Sad, pained, worried facial expressions—e.g., furrowed brows ___ m. Crying, tearfulness ___ n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking		
		<b>LOSS OF INTEREST</b>		
		___ o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends ___ p. Reduced social interaction		
		<b>INDICATORS OF MANIA</b>		
		___ q. Inflated self-worth, exaggerated self-opinion; inflated belief about one's own ability, etc. ___ r. Excited behavior, motor excitation (e.g., heightened physical activity; excited, loud or pressured speech; increased reactivity)		
2.	<b>MOOD PERSISTENCE</b> <i>(Check only one.)</i>	Check if one or more indicators of depressed, sad or anxious mood (above) were not easily altered by attempts to "cheer up", console, or reassure the resident <b>over last 7 days.</b> <input type="checkbox"/> 0. No mood indicators <input type="checkbox"/> 1. Indicators present, easily altered <input type="checkbox"/> 2. Indicators present, not easily altered		
3.	<b>MOOD</b> <i>(Check only one.)</i>	Resident's current mood status compared to resident's status 180 days ago (or since admission if less than 180 days): <input type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined		
4.	<b>BEHAVIORAL SYMPTOMS</b>	<i>(COLUMN A CODES: Record the appropriate code for the frequency of the symptom in last 7 days)</i>		<i>(COLUMN B CODES: Alterability of behavioral symptoms in last 7 days)</i>
		0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days but less than daily 3. Behavior of this type occurred daily		0. Not present or easily altered 1. Behavior not easily altered
		<i>(COLUMN C CODES: History of this behavior in the last 6 months)</i>		
		0. No	1. Yes	
a.	WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)			
b.	VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)			
c.	PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused, gross physical assault)			
d.	SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, sexual behavior, disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings, stealing, self-abusive acts, substance abuse, self-mutilation)			
e.	RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)			
f.	INTIMIDATING BEHAVIOR (made others feel unsafe, at risk, privacy invaded)			
g.	ELOPEMENT			
h.	Dangerous non-violent behavior (e.g., falling asleep while smoking)			
i.	Dangerous violent behavior			
j.	FIRE SETTING			
5.	<b>SUICIDAL IDEATION</b>	Resident demonstrated suicidal thoughts or actions in the <b>last 30 days:</b> <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes		
6.	<b>SLEEP PROBLEMS</b>	Check all present on 2 or more days during last 7 days <input type="checkbox"/> a. Inability to awaken when desired <input type="checkbox"/> d. Interrupted sleep <input type="checkbox"/> b. Difficulty falling asleep <input type="checkbox"/> e. NONE OF ABOVE <input type="checkbox"/> c. Restless or non-restful sleep		
7.	<b>INSIGHT INTO MENTAL HEALTH</b>	Resident has insight about his/her mental problem <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No mental health problems		
8.	<b>BEHAVIORS</b> <i>(Check only one.)</i>	Resident's current behavior status compared to resident's status 180 days ago (or since admission if less than 180 days): <input type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined		

**SECTION F. PSYCHOSOCIAL WELL-BEING**

1.	<b>SENSE OF INITIATIVE/ INVOLVEMENT</b> <i>(Check all that apply.)</i>	<input type="checkbox"/> a. At ease interacting with others <input type="checkbox"/> b. At ease doing planned or structured activities <input type="checkbox"/> c. At ease doing self-initiated activities <input type="checkbox"/> d. Establishes own goals <input type="checkbox"/> e. Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services) <input type="checkbox"/> f. Accepts invitations into most group activities <input type="checkbox"/> g. NONE OF ABOVE
2.	<b>UNSETTLED RELATIONSHIPS</b> <i>(Check all that apply.)</i>	<input type="checkbox"/> a. Covert/open conflict with or repeated criticism of staff <input type="checkbox"/> b. Unhappy with roommate <input type="checkbox"/> c. Unhappy with residents other than roommate <input type="checkbox"/> d. Openly expresses conflict/anger with family/friends <input type="checkbox"/> e. Absence of personal contact with family/friends <input type="checkbox"/> f. Recent loss of close family member/friend <input type="checkbox"/> g. Does not adjust easily to change in routines <input type="checkbox"/> h. NONE OF ABOVE
3.	<b>LIFE-EVENTS HISTORY</b> <i>(Check all that apply.)</i>	Events in past 2 years <input type="checkbox"/> a. Serious accident or physical illness <input type="checkbox"/> b. Health concerns for other person <input type="checkbox"/> c. Death of family member or close friend <input type="checkbox"/> d. Trouble with the law <input type="checkbox"/> e. Robbed/physically attacked <input type="checkbox"/> f. Conflict laden or severed relationship <input type="checkbox"/> g. Loss of income leading to change in lifestyle <input type="checkbox"/> h. Sexual assault/abuse <input type="checkbox"/> i. Child custody issues <input type="checkbox"/> j. Change in marital/partner status <input type="checkbox"/> k. Review hearings (e.g., forensic, certification, capacity hearing) <input type="checkbox"/> l. NONE OF ABOVE

**SECTION G. PHYSICAL FUNCTIONING**

1.	(A) ADL SELF-PERFORMANCE		
0.	<b>INDEPENDENT</b> —No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days		
1.	<b>SUPERVISION</b> —Oversight, encouragement or cueing provided 3 or more times during last 7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days		
2.	<b>LIMITED ASSISTANCE</b> —Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times —OR— Limited assistance (3 or more times), plus weight-bearing support provided only 1 or 2 times.		
3.	<b>EXTENSIVE ASSISTANCE</b> —While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: — Weight-bearing support — Full staff performance during part (but not all) of last 7 days		
4.	<b>TOTAL DEPENDENCE</b> —Full staff performance of activity during last 7 days		
8.	<b>ACTIVITY DID NOT OCCUR DURING LAST 7 DAYS</b>		
(B) ADL SUPPORT CODES (CODE for MOST SUPPORT PROVIDED OVER EACH 24 HOUR PERIOD) during last 7 days; code regardless of person's self-performance classification.			
0. No setup or physical help from staff		SELF-PERFORMANCE	SUPPORT
1. Setup help only			
2. One-person physical assist			
3. Two+ persons physical assist			
8. Activity did not occur during entire 7 days			
a.	<b>BED MOBILITY</b> — How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	<b>TRANSFER</b> — How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	<b>LOCOMOTION</b> — How resident moves to and returns from other locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
d.	<b>DRESSING</b> — How resident puts on, fastens, and takes off all items of <b>street clothing</b> , including donning/removing prosthesis		
e.	<b>EATING</b> — How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
f.	<b>TOILET USE</b> — How resident uses the toilet room (or commode, bed-pan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
g.	<b>PERSONAL HYGIENE</b> — How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		
h.	<b>STAIRS</b> — How resident climbs stairs		

