CERTIFIED
FAMILY HOME PROGRAM

IDAHO DEPARTMENT OF HEALTH & WELFARE

UNIFORM ASSESSMENT FOR A PRIVATE-PAY RESIDENT

The information on this form will be addressed by the resident/representative and current or former healthcare providers to determine the resident's needs requiring a care plan. The Certified Family Home (CFH) provider is not making any diagnosis by completing this form.

1. Certified Family Home Information

CFH Provider:	Certificate Number:
Assessor Name and Title:	Assessment Date:
Assessor Signature:	Phone Number:

2. Resident Identification and Background

Full Legal Name:		Date of Birth:
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed		Gender: ☐ Male ☐ Female
Language(s) Spoken:		Admission Date:
Height Feet:	Height Inches:	Weight:
Other Background Information (e.g., representative, current or former healthcare provider, contact information, etc.):		

3. Medical Diagnoses

Primary Diagnosis:	Onset Date:	☑ Ongoing
Other Diagnosis:	Onset Date:	☐ Ongoing
Other Diagnosis:	Onset Date:	☐ Ongoing
Other Diagnosis:	Onset Date:	☐ Ongoing
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Other Diagnosis:	Onset Date:	☐ Ongoing
Other Diagnosis:	Onset Date:	☐ Ongoing

4. Health Needs

MOBILITY/TRANSFER AND SENSORY DEVICES			
☐ Cane	☐ Bed Rail	☐ Eyeglasses	☐ _____
☐ Walker	☐ Grab Bars	☐ Communication Aid	☐ _____
☐ Wheelchair	☐ Hoyer Lift	☐ Hearing Aid	☐
Continence Issues (incontinent of bowel or bladder, catheter, etc.): ☐ Yes ☐ No If Yes, Describe Condition(s) and Associated Needs:			

Cardiovascular Issues (circulation, blood pressure, heart condition, etc.): ☐ Yes ☐ No If Yes, Describe Condition(s) and Associated Needs:
Respiratory Issues (emphysema, COPD, pneumonia, etc.): ☐ Yes ☐ No If Yes, Describe Condition(s) and Associated Needs:
Muscular/Skeletal Issues (arthritis, fractures, MS, osteoporosis, weakness etc.): ☐ Yes ☐ No If Yes, Describe Condition(s) and Associated Needs:
Skin Integrity Issues (thin skin, pressure wounds, skin tears, etc.): ☐ Yes ☐ No If Yes, Describe Condition(s) and Associated Needs:
Sight Issues (blindness, glaucoma, cataracts, macular degeneration, etc.): ☐ Yes ☐ No If Yes, Describe Condition(s) and Associated Needs:
Hearing Issues (deafness, hearing loss, tinnitus, etc.): ☐ Yes ☐ No If Yes, Describe Condition(s) and Associated Needs:
Developmental Disabilities (intellectual disabilities, autism, cerebral palsy, etc.): ☐ Yes ☐ No If Yes, Describe Condition(s) and Associated Needs:
Mental Health Issues (anxiety, depression, personality disorder, etc.): ☐ Yes ☐ No If Yes, Describe Condition(s) and Associated Needs:
Brain/Neurologic Issues (seizures, dementia, memory loss, etc.): ☐ Yes ☐ No If Yes, Describe Condition(s) and Associated Needs:

Food/Swallowing/Metabolic Issues (obesity, diabetes, dysphagia, special diet, etc.): ☐ Yes ☐ No If Yes, Describe Condition(s) and Associated Needs:
Substance Abuse Issues (alcoholism, drug dependency, etc.): ☐ Yes ☐ No If Yes, Describe Condition(s) and Associated Needs:
Cancer: ☐ Yes ☐ No If Yes, Describe Condition(s) and Associated Needs:
Other Issue(s) Not Captured Above: ☐ Yes ☐ No If Yes, Describe Condition(s) and Associated Needs:

5. Current and Past Behavior Patterns

Identify the resident's current or past behaviors (aggression, attention-seeking, drug-seeking, delusions, elopements, pacing, self-injury or suicidal attempts/ideation, inappropriate sexual behavior, etc.):

6. Psychosocial Needs

Identify the resident's needs regarding support with…

Self-esteem:

Self-advocacy:
Social life:
Spirituality:

7. Cognitive Function

Is the resident currently oriented to:

- ☐ Person (knows own name and recognizes significant others)
- ☐ Place (knows where they are)
- ☐ Time (knows the time of day, date, day of week, and year)
- ☐ Situation (knows what is going on around them)

Comments:

Is the resident's judgement:

- ☐ Good (usually makes appropriate decisions)
- ☐ Occasionally Poor (history of inappropriate decisions in complex or unfamiliar situations)
- ☐ Frequently Poor (history of unsafe or frequently poor decisions)
- ☐ Poor (cannot make appropriate decisions and frequently places self in unsafe situations)

Comments:

Is the resident's memory:

- ☐ Good (no difficulty remembering and using information nor requires direction or reminders)
- ☐ Occasionally Poor (some difficulty remembering and using information and requires occasional direction, reminders, or written instructions)
- ☐ Frequently Poor (regularly has problems remembering and using information and often requires direction and reminders)
- ☐ Poor (cannot recall information and requires continual verbal prompts)

Comments:

8. Functional and Physical Needs

BATHING. Level of care needed to bathe/shower, wash hair, and use safe water temperature)

☐ None ☐ Minimal ☐ Moderate ☐ Extensive ☐ Total

If other than "None," describe the need:

COMMUNICATION. Level of care needed to help express thoughts and choices.
☐ None ☐ Minimal ☐ Moderate ☐ Extensive ☐ Total
If other than "None," describe the need:

DRESSING. Level of care needed to dress/undress, and make clothing choices (seasonal, clean, etc.).
☐ None ☐ Minimal ☐ Moderate ☐ Extensive ☐ Total
If other than "None," describe the need:

EATING. Level of care needed to ensure food and drink is ingested safely.
☐ None ☐ Minimal ☐ Moderate ☐ Extensive ☐ Total
If other than "None," describe the need:

EMERGENCY RESPONSE. Level of care needed to identify an emergency and seek help or safety.
☐ None ☐ Minimal ☐ Moderate ☐ Extensive ☐ Total
If other than "None," describe the need:

GROOMING. Level of care needed to shave or trim body/facial hair, clip nails, or comb/cut/style hair.
☐ None ☐ Minimal ☐ Moderate ☐ Extensive ☐ Total
If other than "None," describe the need:

HOUSEWORK. Level of care needed to clean the living area (housekeeping always offered by CFH).
☐ None ☐ Minimal ☐ Moderate ☐ Extensive ☐ Total
If other than "None," describe the need:

LAUNDRY. Level of care needed to clean clothing and other linens (laundry always offered by CFH).
☐ None ☐ Minimal ☐ Moderate ☐ Extensive ☐ Total
If other than "None," describe the need:

MEDICATION (see corresponding section in the Admission Agreement). Level of care needed to take medications.
☐ None ☐ Minimal ☐ Moderate ☐ Extensive ☐ Total
If other than "None," describe the need:

MOBILITY. Level of care needed to move about freely indoors and outdoors, using devices if necessary.
☐ None ☐ Minimal ☐ Moderate ☐ Extensive ☐ Total
If other than "None," describe the need:

PERSONAL FUNDS AND BELONGINGS (see corresponding section in Admission Agreement). Level of care needed to make spending decisions and be free of exploitation.
☐ None ☐ Minimal ☐ Moderate ☐ Extensive ☐ Total
If other than "None," describe the need:

NIGHT NEEDS. Level of care needed during hours when members of the household are sleeping.
☐ None ☐ Minimal ☐ Moderate ☐ Extensive ☐ Total
If other than "None," describe the need:

PERSONAL HYGIENE. Level of care needed to brush/floss teeth, wash hands, and minimize odors.
☐ None ☐ Minimal ☐ Moderate ☐ Extensive ☐ Total
If other than "None," describe the need:

PREPARING MEALS. Level of care needed to meet dietary requirements during mealtime and snacks, and to safely prepare own food (meals always offered by CFH).
☐ None ☐ Minimal ☐ Moderate ☐ Extensive ☐ Total
If other than "None," describe the need:

SHOPPING. Level of care needed to shop for personal items.
☐ None ☐ Minimal ☐ Moderate ☐ Extensive ☐ Total
If other than "None," describe the need:

SUPERVISION. Level of care needed to safely manage choices and participate in activities.
☐ None ☐ Minimal ☐ Moderate ☐ Extensive ☐ Total
If other than "None," describe the need:

TOILETING. Level of care needed to use the toilet/other device, cleanse afterwards, and adjust clothing.
☐ None ☐ Minimal ☐ Moderate ☐ Extensive ☐ Total
If other than "None," describe the need:

TOOLS & TECHNOLOGY. Level of care needed to operate personal devices, cell phones, televisions, etc.
☐ None ☐ Minimal ☐ Moderate ☐ Extensive ☐ Total
If other than "None," describe the need:

TRANSFERRING. Level of care needed to move out of a bed or wheelchair.
☐ None ☐ Minimal ☐ Moderate ☐ Extensive ☐ Total
If other than "None," describe the need:

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9. Appropriateness of Placement

Upon review of the medications prescribed by the resident's health care professional and their routes of administration, the CFH has the necessary training, delegation, or licensure to assist with or administer these medications (e.g., licensure as a nurse to administer injections).
Comments:

Signature of CFH Provider: _____

Signature of Resident or Representative: _____

Upon review of the treatments prescribed by the resident's health care professional, the CFH has the necessary training, delegation, and skills to assist with these treatments.
Comments:

Signature of CFH Provider: _____

Signature of Resident or Representative: _____

Upon review of the special diet prescribed by the resident's health care professional, the CFH has the necessary training and skills to prepare meals compliant with the special diet.
Comments:

Signature of CFH Provider: _____

Signature of Resident or Representative: _____

Upon review of the resident's identified behaviors, the CFH has the necessary training and skills to manage these stated behaviors.
Comments:

☐ De-escalation Training
☐ Redirection Training
☐ Plain Language Skills
☐ Other

Signature of CFH Provider: _____

Signature of Resident or Representative: _____

Upon review of this assessment, the CFH, in concert with the resident's supportive services, has the necessary time (including sufficient staff to meet this resident's and all other residents' needs), ability, skills, and equipment to safely and effectively meet this resident's needs.
Comments:

Signature of CFH Provider: _____

Signature of Resident or Representative: _____