APPRAISAL/NEEDS AND SERVICES PLAN

CLIENT'S/RESIDENT'S NAME	DATE OF BIRTH	AGE	SEX	DATE
			☐ MALE ☐ FEMALE	

FACILITY NAME	ADDRESS	CHECK TYPE OF NEEDS AND SERVICES PLAN:
ELITE ELDER CARE	2041 Bates Cir. El Dorado Hills, CA 95762	☐ ADMISSION ☐ UPDATE

PERSON(S) OR AGENCY(IES) REFERRING CLIENT/RESIDENT FOR PLACEMENT	FACILITY LICENSE NUMBER	TELEPHONE NUMBER
	097003738	( )

Licensing regulations require that an appraisal of needs be completed for specific clients/residents to identify individual needs and develop a service plan for meeting those needs. If the client/resident is accepted for placement the staff person responsible for admission shall jointly develop a needs and services plan with the client/resident and/or client's/resident's authorized representative referral agency/person, physician, social worker or other appropriate consultant. Additionally, the law requires that the referral agency/person inform the licensee of any dangerous tendencies of the client/resident.

NOTE: *For Residential Care Facilities for the Elderly, this form is not required at the time of admission but must be completed if it is determined that an elderly resident's needs have not been met.*

BACKGROUND INFORMATION: *Brief description of client's/resident's medical history/ emotional, behavioral, and physical problems; functional limitations; physical and mental; functional capabilities; ability to handle personal cash resources and perform simple homemaking tasks; client's/resident's likes and dislikes.*

NEEDS	OBJECTIVE/PLAN	TIME FRAME	PERSON(S) RESPONSIBLE FOR IMPLEMENTATION	METHOD OF EVALUATING PROGRESS
SOCIALIZATION — Difficulty in adjustig socially and unable to maintain reasonable personal relationships				
EMOTIONAL — Difficulty in adjusting emotionally				

NEEDS	OBJECTIVE/PLAN	TIME FRAME	PERSON(S) RESPONSIBLE FOR IMPLEMENTATION	METHOD OF EVALUATING PROGRESS
MENTAL — Difficulty with intellectual functioning including inability to make decisions regarding daily living.				
PHYSICAL/HEALTH — Difficulties with physical development and poor health habits regarding body functions.				

NEEDS	OBJECTIVE/PLAN	TIME FRAME	PERSON(S) RESPONSIBLE FOR IMPLEMENTATION	METHOD OF EVALUATING PROGRESS
FUNCTIONING SKILLS — Difficulty in developing and/or using independent functioning skills.				

We believe this person is compatible with the facility program and with other clients/residents in the facility, and that I/we can provide the care as specified in the above objective(s) and plan(s).

TO THE BEST OF MY KNOWLEDGE THIS CLIENT/RESIDENT DOES NOT NEED SKILLED NURSING CARE.

LICENSEE(S) SIGNATURE ▶ | DATE

I have reviewed and agree with the above assessment and believe the licensee(s) other person(s)/agency can provide the needed services for this client/resident

CLIENT'S/RESIDENT'S AUTHORIZED REPRESENTATIVE(S)/FACILITY SOCIAL WORKER/PHYSICIAN/OTHER APPROPRIATE CONSULTANT SIGNATURE ▶ | DATE

I/We have participated in and agree to release this assessment to the licensee(s) with the condition that it will be held confidential.

CLIENT'S/RESIDENT'S OR CLIENT'S/RESIDENT'S AUTHORIZED REPRESENTATIVE(S) SIGNATURE ▶ | DATE