THE LAKE SHORE

ASSISTED LIVING RESIDENCE

RESIDENCY AGREEMENT

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THIS AGREEMENT is made between Lake Haven Equities, Inc. d/b/a The Lake Shore Assisted Living Residence,_____(the "Resident"), _____(the "Resident's Representative") and_____(the "Resident's Legal Representative").

RECITALS

The Operator is licensed by the New York State Department of Health to operate at 211 Lake Shore Road, Ronkonkoma, New York 11779 as an Assisted Living Residence known as The Lake Shore Assisted Living Residence and as an Adult Home.

You have requested to become a Resident at The Residence and the Operator has accepted your request.

AGREEMENTS

I. **Housing Accommodations and Services**.

Beginning on _____, _____, the Operator shall provide the following housing accommodations and services to You, subject to the other terms, limitations and conditions contained in this Agreement. This Agreement will remain in effect until amended or terminated by the parties in accordance with the provisions of this Agreement.

A. **Housing Accommodations and Services**

1. **Your Apartment/Room**. You may occupy and use a private ( ) or semi-private ( ) room, identified on Exhibit I.A.1., subject to the terms of this Agreement. ____ Room #

2. **Common areas**. You will be provided with the opportunity to use the general purpose rooms at the Residence such as lounges, cocktail lounges, Gift Shops, Game Room and Library.

3. **Furnishings/Appliances Provided By The Operator**

1. Resident's rooms contain no more than two beds.
2. Each resident is provided with a standard size bed with a mattress and box spring, pillow, bed linens, bed spread and blankets maintained by the facility.
3. A wardrobe or closet is provided along with a desk and a desk lamp. A lamp is also provided over the bed.
4. A chair is provided for each resident.
5. A dresser is provided for each resident.
6. The room is equipped for cable television. The resident must provide their own television. The cable charge is nominal.
7. A lockable storage cabinet for personal articles and medications.
8. A hinged entry door.

9. **Furnishings/Appliances Provided by You**

You may bring the following items into your room:

Refrigerator, Television, Three foot surge protector Extension Cord, Telephone, A Dresser no larger than 3 feet in width (a dresser will be provided to you unless you wish to provide your own.

You may not have the following items in your room:

Hot plates or other cooking devices, Microwaves, Coffee makers, Irons.

B. **Basic Services**

The following services will be provided to you, in accordance with your Individualized Services Plan.

1. **Meals and Snacks**. Three nutritionally well-balanced meals per day and two snacks per day are included in Your Basic Rate. The following modified diets will be available to You if ordered by Your physician and included in Your Individualized Service Plan: NAS, NCS, and Regular.

2. **Activities**. The Operator will provide a program of planned activities, opportunities for community participation and services designed to meet Your physical, social and spiritual needs, and will post a monthly schedule of activities in a readily visible common area of the Residence.

3. **Housekeeping**.

4. **Linen Service**. Towels; pillow, pillowcase, blanket, bed sheets, bedspread; all clean and in good condition, are provided by the Operator.

5. **Laundry of Your personal Washable clothing**.

6. **Supervision on a 24-hour basis**. The Operator will provide appropriate staff on-site to provide supervision services in accordance with law. Supervision will include monitoring as well as the other components of supervision as specified in law.

7. **Case Management**. The Operator will provide appropriate staff to provide case management services in accordance with law. Such case management services will include identification and assessment of Your needs and interests, information and referral, and coordination with available resources to best address Your identified needs and interests.

8. **Personal Care**. Include some assistance with bathing, grooming, dressing, toileting, ambulation, transferring, feeding, medication acquisition, storage and disposal, assistance with self-administration of medication.

9. **Development of Individualized Service Plan**. Development of the Individualized Service Plan includes ongoing review and revision as necessary. This Individualized Service Plan will be reviewed and revised every six months and whenever ordered by

Resident physician or as frequently as necessary to reflect the changing needs of the Resident.

C. **Additional Services**.

Exhibit I.C., attached to and made a part of this Agreement, describes in detail, any additional services or amenities available for an additional, supplemental or community fee from the Operator directly or through arrangements with the Operator. Such exhibit states who would provide such services or amenities if other than the Operator.

D. **Licensure/Certification Status**. The Operator does not have any arrangements with outside home care or personal care providers to serve residents. Should this change in the future, you will be provided with a listing of such providers with a statement describing the licensure or certification status of each provider and this will be updated as frequently as necessary.

II. <u>Fees</u>

A. **Basic Rate**.

The Resident, Resident's Representative and Resident's Legal Representative agree that the Resident (or other *specified party*) will pay, and the Operator agrees to accept, the following payment in full satisfaction of the Basic Services described in Section I. B. of this Agreement. The Basic Rate as of the date of this agreement is ($_____ per month). Your Basic Rate is determined by your room selection and

may increase pursuant to Section III.E, below. Pursuant to State Regulations, you will receive a notice 45 days prior to any increase. The current rates for various rooms are set forth in Exhibit III.C.

B. **Supplemental, Additional or Community Fees**

A Supplemental or Additional fee is a fee for service, care or amenities that is in addition to those fees included in the Basic Rate.

A Supplemental fee must be at Resident option. In some cases, the law permits the Operator to charge an Additional fee without the express written approval of the Resident. Supplemental Fees for Additional Services, Supplies or Amenities are set forth in Exhibit I.C.

A Community fee is a one-time fee that the Operator may charge at the time of admission. The Operator must clearly inform the prospective Resident of what the Community fee will be, as well as any terms regarding refund of the Community fee. The prospective Resident, once fully informed of the terms of the Community fee, may choose whether to accept the Community fee as a condition of residency in the Residence, or to reject the Community fee and thereby reject residency at the Residence. The Operator charges a non-refundable, one-time Community Fee in the amount of one (1) month's rent.

Any charges by the Operator, whether a part of the Basic Rate, Supplemental, Additional or Community fees, shall be made only for services and supplies that are actually supplied to the Resident.

C. **Billing and Payment Terms**

Payment is due by the first of the month and shall be delivered to The Lake Shore Assisted Living Residence. ***A late fee of 1.5% per month will be assessed on any payment due that is not received before the 10th of the month and on any outstanding balances.***

In the event that a Resident, Resident's representative or Resident's Legal representative is no longer able to pay for services provided for in this Agreement or additional services or care needed by the Resident, the facility will provide the resident with notification of termination of the Agreement and assist the resident in finding another placement, in accordance with Section XIII of this Agreement. The Resident has the right to contest any determination that payment was received late.

D. **Adjustments to Basic Rate or Additional or Supplemental Fees**

1. You have the right to written notice of any proposed increase of the Basic Rate or any Additional or Supplemental fees forty-five (45) days prior to the effective date of the rate or fee increase, subject to the exceptions stated in paragraphs 3, 4 and 5 below.
2. Since a Community Fee is a one-time fee, there can be no subsequent increase in a Community Fee charged to You by the Operator, once You have been admitted as a resident.
3. If You, or Your Resident Representative or Legal Representative agree in writing to a specific Rate or Fee increase, through an amendment of this Agreement due to Your need for additional

care, services or supplies, the Operator may increase such Rate or Fee upon less than forty-five (45) days written notice.

4. If the Operator provides additional care, services or supplies upon the express written order of Your primary physician, the Operator may, through an amendment to this Agreement, increase the Basic Rate or an Additional or Supplementary fee upon less than forty-five (45) days written Notice.

