

**State of Alaska**  
**Department of Health & Social Services**  
**Division of Public Health**  
**Certification & Licensing**

**ASSISTED LIVING PLAN**  
**WITHOUT HEALTH RELATED SERVICES PROVIDED**  
(Must be completed within 30 days of admission of Resident)  
AS 47.33.220, AS 47.33.230, & AS 47.33.240

Resident Information

Assisted Living Home Information

Name \_\_\_\_\_

Address \_\_\_\_\_

Social Security # \_\_\_\_\_

\_\_\_\_\_

Date of Birth \_\_\_\_\_

Phone # \_\_\_\_\_

Contact Person \_\_\_\_\_

DATE OF THIS PLAN \_\_\_\_\_

CARE COORDINATOR/CASE MANAGER/PROGRAM SPECIALIST \_\_\_\_\_

ADDRESS \_\_\_\_\_

AGENCY AFFILIATION (if any) \_\_\_\_\_

TELEPHONE # \_\_\_\_\_

**ANY PHYSICAL DISABILITIES AND IMPAIRMENTS THAT ARE RELEVANT TO THE SERVICES NEEDED BY THE RESIDENT**

\_\_\_\_\_  
\_\_\_\_\_

**RESIDENT'S STRENGTHS/ABILITIES AND LIMITATIONS IN PERFORMING THE ACTIVITIES OF DAILY LIVING**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**RESIDENT'S PREFERENCES IN THE FOLLOWING AREAS:**

- a. roommates \_\_\_\_\_
- b. living environment \_\_\_\_\_
- c. food \_\_\_\_\_
- d. recreational activities \_\_\_\_\_
- \_\_\_\_\_
- e. religious affiliation \_\_\_\_\_
- f. relationships/visitation with friends, family members, and others \_\_\_\_\_







