# PRIVATE-PAY ASSISTED LIVING PREADMISSION SERVICE & SUPPORT ASSESSMENT

PRIVATE-PAY ONLY

Resident/representative intake for individualized service planning and pricing



## PURPOSE

This assessment gathers information about the prospective resident's current needs, routines, strengths, risks, and preferences. It helps the assisted living provider determine whether it can meet the person's needs and identify the services to include in an individualized private-pay service proposal. It does not replace the provider's nursing assessment, admission agreement, or final service plan.

## WHO COMPLETES WHAT

The prospective resident and/or a family member, representative, guardian, or support person completes the resident-facing sections. Provider staff review the responses and available records. A registered nurse verifies clinical needs when required. The provider completes the service summary and pricing review separately.

## A. DOCUMENT CONTROL & COMPLETION STATUS

| Resident full legal name | Assessment date | Proposed move-in date | Facility/provider |
|---|---|---|---|
| | | | |

Completed by resident  Completed by family/representative  Completed with assistance  Additional records attached

## B. COMPLETION INSTRUCTIONS

1. Answer based on the resident's current needs and what typically happens on both easier and more difficult days. Write "unknown" rather than guessing.
2. Describe how often help is needed, how long it usually takes, time-of-day patterns, known triggers, equipment used, and whether one or two staff are needed.
3. Include services currently performed by family, caregivers, another provider, clinic, school/day program, county worker, nurse, therapist, or transportation provider.
4. Attach or arrange delivery of the medication list, diagnoses, recent assessments, behavior/safety plans, hospital or clinic records, therapy recommendations, guardianship/POA documents, and current support plan when available.
5. The provider may revise proposed services and pricing after record review, nursing assessment, observation, new orders, a change in condition, or if actual needs differ from the information reported.

## BEFORE RETURNING THIS FORM

Complete every section that applies. Write "none," "not applicable," or "unknown" rather than leaving important questions blank. Include examples of the support that works best, recent changes, safety concerns, and any routines that are especially important to the resident. Keep original documents and send copies only.

# RESIDENT, REPRESENTATIVE & CURRENT SUPPORT INFORMATION

Resident/representative-completed section; attach records when available

PRIVATE-PAY ONLY



## A. RESIDENT & CONTACT INFORMATION

**Legal name** | **Preferred name** | **Date of birth** | **Age** | **Pronouns**

**Current address / setting** | **Phone** | **Email**

**Primary language** | **Interpreter / communication accommodation** | **Emergency contact** | **Emergency phone**

## B. REPRESENTATIVE / SUPPORT PERSON / LEGAL AUTHORITY

**Name** | **Relationship** | **Phone** | **Email**

Court-appointed guardian | Power of attorney | Designated representative | Family/support person only | Authority document attached

## C. CURRENT SERVICES & REFERRAL INFORMATION

**Current living setting / provider** | **Current payment arrangement** | **Referring person / agency** | **Case manager / social worker**

**Day program / employment / school** | **Typical weekly schedule** | **Current services or supports** | **Additional contact / phone**

## D. RESIDENT GOALS, PRIORITIES & REASONS FOR MOVE

**What does the resident hope will improve by moving? What does a good day look like?**

**Resident/representative priorities, routines, privacy needs, food preferences, faith/spiritual practices, relationships, and community connections**

## A. RECORDS / INFORMATION NEEDED BEFORE FINAL RATE OR ADMISSION DECISION

- ☐ Current medication list / MAR
- ☐ Diagnoses and problem list
- ☐ Recent physical / discharge summary
- ☐ Mental health records
- ☐ Behavior or crisis plan
- ☐ MnCHOICES / support plan
- ☐ Therapy evaluations
- ☐ Guardianship / POA
- ☐ Diet / swallowing orders
- ☐ Allergy list
- ☐ Immunization information
- ☐ DME / equipment list