Resident Name: \_\_\_\_\_ Date: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Facility Provider # \_\_\_\_\_

**SECTION G. PHYSICAL FUNCTIONING (cont.)**

<p><b>2. BATHING SELF-PERFORMANCE</b></p>	<p>How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) <b>Check for most dependent in self-performance during last 7 days.</b></p> <p><input type="checkbox"/> 0. Independent—No help provided  <input type="checkbox"/> 1. Supervision—Oversight help only  <input type="checkbox"/> 2. Physical help limited to transfer only  <input type="checkbox"/> 3. Physical help in part of bathing activity  <input type="checkbox"/> 4. Total dependence  <input type="checkbox"/> 8. Activity itself did not occur during entire 7 days</p>																				
<p><b>3A. MODES OF LOCOMOTION</b></p>	<p>(Check all that apply during last 7 days.)</p> <p><input type="checkbox"/> a. Cane/walker/crutch  <input type="checkbox"/> b. Wheeled self  <input type="checkbox"/> c. Other person wheeled  <input type="checkbox"/> d. NONE OF ABOVE</p>																				
<p><b>3B. MAIN MODE OF LOCOMOTION</b></p>	<p>Was wheelchair the primary mode of locomotion during the last 7 days?</p> <p><input type="checkbox"/> 0. No                      <input type="checkbox"/> 1. Yes</p>																				
<p><b>3C. BEDFAST/CHAIRFAST</b></p>	<p>(Check if health condition keeps resident in his/her room 22+ hours per day in last 7 days)</p> <p><input type="checkbox"/> a. Bedfast all or most of time  <input type="checkbox"/> b. Chairfast all or most of the time  <input type="checkbox"/> c. NONE OF ABOVE</p>																				
<p><b>4. SELF-PERFORMANCE IN ADLs</b> (Check only one.)</p>	<p>Resident's current ADL status or abilities compared to resident's status 180 days ago (or since admission if less than 180 days):</p> <p><input type="checkbox"/> 0. No change  <input type="checkbox"/> 1. Improved  <input type="checkbox"/> 2. Declined</p>																				
<p><b>5A. IADL SELF-PERFORMANCE</b></p>	<p>Code for level of independence in the last 30 days based on resident's involvement in the activity.</p> <p><b>SELF-PERFORMANCE CODES:</b></p> <p>0. INDEPENDENT: (with/without assistive devices)—No help provided.  1. DONE WITH HELP: Resident involved in activity but help (including supervision, reminders, and/or physical help) is provided.  2. DONE BY OTHERS: Full performance of the activity is done by others. The resident is not involved at all when the activity is performed.  8. Activity did not occur in the last 30 days.</p> <table border="1" data-bbox="212 1087 800 1535"> <tr> <td style="text-align: center; width: 80%;">IADL</td> <td style="text-align: center; width: 20%;">SELF-PERFORMANCE</td> </tr> <tr> <td>a. Resident arranged for shopping for clothing, snacks, other incidentals.</td> <td></td> </tr> <tr> <td>b. Resident shopped for clothing, snacks, or other incidentals.</td> <td></td> </tr> <tr> <td>c. Resident arranged for suitable transportation to get to appointments, outings, necessary engagements.</td> <td></td> </tr> <tr> <td>d. Resident managed finances including banking, handling checkbook, or paying bills.</td> <td></td> </tr> <tr> <td>e. Resident managed cash, personal needs allowance.</td> <td></td> </tr> <tr> <td>f. Resident prepared snacks, light meals.</td> <td></td> </tr> <tr> <td>g. Resident used phone.</td> <td></td> </tr> <tr> <td>h. Resident did light housework such as making own bed, dusting, or taking care of belongings.</td> <td></td> </tr> <tr> <td>i. Resident sorted, folded, or washed own laundry.</td> <td></td> </tr> </table>	IADL	SELF-PERFORMANCE	a. Resident arranged for shopping for clothing, snacks, other incidentals.		b. Resident shopped for clothing, snacks, or other incidentals.		c. Resident arranged for suitable transportation to get to appointments, outings, necessary engagements.		d. Resident managed finances including banking, handling checkbook, or paying bills.		e. Resident managed cash, personal needs allowance.		f. Resident prepared snacks, light meals.		g. Resident used phone.		h. Resident did light housework such as making own bed, dusting, or taking care of belongings.		i. Resident sorted, folded, or washed own laundry.	
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<p><b>5B. TRANSPORTATION</b></p>	<p>Check all that apply for level of independence in the last 30 days based on resident's involvement in the activity.</p> <p><input type="checkbox"/> a. Resident drove car or used public transportation independently to get to medical, dental appointments, necessary engagements, or other activities.  <input type="checkbox"/> b. Resident rode to destination with staff, family, others (in car, van, public transportation) but was <b>not accompanied</b> to medical, dental appointments, necessary engagements, or other activities.  <input type="checkbox"/> c. Resident rode to destination with staff, family, others (in car, van, public transportation) and <b>was accompanied</b> to medical, dental appointments, necessary engagements, or other activities.  <input type="checkbox"/> d. Activity did not occur.</p>																				
<p><b>6. ADL AND IADL FUNCTIONAL REHABILITATION OR IMPROVEMENT POTENTIAL</b> (Check all that apply.)</p>	<p><input type="checkbox"/> a. Resident believes he/she is capable of increased independence in at least some ADLs or IADLs.  <input type="checkbox"/> b. Direct care staff believes resident is capable of increased independence in at least some ADLs or IADLs.  <input type="checkbox"/> c. Resident able to perform tasks/activity but is very slow.  <input type="checkbox"/> d. Difference in ADL/IADL Self-Performance comparing mornings to evenings.  <input type="checkbox"/> e. Resident requires or only understands a one-step direction.</p> <p style="text-align: right;">(continued in next column)</p>																				

