Assisted Living Residence –Assessment-Support Plan (ASP)
For compliance with 55 Pa.Code Chapter 2800

Instructions for Use

Chapter 2800 requires initial assessments, "preliminary" support plans, and "final" support plans. The regulations require that the initial assessment and preliminary support plan be completed 30 days prior to admission unless the resident is being admitted directly to the residence from an acute care hospital, is being admitted to escape from an abusive situation, or has no alternative living arrangement, in which case the residence must complete the documents within 15 days after admission. However, the Department allows a 15-day grace period following admission for completion of the required documents for all residents, not just those who meet the exception criteria.

The assessment and support plan are inseparably linked; one will never be created without the other. As such, they are both contained on this single document, the Assessment-Support Plan, or ASP. The left side of the document is the assessment; the right side of the document is the support plan. The ASP has been designed to easily match the resident's needs with the plan to meet those needs; simply move the assessed need on the left to the plan to meet the need on the right.

Each part of the ASP is separated into different parts, sections and elements. Completion of every single element is strongly recommended, but not required for complete compliance. The following guide describes what elements must be completed to achieve compliance:

Part	Section	Element	Completion Requirement
I	N/A	Name	**Mandatory**
I	N/A	Date of Birth	**Mandatory**
I	N/A	Date of Admission	**Mandatory**
I	Formal Supports		**Mandatory** (All information for each existing support, OR "none" if the support does not exist)
I	Informal Supports		
I	Comments or Related Information		Optional
II	ASSESSMENT AND SUPPORT PLAN INFORMATION		**Mandatory**
III	1	Personal Care Need and Degree	**Mandatory**
III	1	Need, Plan, Frequency, Responsible Party	If "A" is circled= Not required If anything other than "A" is circled = **Mandatory**
III	1	Assessment – Supervision	**Mandatory**

Part	Section	Element	Completion Requirement
III	1	Supervision Description, Plan, Responsible Party	If "None" is checked = Not required If anything other than "None" is checked = **Mandatory**
III	1	Assessment – Mobility	**Mandatory**
III	1	Mobility Description, Plan, Responsible Party	If "Independent" is checked = Not required If anything other than "Independent" is checked = **Mandatory**
III	1	Assessment – Mediations	**Mandatory**
III	1	Medications Description, Plan, Responsible Party	If "Resident can self-administer without assistance" is checked = Not required If anything other than "Resident can self-administer without assistance" is checked = **Mandatory**
III	2	Medical Diagnoses, Plan, Frequency, Responsible Party	**Mandatory** (All information for each existing diagnosis, OR "none" if the resident does not have medical diagnoses)
III	2	Dental Needs, Plan, Frequency, Responsible Party	**Mandatory** OR "none" only if the resident does not have dental needs
III	2	Dietary Needs, Plan, Frequency, Responsible Party	**Mandatory** OR "none" only if the resident does not have dietary needs
III	2	Sensory Needs, Plan, Frequency, Responsible Party	**Mandatory** (All information for each sensory need, OR "No" for each sense for which the resident has no needs)
III	3	Psychological Diagnoses, Plan, Frequency, Responsible Party	**Mandatory** (All information for each existing diagnosis, OR "none" if the resident does not have psychological diagnoses)
III	3	Behavioral or Cognitive Need and Degree	**Mandatory**
III	3	Need, Plan, Frequency, Responsible Party	If "A" is circled= Not required If anything other than "A" is circled = **Mandatory**
III	4	Social and Recreational Needs	**Mandatory**
IV	SUMMARY AND DETERMINATION		**Mandatory**
V	PARTICIPATION		**Mandatory**

Accidental Omissions – Occasionally, residences will accidentally omit an element from a mandatory section. For example, an otherwise-complete plan may be missing the "person responsible" for a single personal care need. In these cases, the Department will consider the circumstances surrounding the omission and may take steps to verify that a person is actually responsible and aware of their responsibilities. If omission is determined to be truly accidental, technical assistance will be provided and no violation will be recorded. However, repeated accidental omissions on a single ASP or one accidental omission on a series of ASPs may result in regulatory violations.