5. In the event of any emergency which affects You, the Operator may assess additional charges for Your benefit as are reasonable and necessary for services, material, equipment and food supplied during such emergency.

E. **Bed Reservation**

The Operator agrees to reserve a residential space as specified in Section I.A.1 above in the event of Your absence. The daily charge for this reservation is prorated from the basic rate as set forth within Exhibit III.C. Rooms may be reserved indefinitely, subject to any increase made pursuant to Section III. G. above. A provision to reserve a residential space does not supersede the requirements for termination as set forth in Section XIII of this agreement. You may choose to terminate this agreement rather than reserve such space, but must provide the Operator with any required notice.

III. **Refund/Return of Resident Monies and Property**

Upon termination of this agreement or at the time of Your discharge, but in no case more than three business days after You leave the Residence, the Operator must provide You, Your Resident Representative or Legal Representative or any person designated by You with a final written statement of Your payment and personal allowance accounts at the Residence. The Operator must also return at the time of Your discharge, but in no case more than three business days any of Your money or property which comes into the possession of the Operator after Your discharge. The Operator must refund on the basis of a per diem proration any advance payment(s) which You have made.

If You die, the Operator must turn over Your property to the legally authorized representative of Your estate.

If You die without a will and the whereabouts of Your next-of-kin is unknown, the Operator shall contact the Surrogate's Court of the County wherein the Residence is located in order to determine what should be done with property of Your estate.

IV. **Fiduciary Responsibility**

If the Operator assumes management responsibility over Your funds, the Operator shall maintain such funds in a fiduciary capacity to You. Any interest on money received and held for You by the Operator shall be Your property.

V. **Tipping**

The Operator must not accept, nor allow Residence staff or agents to accept, any tip or gratuity in any form for any services provided or arranged for as specified by statute, regulation or agreement.

VI. **Personal Allowance Accounts**

The Operator agrees to offer to establish a personal allowance account for any Resident who receives either Supplemental Security Income (SSI) or Safety Net Assistance (SNA) payments by executing a Statement of Offering (DSS-2853) with You or Your Representative.

You agree to inform the Operator if you receive or have applied for Supplemental Security Income (SSI) or Safety Net Assistance (SNA) funds.

You must complete the following:

I receive SSI funds _____ or I have applied for SSI funds_____

I receive SNA funds____ or I have applied for SNA funds____

I do not receive either SSI or SNA funds _____

If You have a signatory to this agreement besides Yourself and if that signatory does not choose to place Your personal allowance funds in a Residence maintained account, then that signatory hereby agrees that he/she will comply with the Supplemental Security Income (SSI) or Safety Net Assistance (SNA) personal allowance requirements.

SSI rates are contingent upon initial and continued eligibility for SSI. Payment of the private pay rate will be required upon ineligibility for SSI.

VII. **Admission and Retention Criteria for an Assisted Living Residence**

A. Under the law which governs Assisted Living Residences (Public Health Law Article 46-b), the Operator shall not admit any Resident if the Operator is not able to meet the care needs of the Resident, within the scope of services authorized under such law, and within the scope of services determined necessary within the Resident's Individualized Services Plan. The Operator shall not admit any Resident in need of 24-hour skilled nursing care.

B. The Operator shall conduct an initial pre-admission evaluation of a prospective Resident to determine whether or not the individual is appropriate for admission.

C. The Operator has conducted such evaluation of Yourself and has determined that You are appropriate for admission to this Residence, and that the Operator is able to meet Your care needs within the scope of services authorized under the law and within the scope of services determined necessary for You under Your Individualized Services Plan.

D. If You are residing in a "Basic" Assisted Living Residence and Your care needs subsequently change in the future to the point that You require either Enhanced Assisted Living Care or 24-hour skilled nursing care, You will no longer be appropriate for residency in this Basic Residence. If this occurs, the Operator will take the appropriate action to terminate this Agreement, pursuant to Section XIII of the Agreement.

VIII. **Rules of the Residence**

By signing this agreement, You and Your representatives agree to adhere to all Rights and Responsibilities of Residents in Assisted Living Residences contained in Exhibit XV and in section XII, below.

IX. **Responsibilities of Resident, Resident's Representative and Resident's Legal Representative**

A. You, or Your Representative or Legal Representative to the extent specified in this Agreement, are responsible for the following:

1. Payment of the Basic Rate and any authorized Additional and agreed-to Supplemental or Community Fees as detailed in this Agreement.
2. Supply of personal clothing and effects.
3. Payment of all medical expenses including transportation for medical purposes, except when payment is available under Medicare, Medicaid or other third party coverage.
4. At the time of admission and at least once every twelve (12) months, or more frequently if a change in condition warrants, providing the Operator with a dated and signed medical evaluation that conforms to regulations of the New York State Department of Health.
5. Informing the Operator promptly of change in health status, change in physician, or change in medications.
6. Informing the Operator promptly of any change of name, address and/or phone number.

B. The Resident's Representative shall be responsible for the following:

(*enter Legal Representative*)

_____

_____

_____

X. **Termination and Discharge**

A. This Residency Agreement and residency in the Residence may be terminated in any of the following ways:

1. By mutual agreement between You and the Operator;
2. Upon 30 days written notice from You or Your Representative to the Operator of Your intention to terminate the agreement and leave the facility. This notice is required regardless of your reason for termination of the agreement;
3. Upon 30 days written notice from the Operator to You, Your Representative, Your next of kin, the person designated in this agreement as the responsible party and any person designated by You. Involuntary termination of a Residency Agreement is permitted only for the reasons listed below, and then only if the Operator initiates a court proceeding and the court rules in favor of the Operator.

B. The grounds upon which involuntary termination may occur are:

1. You require continual medical or nursing care which the Residence is not permitted by law or regulation to provide;
2. If Your behavior poses imminent risk of death or imminent risk of serious physical harm to You or anyone else;
3. You fail to make timely payment for all authorized charges, expenses and other assessments, if any, for services including use and occupancy of the premises, materials, equipment and food which You have agreed to pay under this Agreement. If Your failure to make timely payment resulted from an interruption in Your receipt of any public benefit to which You are entitled, no involuntary termination of this Agreement can take place unless the Operator, during the thirty-day period of notice of termination, assists You in obtaining such public benefits or other available supplemental public benefits. You agree that You will cooperate with such efforts by the Operator to obtain such benefits.
4. You repeatedly behave in a manner that directly impairs the well-being, care or safety of Yourself or any other Resident, or which substantially interferes with the orderly operation of the Residence;
5. The Operator has had his/her operating certificate limited, revoked, temporarily suspended or the Operator has voluntarily surrendered the operation of the facility;
6. A receiver has been appointed pursuant to Section 461-f of the New York State Social Services Law and is providing for the

orderly transfer of all residents in the Residence to other residences or is making other provisions for the Residents' continued safety and care.

If the Operator decides to terminate the Residency Agreement for any of the reasons stated above, the Operator will give You a notice of termination and discharge, which must be at least 30 days after delivery of notice, the reason for termination, a statement of Your right to object and a list of free legal advocacy resources approved by the State Department of Health.

You may object to the Operator about the proposed termination and may be represented by an attorney or advocate. If You challenge the termination, the Operator, in order to terminate, must institute a special proceeding in court. You will not be discharged against Your will unless the court rules in favor of the Operator.