**SECTION G. PHYSICAL FUNCTIONING (cont.)**

<p><b>7. NEW DEVICES NEEDED</b> (Check all that apply.)</p>	<p>Resident expresses or gives evidence of needing new or additional assistive devices</p> <p><input type="checkbox"/> a. Eyeglasses                      <input type="checkbox"/> f. Assistive dressing devices (e.g., button hook, velcro closings)  <input type="checkbox"/> b. Hearing aid                      <input type="checkbox"/> g. Dentures  <input type="checkbox"/> c. Cane or walker                      <input type="checkbox"/> h. Other (specify) _____  <input type="checkbox"/> d. Wheelchair                      <input type="checkbox"/> i. NONE OF ABOVE  <input type="checkbox"/> e. Assistive feeding devices (e.g., plate guard, stabilized built-up utensil)</p>
<p><b>8. SELF-PERFORMANCE IN IADLs</b></p>	<p>Resident's current IADL status or abilities compared to resident's status 180 days ago (or since admission if less than 180 days):</p> <p><input type="checkbox"/> 0. No change                      <input type="checkbox"/> 1. Improved                      <input type="checkbox"/> 2. Declined</p>

**SECTION H. CONTINENCE IN LAST 14 DAYS**

<p><b>1. CONTINENCE SELF-CONTROL CATEGORIES</b> (Code for resident's PERFORMANCE OVER ALL SHIFTS)</p> <p>0. CONTINENT—Complete control (includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool)</p> <p>1. USUALLY CONTINENT—BLADDER, Incontinent episodes once a week or less; BOWEL, less than weekly  2. OCCASIONALLY INCONTINENT—BLADDER, 2 or more times a week but not daily; BOWEL, once a week  3. FREQUENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but some control present (e.g. on day shift); BOWEL, 2-3 times a week  4. INCONTINENT—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time</p>			
<p>a. BOWEL CONTINENCE</p>	<p>Control of bowel movement, with appliance or bowel continence programs, if employed</p>		
<p>b. BLADDER CONTINENCE</p>	<p>Control of urinary bladder function with appliances (e.g. foley) or continence programs, if employed</p>		
<p>2. BOWEL ELIMINATION PATTERN</p>	<p>Bowel elimination pattern regular—at least one movement every three days  Constipation</p>	<p>Diarrhea  Fecal Impaction  Resident is independent  NONE OF ABOVE</p>	<p>c. d. e. f.</p>
<p>3. APPLIANCES and PROGRAMS</p>	<p>Any scheduled toileting plan  Bladder retraining program  External (condom) catheter  Indwelling catheter  Intermittent catheter</p>	<p>Did not use toilet room/ commode/urinal  Pads/briefs used  Enemas/irrigation  Ostomy present  NONE OF ABOVE</p>	<p>a. b. c. d. e. f. g. h. i. j.</p>
<p>4. USE OF INCONTINENCE SUPPLIES (Check only one.)</p>	<p>Resident's management of incontinence supplies (pads, briefs, ostomy, catheter) in last 14 days.</p> <p><input type="checkbox"/> 0. Always continent  <input type="checkbox"/> 1. Resident incontinent and able to manage incontinence supplies independently.  <input type="checkbox"/> 2. Resident incontinent and receives assistance with managing incontinence supplies.  <input type="checkbox"/> 3. Resident incontinent and does not use incontinence supplies.</p>		
<p>5. CHANGES IN URINARY CONTINENCE</p>	<p>Resident's urinary continence has changed as compared to status of 180 days ago (or since last assessment if less than 180 days):</p> <p><input type="checkbox"/> 0. No change                      <input type="checkbox"/> 1. Improved                      <input type="checkbox"/> 2. Deteriorated</p>		

**SECTION I. DIAGNOSES**

Check only those diagnoses that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nurse monitoring, or risk of death. (Do not list inactive diagnoses.) (If none apply, CHECK item xx. NONE OF ABOVE)

<p><b>1. DIAGNOSES</b></p>	<p>ENDOCRINE/METABOLIC/ NUTRITIONAL</p> <p><input type="checkbox"/> a. Diabetes mellitus  <input type="checkbox"/> b. Hyperthyroidism  <input type="checkbox"/> c. Hypothyroidism</p>	<p>HEART/CIRCULATION</p> <p><input type="checkbox"/> d. Arteriosclerotic heart disease (ASHD)  <input type="checkbox"/> e. Cardiac dysrhythmia  <input type="checkbox"/> f. Congestive heart failure  <input type="checkbox"/> g. Deep vein thrombosis  <input type="checkbox"/> h. Hypertension  <input type="checkbox"/> i. Hypotension  <input type="checkbox"/> j. Peripheral vascular disease  <input type="checkbox"/> k. Other cardiovascular disease</p> <p style="text-align: right;">(continued on next page)</p>
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Resident Name: \_\_\_\_\_ Date: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Facility Provider # \_\_\_\_\_

**SECTION I. DIAGNOSES (cont.)**

	<p><b>MUSCULOSKELETAL</b></p> <p><input type="checkbox"/> i. Arthritis</p> <p><input type="checkbox"/> m. Hip fracture</p> <p><input type="checkbox"/> n. Missing limb (e.g., amputation)</p> <p><input type="checkbox"/> o. Osteoporosis</p> <p><input type="checkbox"/> p. Pathological bone fracture</p> <p><b>NEUROLOGICAL</b></p> <p><input type="checkbox"/> q. Alzheimer's disease</p> <p><input type="checkbox"/> r. Aphasia</p> <p><input type="checkbox"/> s. Cerebral palsy</p> <p><input type="checkbox"/> t. Cerebrovascular accident (stroke)</p> <p><input type="checkbox"/> u. Dementia other than Alzheimer's disease</p> <p><input type="checkbox"/> v. Hemiplegia/hemiparesis</p> <p><input type="checkbox"/> w. Multiple sclerosis</p> <p><input type="checkbox"/> x. Paraplegia</p> <p><input type="checkbox"/> y. Parkinson's disease</p> <p><input type="checkbox"/> z. Quadriplegia</p> <p><input type="checkbox"/> aa. Seizure disorder</p> <p><input type="checkbox"/> bb. Transient ischemic attack (TIA)</p> <p><input type="checkbox"/> cc. Traumatic brain injury</p> <p><b>PSYCHIATRIC/MOOD</b></p> <p><input type="checkbox"/> dd. Anxiety disorder</p> <p><input type="checkbox"/> ee. Depression</p>	<p><input type="checkbox"/> ff. Manic depressive (Bipolar)</p> <p><input type="checkbox"/> gg. Schizophrenia</p> <p><b>PULMONARY</b></p> <p><input type="checkbox"/> hh. Asthma</p> <p><input type="checkbox"/> ii. Emphysema/COPD</p> <p><b>SENSORY</b></p> <p><input type="checkbox"/> jj. Cataracts</p> <p><input type="checkbox"/> kk. Diabetic retinopathy</p> <p><input type="checkbox"/> ll. Glaucoma</p> <p><input type="checkbox"/> mm. Macular degeneration</p> <p><b>OTHER</b></p> <p><input type="checkbox"/> nn. Allergies (specify) _____</p> <p><input type="checkbox"/> oo. Anemia</p> <p><input type="checkbox"/> pp. Cancer</p> <p><input type="checkbox"/> qq. Renal failure</p> <p><input type="checkbox"/> rr. Tuberculosis-TB</p> <p><input type="checkbox"/> ss. HIV</p> <p><input type="checkbox"/> tt. Mental retardation (e.g., Down's Syndrome, Autism, or other organic condition related to Mental Retardation or Developmental disability (MR/DD))</p> <p><input type="checkbox"/> uu. Substance abuse (alcohol or drug)</p> <p><input type="checkbox"/> vv. Other psychiatric diagnosis (e.g., paranoia, phobias, personality disorder)</p> <p><input type="checkbox"/> ww. Explicit terminal prognosis</p> <p><input type="checkbox"/> xx. NONE OF ABOVE</p>
	<p><b>2. OTHER CURRENT DIAGNOSIS AND ICD-9 CODES</b></p> <p>a. _____ <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/> . <input type="checkbox"/><input type="checkbox"/></p> <p>b. _____ <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/> . <input type="checkbox"/><input type="checkbox"/></p> <p>c. _____ <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/> . <input type="checkbox"/><input type="checkbox"/></p>	