## B. KNOWN CONDITIONS / DIAGNOSES (CHECK KNOWN OR SUSPECTED; EXPLAIN)

- ☐ Diabetes
- ☐ Seizure disorder
- ☐ Heart/circulatory condition
- ☐ Respiratory condition
- ☐ Kidney/liver condition
- ☐ Chronic pain
- ☐ Neurologic condition / TBI
- ☐ Developmental or intellectual disability
- ☐ Autism spectrum condition
- ☐ Dementia / memory disorder
- ☐ Mobility impairment
- ☐ Vision/hearing impairment
- ☐ Sleep disorder
- ☐ Substance-use concern
- ☐ Other significant condition

**List confirmed diagnoses, date/onset if known, current symptoms and which provider manages each condition**

## C. ALLERGIES, DEVICES, CURRENT PROVIDERS & IMMEDIATE SAFETY

**Allergies / adverse reactions**

**Equipment / devices used**

**Primary care / specialists / pharmacy**

- ☐ Recent falls/injury
- ☐ Recent hospitalization/ER
- ☐ Suicidal or self-harm concern
- ☐ Violence or weapon concern
- ☐ Elopement/wandering risk
- ☐ Fire/smoking risk
- ☐ Medication refusal/nonadherence
- ☐ Unsafe substance use
- ☐ Needs continuous or highly specialized support
- ☐ Immediate medical evaluation needed

# HEALTH-RELATED ASSISTANCE, MEDICATIONS & DELEGATED CLINICAL SUPPORT

PRIVATE-PAY ONLY

Identify current need; final scope depends on orders, RN assessment, delegation and provider capability



| Service / need area | Plain-language description and examples | Need? | Frequency | Support level | Details, routines, risks, preferences |
|---|---|---|---|---|---|
| **Medication reminders** | Verbal, visual or device prompts to take medications; staff observes and documents response. | | | | |
| **Assistance with self-administration** | Help opening packages, positioning, reading labels or bringing medications while the resident retains control. | | | | |
| **Staff medication administration** | Trained staff administer scheduled and PRN medications, document on MAR and follow refusal/missed-dose procedures. | | | | |
| **Comprehensive medication management** | Secure storage, ordering/refills, pharmacy and prescriber coordination, RN review/set-up, side-effect monitoring and change follow-up. | | | | |
| **Injections / diabetes support** | Blood-glucose checks; insulin dose preparation, verification or administration by licensed or trained/delegated staff as permitted. | | | | |
| **Vital signs / clinical observations** | Ordered BP, pulse, respirations, temperature, oxygen saturation, weight, edema, pain, bowel or other monitoring and reporting. | | | | |
| **Treatments / therapeutic routines** | Ordered oxygen, nebulizer, CPAP/BiPAP, compression garments, topical treatments, simple delegated care or prescribed exercises. | | | | |
| **Appointments / clinical follow-up** | Prepare for visits, communicate observations, arrange records, follow orders, coordinate labs/referrals and notify family/representative. | | | | |
| **Other delegated task** | A specific task taught and delegated by an RN or other authorized professional, only when lawful and within provider capability. | | | | |

**Please include frequency, duration, level of help, equipment, known triggers, preferred routines, and what support works best.**

**Medication details: medication names, times, packaging, pharmacy, refusals, PRNs, injections, controlled medications, allergies and known side effects**

# COGNITIVE, MENTAL HEALTH & EXECUTIVE-FUNCTION SUPPORT

PRIVATE-PAY ONLY

Describe diagnoses, symptoms, frequency, triggers and supports that actually work



