

Assisted Living Individualized Service Plan (ISP)

Resident Name: _____

Female Male

Date: _____

For: Initial Six months Other _____

Note: Services to be provided and by whom: *Any additional information or change of service on this ISP must be indicated in bold type, capital letters, or by using a different color ink and dated. Indicate the reason for any change in service in the last column, and the date of the change.*

Key: N/A = Not Applicable, RA = Resident Aide, N = Nurse, P = Physician, L = Lab Tech, T = Therapist, O = Other

Part 1 – Care Needs

Activity – Check all applicable	Services to be provided:	Frequency	By Whom	Changes/Comments
Medical - Nursing				
<input type="checkbox"/> Lab Test				
<input type="checkbox"/> Pacemaker				
<input type="checkbox"/> Dialysis				
<input type="checkbox"/> Skilled Nursing, Treatments &/or Education	<input type="checkbox"/> Injection <input type="checkbox"/> Insulin <input type="checkbox"/> Other – Type _____ <input type="checkbox"/> Dressing <input type="checkbox"/> Other _____			
<input type="checkbox"/> Specialists (eg podiatrist, chiropractor)	Specify _____ _____			
<input type="checkbox"/> Medical Equipment	<input type="checkbox"/> Independent <input type="checkbox"/> Type _____ <input type="checkbox"/> 1+ Assist (<i>requires more than intermittent assistance with equipment – EALR required</i>)			
<input type="checkbox"/> Pain Management				
<input type="checkbox"/> Other	<input type="checkbox"/> health prevention <input type="checkbox"/> aide-level health related activities <input type="checkbox"/> other – specify _____ _____			

Rehabilitation	<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Other: _____			
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Nutritional				
Diet – Meal Assist	<input type="checkbox"/> Regular <input type="checkbox"/> NAS <input type="checkbox"/> NCS <input type="checkbox"/> Chopped as needed <input type="checkbox"/> Soft <input type="checkbox"/> Dietary Supplement Specify: _____	<input type="checkbox"/> Meals <input type="checkbox"/> Snacks		<input type="checkbox"/> Chewing Difficulty <input type="checkbox"/> Swallowing Difficulty <input type="checkbox"/> Other: _____

Resident Name: _____

Date: _____

Activity – Check all applicable	Services to be provided:	Frequency	By Whom	Changes/Comments
Fluid Restrictions/ Encouragement	<input type="checkbox"/> None <input type="checkbox"/> Dietary Supplements _____ <input type="checkbox"/> Other Specify: _____			

Functional				
Personal Hygiene	<input type="checkbox"/> Independent <input type="checkbox"/> Shower <input type="checkbox"/> Bath <input type="checkbox"/> Equipment			
	<input type="checkbox"/> Hearing Aide: <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Eyeglasses <input type="checkbox"/> Reading <input type="checkbox"/> Always			
	Hair: <input type="checkbox"/> Shampoo <input type="checkbox"/> Grooming <input type="checkbox"/> Shave			
	<input type="checkbox"/> Teeth Care <input type="checkbox"/> Denture Care			
	<input type="checkbox"/> Nail Care <input type="checkbox"/> Foot Care			
Contenance	<input type="checkbox"/> Independent <input type="checkbox"/> Assist with bathroom <input type="checkbox"/> Assist with protective garment change <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Chronic unmanaged incontinence <i>(chronically unwilling or unable to participate, with help from staff, so that cleanliness and sanitation can be maintained - EALR required)</i>			
Skin Care	<input type="checkbox"/> None <input type="checkbox"/> Location & Type: _____			
Dressing	<input type="checkbox"/> Independent <input type="checkbox"/> Coordinate <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Other _____			
Medications	<input type="checkbox"/> Self <input type="checkbox"/> Assist			
Transfer	<input type="checkbox"/> Independent <input type="checkbox"/> 1+ Assist (<i>chronically chairfast and/or chronically needs one person assist to transfer – EALR required</i>)			
Mobility	<input type="checkbox"/> Independent <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Wheelchair <input type="checkbox"/> Crutches <input type="checkbox"/> Escort: _____ <input type="checkbox"/> 1+ Assist (<i>chronically needs one person to assist to walk or to climb/descend stairs- EALR required</i>)			
Falls Risk Reduction	<input type="checkbox"/> No Known History <input type="checkbox"/> Other: _____			
Respiratory Therapy & Oxygen	<input type="checkbox"/> None <input type="checkbox"/> Self-managed <input type="checkbox"/> Type: _____			
Equipment	<input type="checkbox"/> None <input type="checkbox"/> Self-managed <input type="checkbox"/> Prosthesis <input type="checkbox"/> Braces <input type="checkbox"/> Other _____			