While legal action is in progress, the Operator must not seek to amend the Residency Agreement in effect as of the date of the notice of termination, fail to provide any of the care and services required by Department regulations and the Residency Agreement, or engage in any action to intimidate or harass You.

Both You and the Operator are free to seek any other judicial relief to which they may be entitled.

The Operator must assist You if the Operator proposes to transfer or discharge You to the extent necessary to assure, whenever

practicable, Your placement in a care setting which is adequate, appropriate and consistent with Your wishes.

XI. **Transfer**

A. Notwithstanding the above, an Operator may seek appropriate evaluation and assistance and may arrange for Your transfer to an appropriate and safe location, prior to termination of a Residency Agreement and without 30 days' notice or court review, for the following reasons:

1. When You develop a communicable disease, medical or mental condition, or sustains an injury such that continual skilled medical or nursing services are required;

2. In the event that Your behavior poses an imminent risk of death or serious physical injury to him/herself or others; or

3. When a Receiver has been appointed under the provisions of New York State Social Services Law and is providing for the orderly transfer of all Residents in the Residence to other residences or is making other provisions for the Residents' continued safety and care.

If You are transferred, in order to terminate Your Residency Agreement, the Operator must proceed with the termination requirements as set forth in Section XIII of this Agreement, except that the written notice of termination must be hand delivered to You at the location to which You have been moved. If such hand delivery is not possible, then the notice must be given by any of the

methods provided by law for personal service upon a natural person.

If the basis for the transfer permitted under parts 1 and 2 above of this Section no longer exists, You are deemed appropriate for placement in this Residence and if the Residency Agreement is still in effect, You must be readmitted.

XII. **Resident Rights and Responsibilities**

Attached as Exhibit XV and made a part of this Agreement is a Statement of Resident Rights and Responsibilities. This Statement will be posted in a readily visible common area in the Residence. The Operator agrees to treat You in accordance with such Statement of Resident Rights and Responsibilities.

XIII. **Complaint Resolution**

The Operator's procedures for receiving and responding to resident grievances and recommendations for change or improvement in the Residence's operations and programs are attached as Exhibit XVI and made a part of this Agreement. In addition, such procedures will be posted in a readily visible common area of the Residence.

The Operator agrees that the Residents of the Residence may organize and maintain councils or such other self-governing body as the Residents may choose. The Operator agrees to address any complaints, problems, issues or suggestions reported by the Residents' Organization and to provide a written report to the Residents' organization that addresses the same.

Complaint handling is a direct service of the Long Term Care Ombudsman Program. The Long Term Care Ombudsman is available to identify, investigate and resolve Your complaints in order to assist in the protection and exercise of Your rights.

XIV. **Miscellaneous Provisions**

A. This Agreement constitutes the entire Agreement of the parties.

B. This Agreement may be amended upon the written agreement of the parties; provided however, that any amendment or provision of this Agreement not consistent with the statute and regulation shall be null and void.

C. The parties agree that assisted living residency agreements and related documents executed by the parties shall be maintained by the Operator in files of the Residence from the date of execution until three years after the Agreement is terminated. The parties further agree that such agreements and related documents shall be made available for inspection by the New York State Department of Health upon request at any time.

D. Waiver by the parties of any provision in this Agreement which is required by statute or regulation shall be null and void.

XV. **Agreement Authorization**

We, the undersigned, have read this Agreement, have received a duplicate copy thereof, and agree to abide by the terms and conditions therein.

Dated:

_____ _____
(Signature of Resident)

Dated:

_____ _____
(Signature of Resident's Representative)

Dated:

_____ _____
(Signature of Resident's Legal Representative)

Dated:

_____ _____
(Signature of Operator or the Operator's Representative)

Personal Guarantee of Payment

_____ personally guarantees payment of charges for Your Basic Rate.

_____ personally guarantees payment of charges for the following services, materials or equipment, provided to You, that are not covered by the Basic Rate:

_____ _____

(Date) Guarantor's Signature

EXHIBIT I.C.

ADDITIONAL SERVICES, SUPPLIES OR AMENITIES

The following services, supplies or amenities are available from the operator directly or through arrangements with the Operator for the following additional charges:

Item	Additional Charge	Provided By
Dry Cleaning	Vendor Cost	Facility
Professional Hair Grooming	Vendor Cost	Beautician
Personal Toilet Articles	Cost Varies	Facility
Commissary Goods	Cost Varies	Facility
Long Distance Telephone Service	Vendor Cost	Phone Company
Local Phone Service	Vendor Cost	Phone Company
Moving Large Furniture	$50.00 item	Facility
Recreational Activities	Some activities may be an additional cost	Facility
Pets	$200.00 per month Cost of dry food	Facility

EXHIBIT II

DISCLOSURE STATEMENT

Lake Haven Equities, Inc. as operator of The Lake Shore Assisted Living Residence , hereby discloses the following, as required by Public Health Law Section 4658 (3).

1. The Consumer Information Guide developed by the Commissioner of Health is hereby attached hereto.
2. The Operator is licensed by the New York State Department of Health to operate 211 Lake Shore Road, Lake Ronkonkoma, New York, 11779 as an Assisted Living Residence as well as an Adult Home.
3. The owner of the real property upon which the Residence is located is Lake Haven Equities. The mailing address of such real property owner is 211 Lake Shore Road, Lake Ronkonkoma, NY 11779. The following individual is authorized to accept personal service on behalf of such real property owner: Harold Henry Marcus, 211 Lake Shore Road, Lake Ronkonkoma, NY 11779.
4. The Operator of the Residence is Harold Henry Marcus. The mailing address of the Operator is 211 Lake Shore Road, Lake Ronkonkoma, NY 11779. The following individual is authorized to accept personal service on behalf of the Operator: Steven Marcus, 211 Lake Shore Road, Lake Ronkonkoma, NY 11779.
5. List any ownership interest in excess of 10% on the part of The Operator (whether a legal or beneficial interest), in any entity which provides care, material, equipment or

other services to residents of the Residence. None

6. List any ownership interest in excess of 10% (whether legal or beneficial interest) on the part of any entity which provides care, material, equipment or other services to residents of The Residence, in the Operator. None

7. All residents have the right to receive services from any provider, regardless of whether the operator of this residence has an arrangement with the provider.

8. Residents shall have the right to choose their health care providers, notwithstanding any other agreement to the contrary.

9. All residents should be aware that public funds for the payment of residential, supportive or home health services are available for eligible individuals. Residents should also be aware that the facility does not accept public funds payments as payment in full. Therefore, if the facility rate exceeds the amount of public funds available to the resident, and the resident is unable to pay (in full) the balance of the facility's basic daily rate, the facility will assist the resident in securing placement at another facility, pursuant to applicable law and regulation.

10. The New York State Department of Health's toll free telephone number for reporting of complaints regarding the services provided by the Assisted Living Operator or Home Care Agencies is 1-866-893-6772.

11. The New York State Long Term Care Ombudsman Program (NYSLTCOP) provides a toll free number 1-800-342-9871 to request an Ombudsman to advocate for the

resident. (631) 427-3700 x 273 is the Local LTCOP telephone number. The NYSLTCOP web site is www.ltcombudsman.ny.gov.

EXHIBIT III.A.2.

