

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

**ASSISTED LIVING PLAN**  
**WITH 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 other \_\_\_\_\_

**Assessment  
Areas**

**Service  
Needs**

**Interventions**

**Provider**

**Date**

1. Activities  
of Daily  
Living

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2. Training  
for Independent  
Living

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3. Personal  
Assistance

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4. Health Services

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5. Health  
(mental/  
emotional)

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6. Legal  
Situation

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<u>Assessment Areas</u>	<u>Service Needs</u>	<u>Interventions</u>	<u>Provider</u>	<u>Date</u>
7. Financial Situation (income)				
8. Transport-				
9. Day Care or Day Activities				
10. Plan for Community Activities				
11. Other				

## Risks

The Resident (or the resident's guardian/representative) and the Home have identified the following risks associated with specific interventions identified in this plan, have evaluated such risks, and have agreed to this plan recognizing these risks. \_\_\_\_\_

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I have participated in the planning of my own care; and have read, or had read to me, in a language that I can understand the foregoing plan of care; and agree with my plan of care.

Resident or Resident's Representative	Date
Care Coordinator/Case Manager/ Program Coordinator	Date
Service Providers (as appropriate)	Date
Assisted Living Home Representative	Date

**EVALUATION OF ASSISTED LIVING PLAN**

If health-related services are provided, an evaluation is required every three months

<b>Date Review Required</b>	<b>Date Completed</b>	<b>Signature of Administrator</b>	<b>Signature of Resident or Rep.</b>
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**Document changes/revisions to the plan of care**