Resident Name: _____

Date: _____

Activity – Check all applicable	Services to be provided:	Frequency	By Whom	Changes/Comments
Cognitive				
Orientation	<input type="checkbox"/> N/A <input type="checkbox"/> Remind <input type="checkbox"/> Cue <input type="checkbox"/> Supervise <input type="checkbox"/> Accompany			
Specialized Services	<input type="checkbox"/> N/A <input type="checkbox"/> Dementia Care, Secured Unit (<i>requires SNALR</i>) <input type="checkbox"/> Environmental modifications <input type="checkbox"/> Supervision/Monitoring			
Sensory	<input type="checkbox"/> None <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Speech <input type="checkbox"/> Other: _____			
Mental Health	<input type="checkbox"/> Diagnosis: _____ <input type="checkbox"/> Treatment Required ___ Yes ___ No <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Coordination with SA provider _____			
Social				
Education & Employment	Desire for continued or future education: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify: _____ Desire to work or volunteer <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify: _____			
Intellectual	Desire for new or continued intellectual activity <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify: _____			
Recreational	Desire for new or continued recreational activity <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify: _____ <input type="checkbox"/> Need assistance of ALR staff Specify: _____			
Spiritual	Desire for new or continued spiritual activity <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify: _____ <input type="checkbox"/> Need assistance of ALR staff Specify: _____			
Cultural	Desire for new or continued cultural activity <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify: _____ <input type="checkbox"/> Need assistance of ALR staff Specify: _____			
Financial	Assistance with access to financial benefits (i.e. Medicare, Medicaid, Social Security, Veteran's Admin., Pensions, etc.) <input type="checkbox"/> Managed Independently <input type="checkbox"/> Assistance of family, resident rep. or legal rep. Specify: _____ <input type="checkbox"/> Need assistance of ALR staff Specify: _____			

Resident Name: _____

Date: _____

Other
Comments: _____

Print Name, Title and Organization of Individuals Participating

Resident _____

Resident's Representative _____

Resident's Legal Representative (if applicable) _____

ALR Provider's Representative _____

Was the Resident's Primary Physician Consulted?

Yes Indicate physician's name and date: _____

No

Home Care Services Agency Rep. Signature
(if applicable)

ALR Provider's Representative Signature

Date

Documentation of ISP Review: For 6-month ISP reviews please consider and review any changes in the following areas: Communication/Dental/Vision/Hearing; Customary Routine, Continence Status/Management, Physical Function, Cognitive Impairment Screen, and Admission Decision.

I am confirming the ISP services as listed above, including any changes that have been made since the last review.

I have reviewed the ISP services as listed above and recommend the following change(s) in service: _____

Name

Title

Date

Signature

Documentation of ISP Review: For 6-month ISP reviews please consider and review any changes in the following areas: Communication/Dental/Vision/Hearing; Customary Routine, Continence Status/Management, Physical Function, Cognitive Impairment Screen, and Admission Decision.

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I have reviewed the ISP services as listed above and recommend the following change(s) in service: _____

Name

Title

Date

Signature

Attach Documentation of additional ISP Reviews as Necessary

**Assisted Living Individualized Service Plan
Addendum for Enriched Housing Program/Assisted Living Residences
(If applicable)**

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The following information pertains to additional tasks not included on the ISP relating to the enriched housing program functional assessment

Activity	Services to be provided:	Frequency	By Whom	Changes/Comments
Instrumental Activities of Daily Living				
<input type="checkbox"/> Transportation	<input type="checkbox"/> independent, drives own car or accesses transportation on own & chooses to do so <input type="checkbox"/> wants or needs someone to drive them, but does not require an escort <input type="checkbox"/> must be accompanied by an escort <input type="checkbox"/> requires special transportation specify _____			
<input type="checkbox"/> Laundry	<input type="checkbox"/> is able & chooses to do own laundry <input type="checkbox"/> is able & chooses to do light laundry, but wants/needs assistance with heavy laundry <input type="checkbox"/> needs or chooses ALR to do all laundry			
<input type="checkbox"/> Housekeeping	<input type="checkbox"/> is able & chooses to do all housekeeping tasks in room/apartment <input type="checkbox"/> is able & chooses to do light housekeeping, but wants/needs assistance with heavier cleaning tasks Specify _____ <input type="checkbox"/> needs or chooses ALR to do all housekeeping			
<input type="checkbox"/> Shopping	<input type="checkbox"/> is able & chooses to shop on their own & carry or transport packages on their own <input type="checkbox"/> is able & chooses to do light shopping on their own, but wants/needs assistance with major shopping Specify _____ <input type="checkbox"/> needs or chooses ALR staff or other person (i.e. family member) to do all of their shopping			
<input type="checkbox"/> Ability to use telephone	<input type="checkbox"/> Independent-has phone & dials numbers and answers calls without assistance <input type="checkbox"/> has specially adapted phone and dials numbers and answers calls without assistance <input type="checkbox"/> chooses or needs ALR staff to help them make calls or make the calls on their behalf			