TIERED FEE ARRANGEMENTS

The tiered fee arrangement is as follows:

Tier 1 includes all basic services plus incontinence management. $ 500/month

** All services will be provided by the Operator unless Resident is notified in writing of third party provider.

EXHIBIT III.B.

SUPPLEMENTAL, ADDITIONAL OR COMMUNITY FEES

A one-time community fee of one (1) month's rent is charged upon admission. This fee is non-refundable.

EXHIBIT III.C

RATE OR FEE SCHEDULE

Monthly Fee Schedule

1st Floor

Semi-Private	From:	$3,000.00
Private	From:	$4,000.00

2nd & 3rd FloorLake View Room

Semi-Private	From:	$3,000.00
Private	From:	$4,000.00

2nd & 3rd FloorNon Lake View Standard Room

Semi-Private	From:	$2,700.00
Private	From:	$3,600.00

Pets:

- If the resident wishes to have a pet in their room, the monthly charge will be $200.00.
- The resident must have a private room unless their roommate agrees to have the pet in their room.
- You must submit in advance and yearly thereafter the current immunization records for the pet.

EXHIBIT XI.

RULES OF THE RESIDENCE

1. All residents and their guests or companions must respect the rights of other residents to maintain a comfortable home. All residents and their guests must treat other residents, their guest and staff with respect and curtail any activities that interrupt other resident's enjoyment of the residence.
2. Respect the property of other residents and of the residence.
3. NO SMOKING is permitted in the facility.
4. Regular visiting hours are from 10am to 8pm. All visitors and residents must sign in and out when entering or leaving the facility. For your safety, all absences past 9pm, including overnight absences, and planned missed meals should be reported to the case manager.
5. If you are ordering or administering any of your medications without the assistance of the residence, including vitamins, herbal medications, over the counter medications, and dietary supplements must always be cleared by your primary care physician and be locked in your room. Residence staff must be informed of your medications. Any medications stored in your room must be under lock and key.
6. PRN medications, or those medications taken as needed, are permitted only if the prescribing physician indicates that you can express the need for the medication or that you can self-administer the PRN.
7. Residents and their guest or companions must participate in all fire drills as per fire department regulations.
8. Provide accurate and complete information, to the best of Your knowledge, about present condition, past illnesses and hospitalizations, medications and other matters relating to Your health
9. Avoid accidents by keeping Your apartment clean. Pick up clothing, books, shoes and other items that might cause someone to trip or fall.
10. Advise staff if anything in Your apartment needs to be repaired or moved.

11. Refrain from storing any personal items outside of your own apartment, which includes refraining from storing your items in common areas both inside and outside of the building, without receiving permission from the administrator.
12. Residents and their guests must obey the speed limit while in the parking area located in the back of the facility, which is 5 MPH.
13. Residents and their guests may not feed the geese and ducks, or any other wild animals due to potential health hazards and overpopulation.
14. If a resident wishes to have a vehicle at the facility for their use. They must provide the facility with a note from their physician stating their ability to drive. They must also be willing to sign our Policy and Procedure on having the car at our facility. They must also provide a copy of their driver's license and proof of insurance.

EXHIBIT XV

RIGHTS AND RESPONSIBILITIES OF RESIDENTS IN ASSISTED LIVING RESIDENCES

RESIDENT'S RIGHTS AND RESPONSIBLITIES SHALL INCLUDE, BUT NOT BE LIMITED TO THE FOLLOWING:

(A) EVERY RESIDENT'S PARTICIPATION IN ASSISTED LIVING SHALL BE VOLUNTARY, AND PROSPECTIVE RESIDENTS SHALL BE PROVIDED WITH SUFFICIENT INFORMATION REGARDING THE RESIDENCE TO MAKE AN INFORMED CHOICE REGARDING PARTICIPATION AND ACCEPTANCE OF SERVICES;

(B) EVERY RESIDENT'S CIVIL AND RELIGIOUS LIBERTIES, INCLUDING THE RIGHT TO INDEPENDENT PERSONAL DECISIONS AND KNOWLEDGE OF AVAILABLE CHOICES, SHALL NOT BE INFRINGED;

(C) EVERY RESIDENT SHALL HAVE THE RIGHT TO HAVE PRIVATE COMMUNICATIONS AND CONSULTATION WITH HIS OR HER PHYSICIAN, ATTORNEY, AND ANY OTHER PERSON;

(D) EVERY RESIDENT, RESIDENT'S REPRESENATATIVE AND RESIDENT'S LEGAL REPRESENTATIVE, IF ANY, SHALL HAVE THE RIGHT TO PRESENT GRIEVANCES ON BEHALF OF HIMSELF OR HERSELF OR OTHERS, TO THE RESIDENCE'S STAFF, ADMINISTRATOR OR ASSISTED LIVING OPERATOR, TO GOVERNMENTAL OFFICIALS, TO LONG TERM CARE OMBUDSMEN OR TO ANY OTHER PERSON WITHOUT FEAR OF REPRISAL, AND TO JOIN WITH OTHER RESIDENTS OR INDIVIDUALS WITHIN OR OUTSIDE OF THE RESIDENCE TO WORK FOR IMPROVEMENTS IN RESIDENT CARE;

(E) EVERY RESIDENT SHALL HAVE THE RIGHT TO MANAGE HIS OR HER OWN FINANCIAL AFFAIRS;

(F) EVERY RESIDENT SHALL HAVE THE RIGHT TO HAVE PRIVACY IN TREATMENT AND IN CARING FOR PERSONAL NEEDS;

(G) EVERY RESIDENT SHALL HAVE THE RIGHT TO CONFIDENTIALITY IN THE TREATMENT OF PERSONAL, SOCIAL, FINANCIAL AND MEDICAL RECORDS, AND SECURITY IN STORING PERSONAL PROSSESSIONS;

(H) EVERY RESIDENT SHALL HAVE THE RIGHT TO RECEIVE COURTEOUS, FAIR AND RESPECTFUL CARE AND TREATMENT AND A

WRITTEN STATEMENT OF THE SERVICES PROVIDED BY THE RESIDENCE, INCLUDING THOSE REQUIRED TO BE OFFERED ON AN AS-NEEDED BASIS;

(I) EVERY RESIDENT SHALL HAVE THE RIGHT TO RECEIVE OR TO SEND PERSONAL MAIL OR ANY OTHER CORRESPONDENCE WITHOUT INTERCEPTION OR INTERFERENCE BY THE OPERATOR OR ANY PERSON AFFILIATED WITH THE OPERATOR;

(J) EVERY RESIDENT SHALL HAVE THE RIGHT NOT TO BE COERCED OR REQUIRED TO PERFORM WORK OF STAFF MEMBERS OR CONTRACTUAL WORK;

(K) EVERY RESIDENT SHALL HAVE THE RIGHT TO HAVE SECURITY FOR ANY PERSONAL POSSESSIONS IF STORED BY THE OPERATOR;