Use of Own Forms – Residences may use their own assessment and support plan forms if they "include the same information" as the Department's forms. A residence may use its own forms if the information labeled "mandatory" above is contained in the forms. The home's form(s) do not need to look like the ASP, but the home must be able to demonstrate to the Department during inspections how its forms "crosswalk" with the ASP, that is, where inspectors can find the ASP information on the home's forms.

Responsible Party – Be advised that the residence is ultimately responsible for meeting residents' needs, even if the "Responsible Person" is a family member or case manager. If a person who is not an employee of the residence is not meeting his obligations, the home must address this and amend the ASP as appropriate.

Significant Change – A "significant change" includes the following situations:
- The resident has been diagnosed with having a previously-undiagnosed disease or disorder that changes the resident's care needs.
  Example: A resident develops diabetes that requires a change in diet.

- An existing disease or disorder changes such that the resident's medical care needs are affected.
  Example: A resident's arthritis worsens such that she develops mobility needs.

- The resident suffers an injury that changes his care needs.
  Example: A resident breaks a hip after an injurious fall and requires physical therapy.

- A health situation occurs that will have any impact on the resident's current care needs
  Example: A resident elects to have her shoulder replaced.

- A resident's behaviors or cognitive functioning status change such that the resident's care needs are affected.
  Example: A resident begins to exhibit wandering behavior.

The following are examples of when a new RASP is not required, but the existing RASP should be amended:

- The resident's social and recreational needs change unrelated to a change in physical, psychological, or cognitive functioning.

- The responsible party or frequency of need changes.

Assisted Living Residence –Assessment and Support Plan (ASP)
For compliance with 55 Pa.Code Chapter 2800

PART I: RESIDENT INFORMATION

Name:	Formal Supports			Informal Supports (Family, Friends, etc.)		
	Support	Name	Telephone Number	Name	Relationship	Telephone Number
	Primary Physician				Designated Person	
Date of Birth:	Dentist					
	Case Manager					
Date of Admission:	Other (specify):					
	Other (specify):					

Comments or related information:

PART II: ASP INFORMATION

Date of Admission (Proposed):	**Reason for ASP**	**Timeframes** Note: "Admission" means the date the resident physically moves into the residence
Date of Admission (Actual):	☐ Initial (Preliminary and Final) ☐ Annual ☐ Significant Change* ☐ Department Request	*Initial-Preliminary* – Within 30 days prior to or 15 days after admission *Initial-Final* – Within 30 days prior to or 30 days after admission *Annual* – Within 380 days (1 year plus 15-day grace period) after most recent ASP *Significant Change* – Within 5 calendar days of significant change *Department Request* – Within 24 hours of request
Date of Last ASP:		

Dates ASP was updated (include the date and page numbers of any updates to the ASP made between the preliminary and final ASPs or between ASPs):

*If the assessment and support plan were completed due to a significant change, please include a description of the change:

PART III: ASSESSMENT AND SUPPORT PLAN INFORMATION

*The left side of the document is the assessment. The assessment is used to determine **what** the resident's needs are. The right side of the document is the support plan. Each resident's support plan is based on the results of the assessment. The support plan is used to record **how** the resident's needs will be met. Complete the assessment portion first, and then use the results to create a support plan. Attach additional pages as necessary.*

Section 1: Assisted Living Care Needs, Supervision, Mobility, and Medications

Assessment:
Assisted Living Care Needs

Degree Codes
A = Independent
B = Prompting/Cueing
C = Some Physical Assistance
D = Total Physical Assistance
E = Not Applicable

Support Plan - Personal Care Needs

Description of Service Need - Specify exactly what service or services are needed to meet the need.
Example: Resident cannot lift eating utensils to mouth due to complications from Parkinson's Disease.

Plan to Meet Service Need - Specify what will be done to make sure the service need is met.
Example: Staff will feed the resident during mealtimes.