**SECTION J. HEALTH CONDITIONS AND POSSIBLE MEDICATION SIDE EFFECTS (cont.)**

<b>5. PAIN INTERFERES</b>	During the last 7 days, how much of the time did pain interfere with resident's normal activities such as visiting with friends, going out, and so on?
	<p><input type="checkbox"/> 1. All of the time</p> <p><input type="checkbox"/> 2. Some of the time</p> <p><input type="checkbox"/> 3. Little of the time</p> <p><input type="checkbox"/> 4. None of the time</p>
<b>6. PAIN MANAGEMENT</b>	<p><input type="checkbox"/> 1. No pain treatment</p> <p><input type="checkbox"/> 2. Treated, full control</p> <p><input type="checkbox"/> 3. Treated, partial control</p> <p><input type="checkbox"/> 4. Treated, no or minimal control</p>
<b>7. ACCIDENTS (Check all that apply.)</b>	<p><input type="checkbox"/> a. Fell in <b>past 30 days</b></p> <p><input type="checkbox"/> b. Fell in <b>past 31-180 days</b></p> <p><input type="checkbox"/> c. Hip fracture in <b>last 180 days</b></p> <p><input type="checkbox"/> d. Other fracture in <b>last 180 days</b></p> <p><input type="checkbox"/> e. <b>NONE OF ABOVE</b></p>
<b>8. DANGER OF FALL (Check all that apply.)</b>	<p><input type="checkbox"/> a. Has unsteady gait</p> <p><input type="checkbox"/> b. Has balance problems when standing</p> <p><input type="checkbox"/> c. Limits activity because resident or family fearful of resident falling</p> <p><input type="checkbox"/> d. Unstable transition from seated to standing</p> <p><input type="checkbox"/> e. Other (specify) _____</p> <p><input type="checkbox"/> f. <b>NONE OF ABOVE</b></p>

**SECTION K. ORAL/NUTRITIONAL STATUS**

<b>1. ORAL PROBLEMS (Check all that apply.)</b>	<p><input type="checkbox"/> a. Mouth is "dry" when eating a meal</p> <p><input type="checkbox"/> b. Chewing Problem</p> <p><input type="checkbox"/> c. Swallowing Problem</p> <p><input type="checkbox"/> d. Mouth Pain</p> <p><input type="checkbox"/> e. <b>NONE OF ABOVE</b></p>
<b>2. HEIGHT AND WEIGHT</b>	Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in <b>last 30 days</b> ; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes.
	a. HT (in.) <input type="text"/> <input type="text"/> <input type="text"/> b. WT (lb.) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>3. WEIGHT CHANGE</b>	<p><b>a. Unintended weight loss—5% or more in last 30 days; or 10% or more in last 180 days</b></p> <p><input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes</p> <p><b>b. Unintended weight gain—5% or more in last 30 days; or 10% or more in last 180 days</b></p> <p><input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes</p>
<b>4. NUTRITIONAL PROBLEMS OR APPROACHES (Check all that apply.)</b>	<p><input type="checkbox"/> a. Complains about the taste of many foods</p> <p><input type="checkbox"/> b. Regular or repetitive complaints of hunger</p> <p><input type="checkbox"/> c. Leaves 25% of food uneaten at most meals</p> <p><input type="checkbox"/> d. Therapeutic diet</p> <p><input type="checkbox"/> e. Mechanically altered (or pureed) diet</p> <p><input type="checkbox"/> f. Noncompliance with diet</p> <p><input type="checkbox"/> g. Eating disorders</p> <p><input type="checkbox"/> h. Food allergies (specify) _____</p> <p><input type="checkbox"/> i. Restrictions (specify) _____</p> <p><input type="checkbox"/> j. <b>NONE OF ABOVE</b></p>