(L) EVERY RESIDENT SHALL HAVE THE RIGHT TO RECEIVE ADEQUATE AND APPROPRIATE ASSISTANCE WITH ACTIVITIES OF DAILY LIVING, TO BE FULLY INFORMED OF THEIR MEDICAL CONDITION AND PROPOSED TREATMENT, UNLESS MEDICALLY CONTRAINDICATED, AND TO REFUSE MEDICATION, TREATMENT OR SERVICES AFTER BEING FULLY INFORMED OF THE CONSEQUENCES OF SUCH ACTIONS, PROVIDED THAT AN OPERATOR SHALL NOT BE HELD LIABLE OR PENALIZED FOR COMPLYING WITH THE REFUSAL OF SUCH MEDICATION, TREATMENT OR SERVICES BY A RESIDENT WHO HAS BEEN FULLY INFORMED OF THE CONSEQUECES OF SUCH REFUSAL;

(M) EVERY RESIDENT AND VISITOR SHALL HAVE THE RESPONSIBILITY TO OBEY ALL REASONABLE REGULATIONS OF THE RESIDENCE AND TO RESPECT THE PERSONAL RIGHTS AND PRIVATE PROPERTY OF THE OTHER RESIDENTS;

(N) EVERY RESIDENT SHALL HAVE THE RIGHT TO INCLUDE THEIR SIGNED AND WITNESSED VERSION OF THE EVENTS LEADING TO AN ACCIDENT OR INCIDENT INVOLVING SUCH RESIDENT IN ANY REPORT OF SUCH ACCIDENT OR INCIDENT;

(O) EVERY RESIDENT SHALL HAVE THE RIGHT TO RECEIVE VISITS FROM FAMILY MEMBERS AND OTHER ADULTS OF THE RESIDENT'S CHOOSING WITHOUT INTERFERENCE FROM THE ASSISTED LIVING RESIDENCE;

(P) EVERY RESIDENT SHALL HAVE THE RIGHT TO WRITTEN NOTICE OF ANY FEE INCREASE NOT LESS THAN FORTY-FIVE DAYS PRIOR TO THE PROPOSED EFFECTIVE DATE OF THE FEE INCREASE; PROVIDED, HOWEVER, PROVIDING ADDITIONAL SERVICES TO A RESIDENT SHALL NOT BE CONSIDERED A FEE INCREASE PURSUANT TO THIS PARAGRAPH; AND

(Q) EVERY RESIDENT OF ANY ASSISTED LIVING RESIDENCE THAT IS ALSO CERTIFIED TO PROVIDE ENHANCED ASSISTED LIVING AND/OR SPECIAL NEEDS ASSISTED LIVING SHALL HAVE A RIGHT TO BE INFORMED BY THE OPERATOR, BY A CONSPICUOUS POSTING IN THE RESIDENCE, ON AT LEAST A MONTHLY BASIS, OF THE THEN-CURRENT VACANCIES AVAILABLE, IF ANY, UNDER THE OPERATOR'S ENHANCED AND/OR SPECIAL NEEDS ASSISTED LIVING PROGRAMS.

WAIVER OF ANY OF THESE RESIDENT RIGHTS SHALL BE VOID. A RESIDENT CANNOT LAWFULLY SIGN AWAY THE ABOVE-STATED RIGHTS AND RESPONSIBILITIES THROUGH A WAIVER OR ANY OTHER MEANS.

EXHIBIT XVI

OPERATOR PROCEDURES: RESIDENT GRIEVANCES AND RECOMMENDATIONS

The Operator welcomes and encourages recommendations from residents for changes or improvements in the Facility. Residents are encouraged to participate in the Resident Council or other member-driven resident organization as a vehicle to provide such recommendations. In addition, residents may submit recommendations directly to the Operator or his designee.

Residents may submit grievances, in writing, to the Operator or his designee. Such grievances shall remain confidential, unless the resident chooses otherwise, and shall be responded to, in writing, within 30 days of receipt. Grievances may also be submitted anonymously through the Resident Council. Under these circumstances, a written response from the Operator or his designee will be directed to the Resident's Council within 30 days of receipt.

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

ALL SPACES MUST BE FILLED OUT

Resident's Name: _____ **Date of Exam:** _____

Facility Name: _____ Date of Birth:_____ Sex:_____

Present Home Address:_____
Street City State Zip

Reason for evaluation: ☐ Pre-Admission ☐ 12 month ☐ Acute change in condition ☐ Other :_____

MEDICAL REVIEW FINDINGS

Vital Signs: BP: _____ Pulse:_____ Resp: _____ T: _____ Height: _____ft _____in. Weight: _____

Primary Diagnosis(s): _____

_____

Secondary Diagnosis(s): _____

_____

Allergies: ☐ **None** or list **Known Allergies:** _____

Diet: ☐ Regular ☐ No Added Salt ☐ No Concentrated Sweets ☐ Other: _____

Immunizations: ☐ Influenza (Date_____) ☐ Pneumococcal Vaccine (Date_____)

TB SCREENING ***(****performed* **within *30 days prior to initial admission*** *unless medically contraindicated)*

☐**Test is contraindicated** **Test:** ☐ TST1 ☐ TST2 ☐TB Blood Test (Type)_____ Date_____ Result_____

TST1: Date placed_____ Date Read_____ mm_____ TST2: Date placed_____ Date Read_____ mm_____

Based on my findings and on my knowledge of this patient, I find that the patient _____ **IS** _____ **IS NOT** exhibiting signs or symptoms suggestive of communicable disease that could be transmitted through casual contact.

CONTINENCE

Bladder: Yes ☐ No ☐ If no, is incontinence managed? Yes ☐ No ☐
Bowel: Yes ☐ No ☐ If no, is incontinence managed? Yes ☐ No ☐

If no, recommendations for management:_____

LABORATORY SERVICES: ☐None

Lab Test	Reason/Frequency	Lab Test	Reason/Frequency
_____	_____	_____	_____
_____	_____	_____	_____

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

Patient/Resident Name: _____ Date: _____

ACTIVITIES OF DAILY LIVING (ADL's)

Activity Restrictions: No ☐ Yes ☐ (describe):_____

Dependent on Medical Equipment: No ☐ Yes ☐ (describe):_____

Level and frequency of assistance required/needed by the resident of another person to perform the following:

1. Ambulate: Independent ☐ Intermittent ☐ Continual ☐
2. Transfer: Independent ☐ Intermittent ☐ Continual ☐
3. Feeding: Independent ☐ Intermittent ☐ Continual ☐
4. Manage Medical Equipment: Manages Independently ☐ Cannot Manage Independently ☐

ADDITIONAL SERVICES IF INDICATED BY RESIDENT NEED:

Pertinent medical/mental findings requiring follow-up by facility (e.g. skin conditions/acute or chronic pain issues) or any additional recommendations for follow-up: None ☐ or if yes, describe_____

_____

Therapies: ☐ None ☐Yes (specify): ☐ Physical Therapy ☐Speech Therapy ☐Occupational Therapy

Home Care: ☐ None ☐Yes (specify):_____ Other (Specify):_____

Is Palliative Care Appropriate/Recommended: ☐No ☐ If yes, describe services: _____

COGNITIVE IMPAIRMENT/MEMORY LOSS (including dementia)

Does the patient have/show signs of dementia or other cognitive impairment? ☐ No ☐ Yes

If yes, do you recommended testing be performed? ☐ No ☐ If yes, referral to:_____

If testing has already been performed, date/place of testing if known:_____

MENTAL HEALTH ASSESSMENT (non-dementia)

Does the patient have a history of or a current mental disability? ☐ No ☐ Yes
Has the patient ever been hospitalized for a mental health condition? ☐ No ☐ Yes

If yes, describe: _____

Based on your examination, would you recommend the patient seek a mental health evaluation? (If yes, provide referral)
☐No ☐Yes Describe: _____

MEDICATIONS

Pursuant to NYCRR Title 18 487.7(f)(2), the patient is **NOT** capable of self-administration of medication if he/she needs assistance to properly carry out **ONE OR MORE** of the following tasks:

- ■ Correctly read the label on a medication container
- ■ Correctly ingest, inject or apply the medication
- ■ Open the container
- ■ Safely store the medication
- ■ Correctly follow instructions as the route, time dosage and frequency
- ■ Measure or prepare medications, including mixing, shaking and filling syringes
- ■ Correctly interpret the label

New York State Department of Health
Division of Assisted Living

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

Patient/Resident Name: _____ **Date:** _____

Resident will receive assistance with <u>all</u> medications <u>unless</u> physician indicates that resident is capable of self-administration.