Frequency - Specify how often the plan will be enacted using one of the choices. *Example: ☒Other: At all mealtimes.*

Responsible Party - Specify who will perform the plan using one of the choices. *Example: ☒DCS*
Responsible Party Codes:
 DCS = Direct-Care Staff on Duty   **F =** Family Member   **CM =** Case Manager
 N/A = Not Applicable (Degree Code A Only)   **SHCP =** Supplemental Health Care Provider   **O** = Other (Specify)

Changing the ASP – When completing a final ASP or updating an existing ASP where information has changed since the last ASP, strike through the outdated information, add the new information, and sign and date the change. *Example:*

Assisted Living Care Need and Degree	Description of Service Need	Plan to Meet Service Need	Frequency		Responsible Party	
Drinking Assistance with fluid intake, such as raising a glass to the resident's mouth **Degree – Preliminary Plan (Circle One):** A (B) C D E **Degree – All Other Plans (Circle One):** A B (C) D E	☐ Not Applicable (Code A Only) Mr. Smith needs occasional reminders to drink water due to his ~~Cozac treatment~~. Mr. Smith knows he must drink water, but has difficulty raising the glass to his mouth due to worsening arthritis. RM, 12.30.12	☐ Not Applicable (Code A Only) ~~Direct care staff will remind Mr. Smith to drink water.~~ Dietary staff will offer assistance with drinking during meals. Direct care staff will offer water and assist Mr. Smith to drink throughout the day. RM, 12.30.12	☐ N/A ☐ Hourly ☒ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☒ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☒ O: Dietary RM, 12.30.12

Assisted Living Care Need and Degree	Description of Service Need	Plan to Meet Service Need	Frequency		Responsible Party	
Eating Assistance with eating, such as feeding the resident or encouraging the resident to eat **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:

Assisted Living Care Need and Degree	Description of Service Need	Plan to Meet Service Need	Frequency		Responsible Party	
Drinking Assistance with fluid intake, such as raising a glass to the resident's mouth **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly		☐ DCS ☐ N/A ☐ F ☐ CM ☐ SHCP ☐ O:	
Transferring in/out of bed/chair Assisting the resident to rise from or sit/lie on a bed or chair **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly		☐ DCS ☐ N/A ☐ F ☐ CM ☐ SHCP ☐ O:	
Toileting Assistance with hygienic practices surrounding toilet use **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly		☐ DCS ☐ N/A ☐ F ☐ CM ☐ SHCP ☐ O:	
Bladder management Assistance with urinary incontinence-related problems **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly		☐ DCS ☐ N/A ☐ F ☐ CM ☐ SHCP ☐ O:	
Bowel management Assistance with fecal incontinence-related problems **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly		☐ DCS ☐ N/A ☐ F ☐ CM ☐ SHCP ☐ O:	
Ambulating Assistance moving from one place to another **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly		☐ DCS ☐ N/A ☐ F ☐ CM ☐ SHCP ☐ O:	
Personal hygiene Assistance with overall personal hygiene, such as hair and nail care **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly		☐ DCS ☐ N/A ☐ F ☐ CM ☐ SHCP ☐ O:	

Assisted Living Care Need and Degree	Description of Service Need	Plan to Meet Service Need	Frequency		Responsible Party	
Managing health care Assistance with overall healthcare coordination, such as tracking different doctors' appointments and medications **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
Securing health care Assistance with locating a health care provider for a specific need **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
Turning and positioning in bed/chair Assistance with moving a resident while in a bed or chair **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
Doing laundry Self-explanatory **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
Shopping Self-explanatory **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
Securing and using transportation Assistance with locating a transportation source and with use of the source **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
Managing finances Self-explanatory **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:

Assisted Living Care Need and Degree	Description of Service Need	Plan to Meet Service Need	Frequency		Responsible Party	
Using the telephone Assistance locating or dialing telephone numbers **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly		☐ DCS ☐ N/A ☐ F ☐ CM ☐ SHCP ☐ O:	
Making and keeping appointments Assistance with scheduling appointments, tracking appointments, and arranging for transportation to appointments **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly		☐ DCS ☐ N/A ☐ F ☐ CM ☐ SHCP ☐ O:	
Caring for personal possessions Self-explanatory **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly		☐ DCS ☐ N/A ☐ F ☐ CM ☐ SHCP ☐ O:	
Writing correspondence Assistance with writing personal and business-related letters and emails **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly		☐ DCS ☐ N/A ☐ F ☐ CM ☐ SHCP ☐ O:	
Engaging in social and leisure activities Assistance with identifying and participating in available activities **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly		☐ DCS ☐ N/A ☐ F ☐ CM ☐ SHCP ☐ O:	
Using a prosthetic device Assistance attaching, removing, or cleaning a prosthetic device **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly		☐ DCS ☐ N/A ☐ F ☐ CM ☐ SHCP ☐ O:	
Obtaining clean, seasonal clothing Self-explanatory **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly		☐ DCS ☐ N/A ☐ F ☐ CM ☐ SHCP ☐ O:	

Supervision			
None - Resident requires no supervision either in the home or when in the community **Minimal** - Resident requires no supervision in the home or when in familiar surroundings, but needs attendance in unfamiliar places **Moderate** - Resident requires some supervision in the home and needs attendance when outside the home, and/or tends to wander **Extensive** - Resident requires regular supervision in the home and cannot leave home unattended; unaware of unsafe areas **Total** - Resident requires 24-hour direct supervision	**Description of Supervision Needs**	**Plan to Meet Supervision Needs**	**Responsible Party**

Preliminary Assessment
☐ **None**   ☐ **Moderate**
☐ **Minimal**   ☐ **Extensive**
         ☐ **Total**
 	
All Other Assessments
☐ **None**   ☐ **Moderate**
☐ **Minimal**   ☐ **Extensive**
         ☐ **Total**
			☐ DCS
			☐ F
			☐ CM
			☐ N/A
			☐ SHCP
			☐ O:

Mobility			
Independent (Mobile) - Resident has **no** mobility needs and can evacuate independently in an emergency **Minimal (Mobile)** - Resident requires **limited** physical or oral assistance to evacuate in an emergency **Moderate (Immobile)** - Resident requires **moderate** physical or oral assistance to evacuate in an emergency **Total (Immobile)** - Resident requires **total** physical or oral assistance to evacuate in an emergency from one or more staff persons	**Description of Mobility Needs**	**Plan to Meet Mobility Needs**	**Responsible Party**
Preliminary Assessment ☐ **Independent** ☐ **Moderate** ☐ **Minimal** ☐ **Total** **All Other Assessments** ☐ **Independent** ☐ **Moderate** ☐ **Minimal** ☐ **Total**			☐ DCS ☐ F ☐ CM ☐ N/A ☐ SHCP ☐ O:

Medications			

Preliminary Assessment
☐ Resident CAN self-administer medications independently
☐ Resident CAN self-administer medications with (check all that apply):
    ☐ Assistance to store medications in secure location
    ☐ Assistance with remembering schedule
    ☐ Assistance by offering medications at prescribed times
    ☐ Assistance with opening container/storage area
☐ Resident CAN self-administer some medications, but not others
☐ Resident CANNOT self-administer medication
	All Other Assessments
	☐ Resident CAN self-administer medications independently
	☐ Resident CAN self-administer medications with (check all that apply):
	    ☐ Assistance to store medications in secure location
	    ☐ Assistance with remembering schedule
	    ☐ Assistance by offering medications at prescribed times
	    ☐ Assistance with opening container/storage area
	☐ Resident CAN self-administer some medications, but not others
	☐ Resident CANNOT self-administer medication
		Description of Medication Needs
		
		Plan to Meet Medication Needs
			Responsible Party
			
			☐ DCS
			☐ F
			☐ CM
			☐ N/A
			☐ SHCP
			☐ O:

Section 2: Medical, Dental, Dietary, and Sensory Needs	
Assessment: **Medical Needs** **Medical Diagnoses – Physical** Using the Documentation of Medical Evaluation Form from the most recent medical evaluation, list all of the resident's physical diagnoses. *Example: Hypertension*	**Support Plan – Medical Needs** **Plan to Meet Medical Need -** Specify what will be done to make sure the need is met. *Example: Staff will measure resident's blood pressure.* **Frequency -** Specify how often the plan will be enacted using one of the choices. *Example:* ☒*Daily* **Responsible Party -** Specify who will perform the plan using one of the choices. *Example:* ☒*DCS* **Responsible Party -** Specify who will perform the plan using one of the choices. *Example:* ☒*DCS* **Responsible Party Codes:** **DCS =** Direct-Care Staff on Duty **F =** Family Member **CM =** Case Manager **N/A =** Not Applicable (Degree Code A Only) **SHCP =** Supplemental Health Care Provider **O** = Other (Specify) **Changing the ASP –** When completing a final ASP or updating an existing ASP where information has changed since the last ASP, strike through the outdated information, add the new information, and sign and date the change. *Example:* <table><tr><td>Medical Diagnoses – Physical</td><td>Plan to Meet Medical Need</td><td>Frequency</td><td>Responsible Party</td></tr><tr><td>Renal failure</td><td>Mr. Smith will receive dialysis at the residence medical center. Mr. Smith's condition is declining. Dialysis is now required 3 dates per week. RJM 12/28/12</td><td>☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☒ Weekly</td><td>☐ DCS ☐ N/A ☐ F ☐ CM ☒SHCP ☐ O:</td></tr></table>

Medical Diagnoses – Physical	Plan to Meet Medical Need	Frequency		Responsible Party	
		☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐SHCP	☐ N/A ☐ CM ☐ O:
		☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐SHCP	☐ N/A ☐ CM ☐ O:
		☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐SHCP	☐ N/A ☐ CM ☐ O:
		☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐SHCP	☐ N/A ☐ CM ☐ O:
		☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐SHCP	☐ N/A ☐ CM ☐ O:

Medical Diagnoses – Physical	Plan to Meet Medical Need	Frequency		Responsible Party	
		☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
		☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
		☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:

| Assessment:
 Dental

 Diagnoses or Needs
 List all of the resident's dental, dietary, and sensory needs
 Examples:
 • *Impacted tooth*
 • *Mechanical soft foods*
 • *Cataracts* | **Support Plan – Dental, Dietary, and Support Needs**
 Plan to Meet Need
 Specify what will be done to make sure the resident's dental, dietary, and sensory needs are addressed.
 Examples: Resident will see dentist, resident will have special diet, resident will see ophthalmologist

 Frequency - Specify how often the plan will be enacted using one of the choices. *Example:* ☒*Monthly*

 Responsible Party - Specify who will perform the plan using one of the choices. *Example:* ☒*CM*

 Responsible Party Codes:
 DCS = Direct-Care Staff on Duty **F =** Family Member **CM =** Case Manager
 N/A = Not Applicable (Degree Code A Only) **SHCP =** Supplemental Health Care Provider **O** = Other (Specify)

 Changing the ASP – When completing a final ASP or updating an existing ASP where information has changed since the last ASP, strike through the outdated information, add the new information, and sign and date the change. See examples above. |||||

Dental Need	Plan to Meet Dental Need	Frequency		Responsible Party	
		☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
		☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:

Dietary Need	Plan to Meet Dietary Need	Frequency		Responsible Party	
		☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
		☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:

Sensory Need	Plan to Meet Sensory Need	Frequency		Responsible Party	
Vision		☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
Hearing		☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
Communication		☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
Olfactory (smell)		☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
Tactile (touch)		☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:

Section 3: Mental Health, Behavioral Health, and Cognitive Functioning Needs

Assessment: Mental Health Needs **Medical Diagnoses – Psychological** Using the Documentation of Medical Evaluation Form from the most recent medical evaluation, list all of the resident's diagnoses. *Example: Schizophrenia*	**Support Plan – Mental Health Needs** **Plan to Meet Mental Health Need -** Specify what will be done to make sure the need is met. *Example: Resident will see therapist* **Frequency -** Specify how often the plan will be enacted using one of the choices. *Example: ☒Weekly* **Responsible Party -** Specify who will perform the plan using one of the choices. *Example: ☒CM* **Responsible Party Codes:** **DCS =** Direct-Care Staff on Duty **F =** Family Member **CM =** Case Manager **N/A =** Not Applicable (Degree Code A Only) **SHCP =** Supplemental Health Care Provider **O** = Other (Specify) **Changing the ASP –** When completing a final ASP or updating an existing ASP where information has changed since the last ASP, strike through the outdated information, add the new information, and sign and date the change. See examples above.

Medical Diagnoses – Psychological	Plan to Meet Psychological Need	Frequency		Responsible Party	
		☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
		☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
		☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:

		☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly	☐ DCS ☐ N/A ☐ F ☐ CM ☐SHCP ☐ O:
		☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly	☐ DCS ☐ N/A ☐ F ☐ CM ☐SHCP ☐ O:
		☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly	☐ DCS ☐ N/A ☐ F ☐ CM ☐SHCP ☐ O:
		☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly	☐ DCS ☐ N/A ☐ F ☐ CM ☐SHCP ☐ O:
		☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly	☐ DCS ☐ N/A ☐ F ☐ CM ☐SHCP ☐ O:

<table>
<tr><td colspan="2">Assessment:
Behavioral or Cognitive Need</td><td colspan="4">Support Plan - Behavioral or Cognitive Care Needs
Description of Service Need - Specify exactly what service or services are needed to meet the need.
Example: Resident is upset by loud noises due to PTSD.</td></tr>
</table>

Assessment:
Behavioral or Cognitive Need

Degree Codes
A = No problem
B = Minimal Problem
C = Moderate Problem
D = Severe Problem
E = Not Applicable

Support Plan - Behavioral or Cognitive Care Needs

Description of Service Need - Specify exactly what service or services are needed to meet the need.
Example: Resident is upset by loud noises due to PTSD.

Plan to Meet Service Need - Specify what will be done to make sure the service need is met.
Example: Staff will sit with resident when loud noises occur.

Frequency - Specify how often the plan will be enacted using one of the choices. *Example: ☒Other: As needed*

Responsible Party - Specify who will perform the plan using one of the choices. *Example: ☒DCS*

Responsible Party Codes:
  DCS = Direct-Care Staff on Duty   **F =** Family Member   **CM =** Case Manager
  N/A = Not Applicable (Degree Code A Only)   **SHCP =** Supplemental Health Care Provider   **O** = Other (Specify)

Changing the ASP – When completing a final ASP or updating an existing ASP where information has changed since the last ASP, strike through the outdated information, add the new information, and sign and date the change. See examples above.

Behavioral or Cognitive Need and Degree	Description of Service Need	Plan to Meet Service Need	Frequency		Responsible Party	
Orientation to time, place, and person Resident does not know when, where, or who s/he is **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
Irritability Resident is easily upset **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
Judgment Resident's decisions are harmful to self or others **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
Agitation Resident is easily upset or unsettled **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
Aggression Resident is violent, verbally or physically **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:

Behavioral or Cognitive Need and Degree	Description of Service Need	Plan to Meet Service Need	Frequency		Responsible Party	
Hallucinations Resident hears or sees things that are not there **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
Communication of needs Resident cannot express needs or desires **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
Understanding instructions Resident cannot understand instructions or directions **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
Short-Term memory Resident is unable to retain small amounts of information in mind in an active, readily-available state for a limited period time **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
Long-Term memory Resident is unable to store information in mind for a long period of time to be recalled at a later date **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
Ability to use and avoid poisonous materials Resident is unable to safely use and avoid poisonous materials **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:
Ability to safely use key-locking devices Resident is unable to safely use key-locking devices **Degree – Preliminary Plan (Circle One):** A B C D E **Degree – All Other Plans (Circle One):** A B C D E	☐ Not Applicable (Code A Only)	☐ Not Applicable (Code A Only)	☐ N/A ☐ Hourly ☐ Daily ☐ Weekly	☐ Monthly ☐ Other (Specify):	☐ DCS ☐ F ☐ SHCP	☐ N/A ☐ CM ☐ O:

Section 4: Social and Recreational Needs

Assessment:	Support Plan - Social and Recreational Needs

Social and Recreational Needs
List all of the resident's social and recreational needs in each section.
	Plan to Meet Service Need - Specify what will be done to make sure the residents' social/recreational needs are addressed. *Example: Resident will be offered mystery novels to read.*
	
	Frequency - Specify how often the plan will be enacted using one of the choices. *Example: ☒Other: As needed*
	
	Responsible Party - Specify who will perform the plan using one of the choices. *Example: ☒DCS*
	Responsible Party Codes:
	  DCS = Direct-Care Staff on Duty **F =** Family Member **CM =** Case Manager
	  N/A = Not Applicable (Degree Code A Only) **SHCP =** Supplemental Health Care Provider **O** = Other (Specify)
	
	Changing the ASP – When completing a final ASP or updating an existing ASP where information has changed since the last ASP, strike through the outdated information, add the new information, and sign and date the change. See examples above.

Social and Recreational Need	Plan to Meet Social and Recreational Need	Frequency	Responsible Party
The resident's hobbies/interests include:		☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly	☐ DCS ☐ N/A ☐ F ☐ O: ☐ CM
The resident enjoys the following solitary activities:		☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly	☐ DCS ☐ N/A ☐ F ☐ O: ☐ CM
The resident enjoys the following group activities:		☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly	☐ DCS ☐ N/A ☐ F ☐ O: ☐ CM
The resident's religious affiliation, if any, is:		☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly	☐ DCS ☐ N/A ☐ F ☐ O: ☐ CM
The resident does not participate in solitary or group activities because:		☐ N/A ☐ Monthly ☐ Hourly ☐ Other ☐ Daily (Specify): ☐ Weekly	☐ DCS ☐ N/A ☐ F ☐ O: ☐ CM

PART III: SUMMARY AND DETERMINATION

Summary of Resident's Overall Wellness (include significant changes identified through the assessment process, comments for improving quality of care, or other relevant information not capture above):

Determination – By signing below, I certify that...
- I am the home's administrator, a staff person authorized to complete this document, a Licensed Practical Nurse (LPN) or a Registered Nurse (RN). If am not an RN, I verify by signing that the residence has a means of quality assurance through RN review of all ASPs.
- The information on this assessment is accurate and was developed based on records and/or interviews.
- The above-named resident's needs may be met in this assisted living residence.

Assessor's Printed Name:	**Assessor's Title:**
Assessor's Signature:	**Date Signed:**

PART IV: PARTICIPATION
By signing below, the signature verifies that s/he participated in the assessment and/or support plan process

Name	Relationship to Resident	Signature	Date Signed	Copy of Document Requested?	Copy Provided?
	Self	**OR** ☐ Unable to participate ☐ Refused to sign ☐ Declined to participate ☐ Unable to sign		☐ Yes ☐ No	☐ Yes ☐ No ☐ N/A
		OR (check one) ☐ Refused to sign ☐ Unable to sign		☐ Yes ☐ No	☐ Yes ☐ No ☐ N/A
		OR (check one) ☐ Refused to sign ☐ Unable to sign		☐ Yes ☐ No	☐ Yes ☐ No ☐ N/A
		OR (check one) ☐ Refused to sign ☐ Unable to sign		☐ Yes ☐ No	☐ Yes ☐ No ☐ N/A