| Service / need area | Plain-language description and examples | Need? | Frequency | Support level | Details, routines, risks, preferences |
|---|---|---|---|---|---|
| **Orientation / memory** | Help knowing date, place, people, schedule and next step; reminders for belongings, tasks and appointments. | | | | |
| **Executive-function support** | Help initiating, sequencing, organizing, making safe decisions, completing routines and understanding consequences. | | | | |
| **Anxiety / panic** | Reassurance, grounding, calm approach, choices, coping tools, early intervention and monitoring for escalation. | | | | |
| **Depression / low motivation** | Cueing, engagement, observation for change, support with routines and prompt reporting of concerning statements. | | | | |
| **Psychosis / paranoia** | Support during hallucinations, delusions or suspiciousness; nonconfrontational redirection, safety monitoring and provider notification. | | | | |
| **Bipolar / mood instability** | Observe sleep, energy, impulsivity, irritability or mood changes; structure routine and report significant changes. | | | | |
| **Trauma / PTSD** | Trauma-informed approach, avoidance of known triggers, predictable routines, emotional regulation and crisis support. | | | | |
| **Developmental / autism-related support** | Concrete communication, visual schedules, sensory accommodations, repetition, skill-building and individualized routines. | | | | |
| **Other psychiatric / cognitive need** | List all known conditions, symptoms, communication needs and provider recommendations. | | | | |

**Please include frequency, duration, level of help, equipment, known triggers, preferred routines, and what support works best.**

**Psychiatric/cognitive diagnoses, treating clinicians, hospitalizations, crisis contacts, preferred de-escalation strategies and medications**

# BEHAVIORAL SUPPORT, SAFETY & POSITIVE INTERVENTION NEEDS

PRIVATE-PAY ONLY

Use observable descriptions; distinguish history, current frequency and foreseeable risk



| Service / need area | Plain-language description and examples | Need? | Frequency | Support level | Details, routines, risks, preferences |
|---|---|---|---|---|---|
| **Repetitive / perseverative behavior** | Repeated questions, requests, calls, pacing or fixation requiring reassurance, redirection, structured choices or monitoring. | | | | |
| **Agitation / escalation** | Restlessness, yelling, threats, distress or rapid escalation requiring early intervention, space, calm communication and documentation. | | | | |
| **Verbal aggression** | Insults, threats, shouting or intimidating language; staff maintains boundaries, de-escalates and protects others. | | | | |
| **Physical aggression** | Hitting, pushing, grabbing, kicking, throwing objects or attempts to harm; requires safety response and incident follow-up. | | | | |
| **Property destruction** | Breaking, throwing, damaging or striking objects; staff protects people, reduces triggers, secures hazards and documents loss/damage. | | | | |
| **Self-injury / suicidal concern** | Self-hitting, cutting, head-banging, threats, plans or other self-harm risk; requires immediate risk-specific response. | | | | |
| **Wandering / exit-seeking** | Leaving safe areas, getting lost, unsafe community access or repeated exit attempts; requires checks, redirection and safe return support. | | | | |
| **Refusal / nonadherence** | Refusal of medications, hygiene, meals, appointments or safety directions; staff uses informed choice, alternatives and required reporting. | | | | |
| **Boundary / disinhibition concerns** | Unsafe sexual, social, financial or personal-boundary behavior requiring cueing, supervision, privacy protection and documentation. | | | | |
| **Other behavior or crisis need** | Substance use, hoarding, fire-setting, sleep reversal, pica, unsafe internet use, theft, exploitation risk or other concern. | | | | |

**Please include frequency, duration, level of help, equipment, known triggers, preferred routines, and what support works best.**

**For each significant behavior: describe what it looks like, current frequency/duration, warning signs, triggers, successful response, prohibited/ineffective response and emergency threshold**