1. Does the patient/resident require assistance with medications (see criteria on page 2)? Yes ☐ No ☐
2. List all prescription, OTC medications, supplements and vitamins. Attach additional sheets if necessary or attach current discharge note, signed by the physician, listing ALL medications.

Medication	Dosage	Type	Frequency	Route	Diagnosis/Indication	Prescriber (name of MD/NP)

STATEMENT OF PURPOSE

Adult Homes (AH), Enriched Housing Programs (EHP), Residences for Adults (RFA), Assisted Living Residences (ALR), Enhanced Assisted Living Residences (EALR) and Special Needs Assisted Living Residences (SNALR):

- provide 24-hour residential care for dependent adults
- are not medical facilities
- are not appropriate for persons in need of constant medical care and medical supervision and these persons should not be admitted or retained in these settings because the facility lacks the staff and expertise to provide needed services.
- Persons who, by reason of age and/or physical and/or mental limitations who are in need of assistance with activities of daily living, can be cared for in adult residential care settings listed above, or if applicable, an EALR or SNALR.

<u>PHYSICIAN CERTIFICATION</u>

I certify that I have physically examined this patient and have accurately described the individual's medical condition, medication regimen and need for skilled and/or personal care services. Based on this examination and my knowledge of the patient, this individual (see Statement of Purpose):

☐ **Yes** ☐ **No** **Is** mentally **suited** for care in an Adult Home/Enriched Housing Program/Assisted Living Residence/ Enhanced Assisted Living Residence (EALR)/Special Needs Assisted Living Residence (SNALR).

☐ **Yes** ☐ **No** **Is** medically **suited** for care in an Adult Home or Enriched Housing Program/Assisted Living Residence / Enhanced Assisted Living Residence (EALR)/Special Needs Assisted Living Residence (SNALR).

☐ **Yes** ☐ **No** **Is not** in need of continual acute or long term medical or nursing care, including 24-hour skilled nursing care or supervision, which would require placement in a hospital or nursing home.

Name/Title of individual completing form:_____ **Date:**_____

Physician Signature: _____ **Date** _____

New York State Department of Health
Division of Assisted Living

ASSISTED LIVING RESIDENCE
RESIDENT PERSONAL DATA FORM

Resident's Name: _____ Facility Name: _____

ADMISSION / DISCHARGE INFORMATION

Date of Admission: _____ **County:**_____

Admitted from: ☐ **Own Home** ☐ **Hospital** ☐ **NH** ☐ **OMH** ☐ **Other (specify):** _____

Address Admitted from (Street, City, State, Zip): _____

Discharge Date: _____ **Discharge to:** ☐ **Own Home** ☐ **Hospital** ☐ **NH** ☐ **OMH**

☐ **Other (Specify):** _____

Address Discharged to (Street, City, State, Zip Code): _____

Reason for Discharge:_____

_____

SECTION 1: PERSONAL DATA

Date of Birth: _____/_____/_____ (Month / Day / Year) Gender: ☐ M ☐ F Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Partner

NOTIFY IN CASE OF EMERGENCY

Name _____

Relationship _____

Home: _____ Work:_____

Cell Phone:_____ Other:_____

Address _____

City _____ State _____ Zip _____

ATTENDING PHYSICIAN

Name _____

Address _____

City _____ State _____ Zip _____

Phone:_____ Fax:_____

OTHER HEALTH CARE PROVIDERS

Name _____

Specialty _____

Phone: _____ Fax:_____

Address _____

City _____ State _____ Zip _____

Name _____

Specialty _____

Phone: _____ Fax:_____

Address _____

City _____ State _____ Zip _____

OTHER HEALTH CARE PROVIDERS

Name _____

Specialty _____

Phone: _____ Fax:_____

Address _____

City _____ State _____ Zip _____

Name _____

Specialty _____

Phone: _____ Fax:_____

Address _____

City _____ State _____ Zip _____

AREA HOSPITAL / CLINIC OF CHOICE

Name _____

Address_____

Additional Information:_____

_____

_____

ASSISTED LIVING RESIDENCE
RESIDENT PERSONAL DATA FORM

Resident's Name: _____ Facility Name: _____

SECTION 1: PERSONAL DATA Cont.: HEALTH INSURANCE

Insurer _____ID # _____

Medicaid No. _____

Medicare No. _____

Prescription Drug Plan (if any) _____

Plan ID # _____

Other Health Care Coverage _____

_____

PHARMACY

Pharmacy(ies) _____

_____

Phone _____Phone _____

Address(es) _____

_____

City _____ State _____ Zip_____

SECTION 2: PERSONAL BACKGROUND

Wishes to be addressed as: _____

Address (if different from ALR): _____

Resident's Representative: _____

Relationship: _____

Address:_____

_____

Phone: Home_____

Work _____

Cell _____

Significant Other:_____

Relationship:_____

Address:_____

_____

Phone: Home_____

Work_____

Cell_____

Resident's Representative: _____

Relationship: _____

Address:_____

_____

Phone: Home_____

Work _____

Cell _____

Significant Other:_____

Relationship:_____

Address: _____

_____

Phone: Home _____

Work _____

Cell _____

Residential Background (born/raised, lived most of life):_____

_____

Occupational/Educational Background: _____

_____

Religious Affiliation (if any): _____ **Place of Worship:** _____ **Phone:** _____

Health Care Proxy: ☐Yes ☐ No _____ **DNR**: ☐ Yes ☐ No
(Name)

Power of Attorney: ☐ Yes ☐ No _____ **Living Will:** Yes ☐ No ☐
(Name)

Burial Instructions: _____

_____

ASSISTED LIVING RESIDENCE
RESIDENT EVALUATION

Resident's Name: _____
Facility Name: _____ Date of Evaluation: _____

SECTION 1: COMMUNICATION/DENTAL/VISION/HEARING

Can the individual Speak English? ☐ Yes ☐ No **Read English?** ☐ Yes ☐ No **Write in English?** ☐ Yes ☐ No

Can the individual understand instructions in English? ☐ Yes ☐ No

If no to any of the above, indicate dominant language: Speak:_____ Read:_____ Write:_____

Verbal Expression/Speech (check all that apply):

Easily Understood ☐ Yes ☐ No Difficulty finding words or expressing self ☐ Yes ☐ No
Slurred or mumbled speech ☐ Yes ☐ No Understands directions ☐Yes ☐No