**SECTION J. HEALTH CONDITIONS and POSSIBLE MEDICATION SIDE EFFECTS**

<b>1. PROBLEM CONDITIONS</b>	(Check all problems present in last 7 days unless other time frame is indicated)
	<p><input type="checkbox"/> a. Inability to lie flat due to shortness of breath</p> <p><input type="checkbox"/> b. Shortness of breath</p> <p><input type="checkbox"/> c. Edema</p> <p><input type="checkbox"/> d. Dizziness/vertigo</p> <p><input type="checkbox"/> e. Delusions</p> <p><input type="checkbox"/> f. Hallucinations</p> <p><input type="checkbox"/> g. Hostility</p> <p><input type="checkbox"/> h. Suspiciousness</p> <p><input type="checkbox"/> i. Headache</p> <p><input type="checkbox"/> j. Numbness/tingling</p> <p><input type="checkbox"/> k. Blurred vision</p> <p><input type="checkbox"/> l. Dry mouth</p> <p><input type="checkbox"/> m. Excessive salivation or drooling</p> <p><input type="checkbox"/> n. Change in normal appetite</p> <p><input type="checkbox"/> o. Other (specify) _____</p> <p><input type="checkbox"/> p. <b>NONE OF ABOVE</b></p>
<b>2. EXTRA-PYRAMIDAL SIGNS AND SYMPTOMS</b>	Check all present at any point during <b>last 3 days</b>
	<p><b>INCREASE IN MOTOR ACTIVITY</b></p> <p><input type="checkbox"/> a. Akathisia—resident reports subjective feeling of restlessness or need for movement</p> <p><input type="checkbox"/> b. Dyskinesia—chewing, puckering movements of mouth; abnormal irregular movements of lips; or rocking or writhing of trunk</p> <p><input type="checkbox"/> c. Tremor—regular rhythmic movements of the fingers, limbs, head, mouth, or tongue</p> <p><b>DECREASE IN MOTOR ACTIVITY</b></p> <p><input type="checkbox"/> d. Rigidity—resistance to flexion and extension of muscles (e.g., continuous or cogwheeling rigidity)</p> <p><input type="checkbox"/> e. Slow shuffling gait—reduction in speed and stride length of gait, usually with a decrease in pendular arm movement</p> <p><input type="checkbox"/> f. Bradykinesia—decrease in spontaneous movements (e.g., reduced body movement or poverty of facial expression, gestures, speech)</p> <p><b>MUSCLE CONTRACTIONS</b></p> <p><input type="checkbox"/> g. Dystonia—muscle hypertonicity (e.g., muscle spasms or stiffness, protruding tongue, upward deviation of the eyes)</p> <p><input type="checkbox"/> h. <b>NONE OF ABOVE</b></p>
<b>3. PAIN SYMPTOMS</b>	(Code the highest level of resident's pain present in the last 7 days)
	On a scale of 1 to 10, where 1 is the least and 10 is the most, how would you rate your pain? (If no pain, code 0 and skip to J7)
<b>4. PAIN SITE</b>	(If pain is present in the last 7 days)
	<p><input type="checkbox"/> a. Back pain</p> <p><input type="checkbox"/> b. Bone pain</p> <p><input type="checkbox"/> c. Chest pain while doing usual activities</p> <p><input type="checkbox"/> d. Headache</p> <p><input type="checkbox"/> e. Hip pain</p> <p><input type="checkbox"/> f. Incisional pain</p> <p><input type="checkbox"/> g. Joint pain (other than hip)</p> <p><input type="checkbox"/> h. Soft tissue pain (e.g., lesion, muscle)</p> <p><input type="checkbox"/> i. Stomach pain</p> <p><input type="checkbox"/> j. Other (specify) _____</p>

**SECTION L. ORAL/DENTAL STATUS**

<b>1. ORAL STATUS AND DISEASE PREVENTION (Check all that apply.)</b>	<p><input type="checkbox"/> a. Has dentures or removable bridge</p> <p><input type="checkbox"/> b. Some/all natural teeth lost—does not have or does not use dentures (or partial plates)</p> <p><input type="checkbox"/> c. Broken, loose or carious teeth</p> <p><input type="checkbox"/> d. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes</p> <p><input type="checkbox"/> e. Daily cleaning of teeth/dentures or daily mouth care—by resident or staff</p> <p><input type="checkbox"/> f. Resident has difficulty brushing teeth or dentures</p> <p><input type="checkbox"/> g. <b>NONE OF ABOVE</b></p>
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**SECTION M. SKIN CONDITION**

<b>1. SKIN PROBLEMS (Check all that apply.)</b>	Any troubling skin conditions or changes in the <b>last 7 days</b> ?
	<p><input type="checkbox"/> a. Abrasions (scrapes) or cuts</p> <p><input type="checkbox"/> b. Bums (2nd or 3rd degree)</p> <p><input type="checkbox"/> c. Bruises</p> <p><input type="checkbox"/> d. Rashes, itchiness, body lice</p> <p><input type="checkbox"/> e. Open sores or lesions</p> <p><input type="checkbox"/> f. Other (specify) _____</p> <p><input type="checkbox"/> g. <b>NONE OF ABOVE</b></p>
<b>2. ULCERS (Due to any cause.)</b>	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during <b>last 7 days</b> . Code 9=9 or more.) Requires full body exam.
	<p><b>a. Stage 1.</b> A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.</p> <p><b>b. Stage 2.</b> A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.</p> <p><b>c. Stage 3.</b> A full thickness of skin is lost, exposing the subcutaneous tissues—presents as a deep crater with or without undermining adjacent tissue.</p> <p><b>d. Stage 4.</b> A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.</p>
	<b>Number at Stage</b>

Resident Name: \_\_\_\_\_ Date: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Facility Provider # \_\_\_\_\_

**SECTION M. SKIN CONDITION (cont.)**

<b>3. FOOT PROBLEMS</b>	a. Resident or someone else inspects resident's feet on a regular basis? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
	b. One or more foot problems or infections such as corns, calluses, bunions, hammer toes, overlapping toes, pain, structural problems, gangrene toe, foot fungus, enlarged toe in last 7 days? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes

**SECTION N. ACTIVITY PURSUIT PATTERNS**

<b>1. TIME AWAKE</b>	<i>(Check appropriate time periods over last 7 days)</i> Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: <input type="checkbox"/> a. Morning <input type="checkbox"/> d. Night (Bedtime to A.M.) <input type="checkbox"/> b. Afternoon <input type="checkbox"/> e. NONE OF ABOVE <input type="checkbox"/> c. Evening
<b>2. AVERAGE TIME INVOLVED IN ACTIVITIES</b> <i>(Check only one.)</i>	<i>(When awake and not receiving treatments or ADL care)</i> <input type="checkbox"/> 1. Most—more than 2/3 of time <input type="checkbox"/> 2. Some—from 1/3 to 2/3 of time <input type="checkbox"/> 3. Little—less than 1/3 of time <input type="checkbox"/> 4. None
<b>3. PREFERRED ACTIVITY SETTINGS</b>	<i>(Check all settings in which activities are preferred)</i> <input type="checkbox"/> a. Own room <input type="checkbox"/> d. Away from facility <input type="checkbox"/> b. Day/activity room <input type="checkbox"/> e. NONE OF ABOVE <input type="checkbox"/> c. Outside facility (e.g., in yard)
<b>4. GENERAL ACTIVITY PREFERENCES</b> <i>(Adapted to resident's current abilities.)</i>	<i>(Check all PREFERENCES whether or not activity is currently available to resident)</i> <input type="checkbox"/> a. Cards/other games <input type="checkbox"/> k. Gardening or plants <input type="checkbox"/> b. Crafts/arts <input type="checkbox"/> l. Talking or conversing <input type="checkbox"/> c. Exercise/sports <input type="checkbox"/> m. Helping others <input type="checkbox"/> d. Dancing <input type="checkbox"/> n. Doing chores around the house/facility <input type="checkbox"/> e. Music <input type="checkbox"/> o. Cooking/baking <input type="checkbox"/> f. Reading/writing <input type="checkbox"/> p. Computer activities <input type="checkbox"/> g. Spiritual/religious activity <input type="checkbox"/> q. Volunteering <input type="checkbox"/> h. Trips/shopping <input type="checkbox"/> r. Other <i>(specify)</i> _____ <input type="checkbox"/> i. Walking/wheeling outdoors <input type="checkbox"/> s. NONE OF ABOVE <input type="checkbox"/> j. Watching TV
<b>5. PREFERRED ACTIVITY SIZE</b>	<i>(Check all that apply)</i> <input type="checkbox"/> a. Individual <input type="checkbox"/> c. Larger group <input type="checkbox"/> b. Small group <input type="checkbox"/> d. No preference
<b>6. PREFERENCES IN DAILY ROUTINE</b> <i>(Check all that apply.)</i>	<input type="checkbox"/> a. Resident prefers change in type of activity <input type="checkbox"/> b. Resident prefers change in extent of involvement in activities (e.g., more or less) <input type="checkbox"/> c. Resident prefers change in location of activities <input type="checkbox"/> d. Resident prefers activity at different time of day <input type="checkbox"/> e. Resident prefers stability in daily routine <input type="checkbox"/> f. NONE OF ABOVE
<b>7. INTERACTION WITH FAMILY AND FRIENDS</b>	a. How often has resident visited or been visited by family and friends in the last 30 days? <i>(check only one)</i> <input type="checkbox"/> 1. No family or friends outside facility <input type="checkbox"/> 4. Once a week <input type="checkbox"/> 2. None <input type="checkbox"/> 5. 2 or 3 times a week but not daily <input type="checkbox"/> 3. 1-3 times/month <input type="checkbox"/> 6. Daily  b. How often has resident talked by telephone with family and friends in the last 30 days? <i>(check only one)</i> <input type="checkbox"/> 1. No family or friends outside facility <input type="checkbox"/> 4. Once a week <input type="checkbox"/> 2. None <input type="checkbox"/> 5. 2 or 3 times a week but not daily <input type="checkbox"/> 3. 1-3 times/month <input type="checkbox"/> 6. Daily
<b>8. VOTING</b>	Is resident registered to vote? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
<b>9. SOCIAL ACTIVITIES</b> <i>(Check only one.)</i>	Resident's current level of participation in social, religious or other personal activities compared to resident's status 180 days ago (since admission if less than 180 days): <input type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined

**SECTION O. MEDICATIONS**

<b>1. NUMBER OF MEDICATIONS</b>	<i>(Record the number of different medications used in the last 7 days; enter "0" if none used)</i> <input type="text"/> <input type="text"/>
<b>2. NEW MEDICATIONS</b>	<i>(Resident currently receiving medications that were initiated during the last 90 days)</i> <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
<b>3. INJECTIONS</b>	<i>(Record the number of DAYS injections of any type received during the last 30 days; enter "0" if none used)</i> <input type="text"/> <input type="text"/>

**SECTION O. MEDICATIONS (cont.)**

<b>4A. DAYS RECEIVED THE FOLLOWING MEDICATION</b>	<i>(Record the number of DAYS during the last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly)</i> <input type="checkbox"/> a. Antipsychotic <input type="checkbox"/> d. Hypnotic <input type="checkbox"/> g. Insulin <input type="checkbox"/> b. Antianxiety <input type="checkbox"/> e. Diuretic <input type="checkbox"/> c. Antidepressant <input type="checkbox"/> f. Aricept
<b>4B. PRN MEDICATIONS</b>	Does resident have a prescription for any PRN medication for a mental, emotional or nervous condition, or behavioral problem? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
<b>5. SELF-ADMINISTERED MEDICATIONS</b> <i>(Check all that apply.)</i>	Did resident self-administer any of the following in the last 7 days: <input type="checkbox"/> a. Insulin <input type="checkbox"/> e. Glucosan <input type="checkbox"/> b. Oxygen <input type="checkbox"/> f. Over-the-counter Meds <input type="checkbox"/> c. Nebulizers <input type="checkbox"/> g. Other (specify) _____ <input type="checkbox"/> d. Nitropatch <input type="checkbox"/> h. NONE OF ABOVE
<b>6. MEDICATION PREPARATION ADMINISTRATION</b>	Did resident prepare and administer his/her own medications in last 7 days? <i>(Check only one.)</i> <input type="checkbox"/> 0. No Meds <input type="checkbox"/> 1. Resident prepared and administered <b>NONE</b> of his/her own medications. <input type="checkbox"/> 2. Resident prepared and administered <b>SOME</b> of his/her own medications. <input type="checkbox"/> 3. Resident prepared and administered <b>ALL</b> of his/her own medications.
<b>7. MEDICATION COMPLIANCE</b> <i>(Check only one.)</i>	Resident's level of compliance with medications prescribed by a physician/psychiatrist <b>during last 30 days:</b> <input type="checkbox"/> 0. No Meds <input type="checkbox"/> 1. Always compliant <input type="checkbox"/> 2. Always compliant with reminder, verbal prompts <input type="checkbox"/> 3. Compliant some of the time (80% of time or more often) <b>or</b> with some medications <input type="checkbox"/> 4. Rarely or never compliant
<b>8. MISUSE OF MEDICATION</b>	Misuse of prescription or over-the-counter medications in the last 6 months (e.g., resident uses more or less than the directed dose, is using medication for a purpose other than intended) <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes

**SECTION P. SPECIAL TREATMENTS and PROCEDURES**

<b>1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS</b>	a. <b>SPECIAL CARE—Check treatments or programs received during the last 14 days</b> [Note—count only post admission treatments] <input type="checkbox"/> a. Chemotherapy or radiation <input type="checkbox"/> i. Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) <input type="checkbox"/> b. Oxygen therapy <input type="checkbox"/> j. Case management <input type="checkbox"/> c. Dialysis <input type="checkbox"/> k. Day treatment program <input type="checkbox"/> d. Alcohol/drug treatment program <input type="checkbox"/> l. Sheltered workshop/employment <input type="checkbox"/> e. Alzheimer's/dementia special care unit <input type="checkbox"/> m. Job training <input type="checkbox"/> f. Hospice care <input type="checkbox"/> n. Transportation <input type="checkbox"/> g. Home health <input type="checkbox"/> o. Psychological rehabilitation <input type="checkbox"/> h. Home care <input type="checkbox"/> p. Formal education <input type="checkbox"/> q. NONE OF ABOVE	Days (A) ON SITE (B) OFF SITE (C)
	b. <b>THERAPIES—Record the number of days each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days</b> (Enter 0 if none or less than 15 min. a day) <i>(Note—count only post admission therapies)</i> <b>(A) = # of days administered for 15 minutes or more</b> <b>Check B if therapy was received at home or in facility</b> <b>Check C if therapy was received out-of-home or facility</b>	
	a. Speech-language pathology and auditory services	
	b. Occupational therapy	
	c. Physical therapy	
	d. Respiratory therapy	
	e. Psychological therapy (by any licensed mental health professional)	
<b>2. INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS</b>	<i>(Check all interventions or strategies used in the last 7 days unless other time specified—no matter where received)</i> <input type="checkbox"/> a. Special behavior symptom evaluation program                      environment to address mood/behavior patterns—e.g., providing bureau in which to rummage <input type="checkbox"/> b. Special behavior management program <input type="checkbox"/> f. Reorientation—e.g., cueing <input type="checkbox"/> c. Evaluation by a licensed mental health specialist in last 90 days <input type="checkbox"/> g. Validation/Redirection <input type="checkbox"/> d. Group therapy <input type="checkbox"/> h. Crisis intervention in facility <input type="checkbox"/> e. Resident-specific deliberate changes in the <input type="checkbox"/> i. Crisis stabilization unit in last 90 days <input type="checkbox"/> j. Other <i>(specify)</i> _____ <input type="checkbox"/> k. NONE OF ABOVE	

Resident Name: \_\_\_\_\_ Date: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Facility Provider # \_\_\_\_\_

**SECTION P. SPECIAL TREATMENTS AND PROCEDURES (cont.)**

3. NEED FOR ON-GOING MONITORING	<p>(Code for person responsible for monitoring)</p> <p>0. No monitoring required      2. RCF Other Staff</p> <p>1. RCF nurse                      3. Home health nurse</p> <p>_____ a. Acute physical or psychiatric condition - not chronic      _____ b. New treatment/medication</p>
4. REHABILITATION/RESTORATIVE CARE	<p>RECORD THE number of days each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily.)</p> <p>_____ a. Range of motion (passive)</p> <p>_____ b. Range of motion (active)</p> <p>_____ c. Splint or brace assistance</p> <p><b>TRAINING/SKILL PRACTICE IN:</b></p> <p>_____ d. Bed mobility                      _____ i. Amputation/prosthesis care</p> <p>_____ e. Transfer                              _____ j. Communication</p> <p>_____ f. Walking                                _____ k. Time management</p> <p>_____ g. Dressing or grooming            _____ l. Other (specify) _____</p> <p>_____ h. Eating or swallowing</p>
5. SKILL TRAINING	<p>Record the number of days, in the last 30 days that each of the following IADLs were performed with assistance from staff as a skill training activity identified in the resident's service plan.</p> <p>_____ a. Meal Preparation (snacks, light meals)      _____ h. Arranges Shopping (makes list, acquires help)</p> <p>_____ b. Telephone Use                      _____ i. Shopping (for groceries, clothes, or other incidentals)</p> <p>_____ c. Light Housework (makes own bed, takes care of belongings)      _____ j. Transportation (travel by various means to get to medical appointments or other necessary engagements)</p> <p>_____ d. Laundry (sorts, folds, or washes own laundry)      _____ k. Medications (preparation and administration of medications)</p> <p>_____ e. Managing Incontinence Supplies (pads, briefs, ostomy, catheter)      _____ l. Other (specify) _____</p> <p>_____ f. Managing Cash (handles cash, makes purchases)</p> <p>_____ g. Managing Finances (banking, handling checkbook, or paying bills)</p>
6. ADHERENCE WITH TREATMENTS/THERAPIES/PROGRAMS	<p>In the last 6 months, compliant all or most of the time with special treatments, therapies and programs:</p> <p><input type="checkbox"/> 0. Always compliant                      <input type="checkbox"/> 3. No treatments or programs</p> <p><input type="checkbox"/> 1. Compliant 80% of time                <input type="checkbox"/> 8. Unknown</p> <p><input type="checkbox"/> 2. Compliant less than 80% of the time</p>
7. GENERAL HOSPITAL STAY(S)	<p>Record number of times resident was admitted to an acute care hospital with an overnight stay in last 6 months (or since last assessment if less than 6 months.) (Enter "0" if no hospital admissions)</p>
8. EMERGENCY ROOM (ER) VISIT(S)	<p>Record number of times resident visited ER without an overnight stay in last 6 months (or since last assessment if less than 6 months.) (Enter "0" if no ER visits)</p>
9. PHYSICIAN VISITS	<p>In the last 6 months (or since admission to facility if less than 6 months) how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter "0" if none)</p>
10. PHYSICIAN ORDERS	<p>In the last 14 days (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter "0" if none)</p>
11. ABNORMAL LAB VALUES	<p>Has the resident had any abnormal lab values during the last 90 days (or since admission if less than 90 days)? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes</p>
12. PSYCHIATRIC HOSPITAL STAY(S)	<p>Record number of times resident was admitted to a psychiatric hospital with an overnight stay in the last 6 months (or since last assessment if less than 6 months.) (Enter "0" if no psychiatric hospital admissions)</p>
13. OUTPATIENT SURGERY	<p>Record number of times resident had outpatient surgery in the last 6 months (or since last assessment if less than 6 months.) (Enter "0" if no outpatient surgery)</p>

**SECTION Q. SERVICE PLANNING**

1. RESIDENT GOALS <i>(Check all areas in which resident has self-identified goals)</i>	<p><input type="checkbox"/> a. Health promotion/wellness/exercise</p> <p><input type="checkbox"/> b. Social involvement/making friends</p> <p><input type="checkbox"/> c. Activities/hobbies/adult learning</p> <p><input type="checkbox"/> d. Rehabilitation-skilled</p> <p><input type="checkbox"/> e. Maintaining physical or cognitive function</p> <p><input type="checkbox"/> f. Participation in the community</p> <p><input type="checkbox"/> g. Other (specify) _____</p> <p><input type="checkbox"/> h. No goals</p>
2. CONFLICT	<p>a. Any disagreement between resident and family about goals or service plan?      <input type="checkbox"/> 0. No      <input type="checkbox"/> 1. Yes</p> <p>b. Any disagreement between resident/family and staff about goals or service plan?      <input type="checkbox"/> 0. No      <input type="checkbox"/> 1. Yes</p>