SPEECH: Does the resident have a speech defect / impairment? ☐Yes ☐ No

If yes, describe:_____

DENTAL Prosthetics: _____

VISION: Glasses: ☐Yes ☐ No Glaucoma: L ☐ R ☐ Legally Blind: L ☐ R ☐ Contact Lenses: ☐Yes ☐ No

Comments:_____

HEARING: Does the patient have a hearing deficit? ☐Yes ☐ No Hearing Aid: L ☐ R ☐

Comment(s): _____

SECTION 2: CUSTOMARY ROUTINE

Sleeping routine: **Preferred wake up time:** _____ **Napping routine:** _____
Preferred bedtime: _____ **Nighttime sleep pattern:** _____

Comments: _____

_____

Bathing routine: **Prefers** ☐ **Bath** ☐ **Shower** **Frequency:** _____

Comments: _____

_____

Eating routine: **Food preferences (religious, cultural, other):** _____ _____ _____
Food dislikes: _____ _____ _____

Comments: _____

_____

_____

Daily Events: (check all that apply)

☐ Goes out _____days a week (Specify 1 – 7)
☐ Stays busy with hobbies, reading, fixed daily routine
☐ Spends most time alone
☐ Contact with relatives/close friends _____days per week (Specify 1 – 7)
☐ Spends most time watching TV
☐ Usually attends church, synagogue, mosque, etc.
☐ Prefers small group activities
☐ Prefers large group activities

Comments: _____

_____

Resident's Name: _____
Facility Name: _____ Date of Evaluation: _____

SECTION 3: CONTINENCE STATUS/MANAGEMENT

Is the resident continent of urinary function? ☐ Yes ☐ No
Is the resident continent of bowel function? ☐ Yes ☐ No

IF ANSWER IS "NO" TO EITHER QUESTION, COMPLETE THIS SECTION, AS APPROPRIATE.

Urinary Incontinence		**Bowel Incontinence**	
☐ Several times a week ☐ Daily	☐ Day Only ☐ Night only ☐ Day and night	☐ Several times a week ☐ Daily	☐ Day only ☐ Night only ☐ Day and night
Current management techniques		**Current management techniques**	
☐ Prompting/reminding defers incontinence ☐ Timed voiding defers incontinence ☐ Uses incontinence pads/adult diapers: ☐ Day only ☐ Night only ☐ Day and night Catheter (specify type) _____ Comments: _____ _____ Self-manage continence? ☐ Yes ☐ No		☐ Uses incontinence pads/adult diapers: ☐ Day only ☐ Night only ☐ Day and night Comments: _____ _____ _____ Self-manage continence? ☐ Yes ☐ No	

SECTION 4: PHYSICAL FUNCTION

TASK	**LEVEL OF ASSISTANCE**	**COMMENTS**
Eating: (Ability to feed self meals and snacks)	☐ **Independent:** Able to feed self independently with or without assistive device. ☐ **Intermittent Assistance:** Requires minimal, intermittent supervision and/or assistance. ☐ **Continual Assistance:** Requires constant assistance and/or supervision throughout meal. ☐ **Total Assistance:** Unable to feed self, needs to be fed. Unable to take nutrients orally, requires enteral nutrition.	Dentures Upper ☐ Yes ☐ No Lower ☐ Yes ☐ No Chewing difficulties ☐ Yes ☐ No Difficulty swallowing ☐ Yes ☐ No Modified consistency ☐ Yes ☐ No Specify _____ **Comments:**
Ambulation: (Ability to safely walk and move about once in a standing position)	☐ **Independent:** Walks and climbs and descends stairs independently with or without assistive device. ☐ **Intermittent Assistance:** Walks and climbs and descends stairs with minimal, intermittent assistance and/or supervision. ☐ **Continual Assistance:** Walks and climbs and descends stairs with constant supervision and/or assistance. ☐ **Total Assistance:** Chairfast or bedfast. Requires total assistance for mobility.	☐ Wheelchair ☐ Walker ☐ Quad cane ☐ Cane ☐ Other: _____ Falls within the last 3 months? ☐ Yes ☐ No Frequency #: _____ Injury: _____ **Comments:**

Resident's Name: _____
Facility Name: _____ Date of Evaluation: _____

TASK	LEVEL OF ASSISTANCE	COMMENTS
Transferring: (Moving from bed to chair, on/off toilet, in/out of shower or tub)	☐ **Independent:** Able to transfer independently with or without assistive device. ☐ **Intermittent Assistance:** Transfers with minimal human assistance and/or supervision. ☐ **Continual Assistance:** Unable to transfer but can bear weight and pivot when transferred by at least one other person. ☐ **Total Assistance:** Chairfast or bedfast, unable to transfer, pivot, bear weight or turn self in bed.	**Comments:**

PROSTHESIS: ☐ No ☐ Yes (describe)_____

AMPUTATION: ☐No ☐ Yes (describe)_____

PODIATRIC: Does the resident have podiatric concerns requiring treatment or which impair ability to ambulate or transfer? ☐ No ☐ Yes

(describe)_____

TASK	LEVEL OF ASSISTANCE	COMMENTS
Toileting: (Getting to/from and on/off the toilet, cleansing self after elimination and adjusting clothing)	☐ **Independent:** Able to toilet independently with or without assistive device. ☐ **Intermittent Assistance:** Able to toilet with minimal intermittent assistance and/or supervision. ☐ **Continual Assistance:** Able to toilet with constant assistance and/or supervision. ☐ **Total Assistance:** Unable to toilet. Requires total assistance with toileting.	**Ostomy** ☐ Yes ☐ No **Comments:**
Bathing: (Getting in and out of tub or shower, washing and drying entire body)	☐ **Independent:** Able to bathe or shower independently with or without assistive device. ☐ **Intermittent Assistance:** Able to bathe or shower w/minimal intermittent assistance and/or supervision. ☐ **Continual Assistance:** Able to bathe or shower with constant assistance and/or supervision. ☐ **Total Assistance:** Unable to use shower or tub. Bathed in bed or at bedside.	**Comments:**
Dressing: (Getting clothes from closets and drawers, dressing and undressing upper/lower body including buttons, snaps, zippers, socks and shoes)	☐ **Independent:** Able to dress and undress independently with or without assistive device. ☐ **Intermittent Assistance:** Able to dress and undress with minimal, intermittent assistance and/or supervision. ☐ **Continual Assistance:** Requires assistance throughout the dressing and undressing process. ☐ **Total Assistance:** Requires another person to dress and undress upper and lower body.	**Comments:**

Resident's Name: _____
Facility Name: _____ Date of Evaluation: _____

SECTION 4: PHYSICAL FUNCTION Cont.

TASK	LEVEL OF ASSISTANCE	COMMENTS
Grooming: (Washing face, hair care, shaving, teeth/denture, fingernail care, eyeglasses care)	☐ **Independent:** Able to groom self independently with or without assistive device. ☐ **Intermittent Assistance**: Requires grooming utensils to be set up and placed within reach. ☐ **Continual Assistance:** Requires assistance throughout the grooming process. ☐ **Total Assistance:** Depends entirely upon someone else for grooming.	**Comments:**
Transportation: (Physical and mental ability to safely use a car, taxi, or public transportation [bus, train, subway)	☐ **Independent:** Able to independently drive a regular or adapted car; *OR* uses a regular or handicap accessible public bus, train or subway. ☐ **Independent:** But requests facility perform task. ☐ **Intermittent Assistance:** Able to ride in a car only when driven by another person; *AND/OR* due to physical, cognitive or mental limitations occasionally requires another person to accompany him/her when using a bus, train or subway. ☐ **Continual Assistance:** Able to ride in a car only when driven by another person; *OR* able to use a bus or handicap van, train or subway only when assisted or accompanied by another person. ☐ **Total Assistance:** Unable to ride in a car, taxi, bus or van, and requires transportation by ambulance.	**Comments:**
Laundry: (Ability to do own laundry – to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand)	☐ **Independent:** Able to independently take care of all laundry tasks. ☐ **Independent:** But requests facility perform task. ☐ **Intermittent Assistance:** Able to do only light laundry, such as minor hand wash or light washer loads. Needs assistance with heavy laundry, such as carrying large loads of laundry. ☐ **Continual Assistance:** Due to physical, cognitive or mental limitations, needs continual supervision and assistance to do any laundry. ☐**Total Assistance:** Unable to do any laundry.	**Comments:**
Housekeeping: (Ability to safely and effectively perform light housekeeping and heavier cleaning tasks)	☐ **Independent:** Able to independently perform all housekeeping tasks. ☐ **Independent:** But requests facility perform task. ☐ **Intermittent Assistance:** Able to perform only light housekeeping (e.g., dusting, wiping kitchen counters) tasks independently; *AND/OR* able to perform housekeeping tasks with intermittent assistance or supervision from another person. ☐ **Continual Assistance:** *Unable* to consistently perform any housekeeping tasks unless assisted by another person throughout the process. ☐**Total Assistance:** Unable to effectively participate in any housekeeping tasks.	**Comments:**

Resident's Name: _____
Facility Name: _____ Date of Evaluation: _____

SECTION 4: PHYSICAL FUNCTION cont.

TASK	LEVEL OF ASSISTANCE	COMMENTS
Shopping: (Ability to plan form, select and purchase items in a store and to carry them home or arrange delivery)	☐ **Independent:** Able to plan for shopping needs and independently perform shopping tasks, including carrying package. ☐ **Independent:** But requests facility perform task. ☐ **Intermittent Assistance:** Able to do only light shopping and carry small packages, but needs someone to do occasional major shopping. ☐ **Continual Assistance:** *Unable* to go shopping alone, but can go with someone to assist; *OR* unable to go shopping but is able to identify items needed, place orders, and arrange for home delivery. ☐ T**otal Assistance:** Needs someone to do all shopping and errands.	**Comments:**
Ability to use a Telephone: (Ability to answer the telephone, dial numbers, and *effectively* use the telephone to communicate)	☐ **Independent:** Able to dial numbers and answers calls appropriately and as desired. ☐ **Independent:** But requests facility perform task. ☐ **Intermittent Assistance:** Able to use a specially adapted telephone (i.e., large numbers on the dial pad, teletype phone for the deaf) and call essential numbers; able to answer the telephone and carry on a normal conversation but has difficulty with placing calls; able to answer the telephone only some of the time or is able to carry on only a limited conversation. ☐ **Continual Assistance:** Unable to make calls or answer the telephone at all, but can listen if assisted with equipment. ☐ **Total Assistance:** Totally unable to use the telephone. Requires someone else to make calls.	**Comments:**

SECTION 5: COGNITIVE IMPAIRMENT SCREEN

Cognitive Functioning: Individual's current level of alertness, orientation, comprehension, concentration and immediate memory.

Response: What is today's date? ☐ Correct ☐ Incorrect (correct, if within 2 days) What day of the week is today: ☐ Correct ☐ Incorrect
How old are you? ☐ Correct ☐ Incorrect When were you born? ☐ Correct ☐ Incorrect

Behaviors of Note: (check all that apply):
☐ Wanders Day/Night ☐ Sleep disturbance ☐ Confused ☐ Depressive Feelings ☐ Anxious ☐ Withdrawn/Refuses to Socialize
☐ Agitated (repeated vocalizations, screaming, shouting, moaning, cursing, fidgeting, etc.) ☐ Other:_____

Overall Cognitive Functioning:(check all that apply):
- ☐ Is alert and oriented, comprehends verbal questions and commands and has accurate recall
- ☐ Requires prompting and redirection, on occasion, to complete tasks
- ☐ Has occasional fluctuation in orientation, memory/alertness
- ☐ Has significant memory loss and is disoriented to person, place and/or time

This screen includes indicators, which are often related to cognitive impairment. This is a screen ONLY and is intended to assist the residence in determining if an individual is appropriate for care in an ALR and/or if the individual should be referred to his/her physician for consultation and/or further evaluation or treatment.
Comments: _____

_____

_____

Resident's Name: _____
Facility Name: _____ Date of Evaluation: _____

SECTION 6: ADMISSION DECISION

ACCEPTED TO: ☐ ALR/AH/EHP ☐ Enhanced ALR ☐Special Needs ALR

Upon admission, the following documents were provided to the applicant at, or prior to, the admissions interview:

_____ Consumer Information Guide

_____ Copy of the Residency Agreement

_____ Copy of the statement of resident rights

_____ Copy of any facility regulations relating to resident activities, office and visiting hours and like information

_____ If made available to the operator by the Long-Term Care Ombudsman Program, a fact sheet about the program and the listing of legal services or advocacy agencies.

_____ Personal Allowance Protections (SSI and Temporary Assistance (TA) recipients only)

_____ Most recent Statement of Deficiencies (shown to applicant)

Signature(s) of ALR staff participating in this evaluation.

Name: _____ Title: _____ Date: _____

Name: _____ Title: _____ Date: _____

Name: _____ Title: _____ Date: _____

Signature of Administrator/Case Manager/or ISP Planner: _____ **Date:** _____

Signature of Individual/Resident: _____ **Date:** _____

Signature of Resident Representative: _____ **Date**: _____

Name(s) of others participating in this evaluation.

Name: _____ Relationship: _____ Date: _____

Name: _____ Relationship: _____ Date: _____

Assisted Living Individualized Service Plan

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				
❑ Lab Test				
❑ Pacemaker				
❑ Dialysis				
❑ Skilled Nursing, Treatments &/or Education	❑ Injection ❑ Insulin ❑ Other – Type _____ ❑ Dressing ❑ Other _____			
❑ Specialists (eg podiatrist, chiropractor)	Specify_____ _____			
❑ Medical Equipment	❑ Independent ❑ Type _____ ❑ 1+ Assist *(requires more than intermittent assistance with equipment – EALR required)*			
❑ Pain Management				
❑ Other	❑ health prevention ❑ aide-level health related activities ❑ other – specify_____ _____			
Rehabilitation	❑ PT ❑ OT ❑ Speech Therapy ❑ Other: _____			
Nutritional				
Diet – Meal Assist	❑ Regular ❑ NAS ❑ NCS ❑ Chopped as needed ❑ Soft ❑ Dietary Supplement	❑ Meals		❑ Chewing Difficulty ❑ Swallowing Difficulty

Activity – Check all applicable	Services to be provided:	Frequency	By Whom	Changes/Comments
	Specify: _____	❑ Snacks		❑ Other: _____
Fluid Restrictions/ Encouragement	❑ None ❑ Dietary Supplements _____ ❑ Other Specify: _____			

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

Name: _____

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

Name: _____

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

Attach Documentation of Additional ISP Reviews as Necessary