**SECTION R. DISCHARGE POTENTIAL**

1. DISCHARGE POTENTIAL	<p>a. Does resident or family indicate a preference to return to community?      <input type="checkbox"/> 0. No      <input type="checkbox"/> 1. Yes</p> <p>b. Does resident have a support person who is positive towards discharge?      <input type="checkbox"/> 0. No      <input type="checkbox"/> 1. Yes</p> <p>c. Has resident's self-sufficiency changed compared to 6 months or since admission, if less than 6 months?      <input type="checkbox"/> 0. No change      <input type="checkbox"/> 1. Improved      <input type="checkbox"/> 2. Declined</p>
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**SECTION S. ASSESSMENT INFORMATION**

1. PARTICIPATION IN ASSESSMENT	<p>a. Resident:      <input type="checkbox"/> 0. No      <input type="checkbox"/> 1. Yes</p> <p>b. Family:      <input type="checkbox"/> 0. No      <input type="checkbox"/> 1. Yes      <input type="checkbox"/> 2. No Family</p> <p>c. Other Non-Staff:      <input type="checkbox"/> 0. No      <input type="checkbox"/> 1. Yes      <input type="checkbox"/> 2. None</p>
2. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:	
<p>a. Signature of Assessment Coordinator (sign on line above)</p> <p>b. Date Assessment Coordinator signed as complete      <input type="text"/> - <input type="text"/> - <input type="text"/> Month                      Day                      Year</p> <p>c. Other Signatures                      Title                      Sections                      Date</p> <p>d. _____ Date</p> <p>e. _____ Date</p>	
3. CASE MIX GROUP	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

**SECTION T. PREVENTIVE HEALTH/HEALTH BEHAVIORS**

1. PREVENTIVE HEALTH	<p><i>(Check all the procedures the resident received during the past 12 months)</i></p> <p><input type="checkbox"/> a. Blood pressure monitoring      <input type="checkbox"/> g. Breast exam or mammogram</p> <p><input type="checkbox"/> b. Hearing assessment                      <input type="checkbox"/> h. Pap smear</p> <p><input type="checkbox"/> c. Vision test                                <input type="checkbox"/> i. PSA or rectal exam</p> <p><input type="checkbox"/> d. Dental visit                                <input type="checkbox"/> j. Other (specify) _____</p> <p><input type="checkbox"/> e. Influenza vaccine</p> <p><input type="checkbox"/> f. Pneumococcal vaccine (ANY time)</p>
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Resident Name: \_\_\_\_\_ Date: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Facility Provider # \_\_\_\_\_

**MINIMUM DATA SET (MDS)<sup>®</sup>**  
**ASSISTED LIVING SERVICES (ALS)**

**DISCHARGE FORM**

**SECTION D1. IDENTIFICATION INFORMATION**

1.	<b>RESIDENT NAME</b>	a. (First)      b. (Middle Initial)      c. (Last)      d. (Jr/Sr)																				
2.	<b>GENDER</b>	<input type="checkbox"/> 1. Male <input type="checkbox"/> 2. Female																				
3.	<b>BIRTHDATE</b>	<table border="1"> <tr> <td> </td><td> </td> <td>—</td> <td> </td><td> </td> <td>—</td> <td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td colspan="2">Month</td> <td></td> <td colspan="2">Day</td> <td></td> <td colspan="4">Year</td> </tr> </table>			—			—					Month			Day			Year			
		—			—																	
Month			Day			Year																
4.	<b>RACE/ETHNICITY</b> <i>(Check only one.)</i>	<input type="checkbox"/> 1. American Indian/Alaskan Native <input type="checkbox"/> 5. White, not of Hispanic origin <input type="checkbox"/> 2. Asian/Pacific Islander <input type="checkbox"/> 3. Black, not of Hispanic origin <input type="checkbox"/> 6. Other <input type="checkbox"/> 4. Hispanic																				
5.	<b>SOCIAL SECURITY AND MEDICARE NUMBERS</b> <i>[C in 1<sup>st</sup> box if no med. no.]</i>	a. Social Security Number																				
		b. Medicare number (or comparable railroad insurance number)																				
6.	<b>FACILITY NAME AND PROVIDER NO.</b>	a. Facility Name _____  b. Provider No. <table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>																				
7.	<b>MAINECARE NO.</b>	<i>[Record a "+" if pending, "N" if not a MaineCare recipient]</i> <table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>																				
8.	<b>REASON FOR ASSESSMENT</b>	(NOTE: Other codes do not apply to this form) <input type="checkbox"/> 6. Discharged <input type="checkbox"/> 7. Discharged prior to completing initial assessment																				

**SECTION D3. ASSESSMENT/DISCHARGE INFORMATION**

1.	<b>DISCHARGE STATUS</b>	Code for resident disposition upon discharge 1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Residential care facility (specify) _____ 4. Nursing home (specify) _____ 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Deceased 9. Other (specify) _____																				
2.	<b>DISCHARGE DATE</b>	Date of death or discharge <table border="1"> <tr> <td> </td><td> </td> <td>—</td> <td> </td><td> </td> <td>—</td> <td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td colspan="2">Month</td> <td></td> <td colspan="2">Day</td> <td></td> <td colspan="4">Year</td> </tr> </table>			—			—					Month			Day			Year			
		—			—																	
Month			Day			Year																
3. <b>SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:</b>																						
a. Signatures		Title      Date																				
b.		Date																				
c.		Date																				

**SECTION D2. DEMOGRAPHIC INFORMATION**

1.	<b>DATE OF ENTRY</b>	Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date <table border="1"> <tr> <td> </td><td> </td> <td>—</td> <td> </td><td> </td> <td>—</td> <td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td colspan="2">Month</td> <td></td> <td colspan="2">Day</td> <td></td> <td colspan="4">Year</td> </tr> </table>			—			—					Month			Day			Year			
		—			—																	
Month			Day			Year																
2.	<b>ADMITTED FROM (AT ENTRY)</b> <i>(Check only one.)</i>	<input type="checkbox"/> 1. Private home/apt. <input type="checkbox"/> 2. Other residential care/assisted living/group home <input type="checkbox"/> 3. Nursing home <input type="checkbox"/> 4. Acute care hospital <input type="checkbox"/> 5. Psychiatric hospital <input type="checkbox"/> 6. MR/DD facility <input type="checkbox"/> 7. Rehabilitation hospital <input type="checkbox"/> 8. Other (specify) _____																				