# ACTIVITIES OF DAILY LIVING - PERSONAL CARE

PRIVATE-PAY ONLY

Use the support level that reflects the most assistance typically required



| Service / need area | Plain-language description and examples | Need? | Frequency | Support level | Details, routines, risks, preferences |
|---|---|---|---|---|---|
| **Bathing / showering** | Set-up, cueing, temperature safety, entering/exiting, washing body/hair, drying and privacy; include frequency and equipment. | | | | |
| **Grooming / oral care** | Hair, shaving, deodorant, skin care, nail care within scope, dentures/teeth and daily appearance. | | | | |
| **Dressing** | Selecting weather-appropriate clothing, sequencing, fasteners, shoes, compression garments and changing soiled clothing. | | | | |
| **Toileting** | Getting to toilet/commode, clothing management, hygiene, flushing, handwashing, schedule and nighttime needs. | | | | |
| **Continence care** | Brief/pad changes, cleansing, skin protection, cueing, accident response, bowel routine and supply management. | | | | |
| **Eating / feeding** | Meal set-up, cutting food, adaptive utensils, cueing, pacing, direct feeding and observation for choking or fatigue. | | | | |
| **Repositioning / pressure relief** | Turning in bed/chair, weight shifts, off-loading, positioning devices and scheduled skin-protection routines. | | | | |
| **Personal-care initiation / sequencing** | Prompts and step-by-step support needed because of cognition, mental health, low motivation or poor judgment. | | | | |
| **Other personal-care ADL** | Menstrual care, prosthetic/orthotic care, hearing aids, glasses or another personal-care routine. | | | | |

**Please include frequency, duration, level of help, equipment, known triggers, preferred routines, and what support works best.**

**Personal-care routines, preferred times, privacy/gender preference, equipment, refusal patterns, skin concerns and two-person tasks**

| Service / need area | Plain-language description and examples | Need? | Frequency | Support level | Details, routines, risks, preferences |
|---|---|---|---|---|---|
| **Walking / ambulation** | Independent, cueing, standby, contact guard or hands-on assistance; include distance, device, fatigue and uneven surfaces. | | | | |
| **Wheelchair mobility** | Propelling, steering, footrests, brakes, positioning, pressure relief, ramps and staff pushing. | | | | |
| **Transfers** | Bed, chair, toilet, shower, vehicle and floor transfers; specify pivot, slide board, lift device and one- or two-person assistance. | | | | |
| **Bed mobility** | Rolling, scooting, sitting up, lying down, leg management and use of rails or positioning devices after assessment. | | | | |
| **Stairs / thresholds** | Ability, cueing, handrail use, staff position, number of steps and whether stairs are prohibited. | | | | |
| **Fall-prevention support** | Footwear, clutter reduction, scheduled checks/toileting, alarm or device use, supervision and post-fall response. | | | | |
| **Range of motion / therapeutic exercise** | Prescribed walking, stretching, strengthening or PT/OT routine; include repetitions, precautions and tolerance. | | | | |
| **Transportation transfer assistance** | Entering/exiting vehicle, wheelchair securement, mobility device handling and escort from door to destination. | | | | |
| **Other physical support** | Spasticity, tremor, orthostasis, dizziness, pain behavior, seizure precautions or activity restrictions. | | | | |

**Please include frequency, duration, level of help, equipment, known triggers, preferred routines, and what support works best.**

**Falls in last 12 months, injuries, transfer method, weight-bearing status, equipment brand/type, current therapy recommendations and staff count**

# RESIDENTIAL DINING, NUTRITION & HYDRATION SUPPORT

PRIVATE-PAY ONLY

Please describe meal, nutrition, hydration, and dining support needs.



| Service / need area | Plain-language description and examples | Need? | Frequency | Support level | Details, routines, risks, preferences |
|---|---|---|---|---|---|
| **Morning meal service** | Breakfast preparation/service, preferred foods, beverage, set-up, cueing, monitoring and clean-up. | | | | |
| **Midday meal service** | Lunch preparation/service, preferred foods, set-up, cueing, monitoring and clean-up. | | | | |
| **Evening meal service** | Supper/dinner preparation/service, preferred foods, set-up, cueing, monitoring and clean-up. | | | | |
| **Planned snacks** | Scheduled or PRN snacks, nutrition supplements, diabetes considerations and overnight snack needs. | | | | |
| **Individual meal preparation** | Resident-specific meal separate from the household menu because of preference, tolerance, order or schedule. | | | | |
| **Therapeutic / texture-modified diet** | Low sodium, carbohydrate consistency, renal, allergy, puree, minced, easy-to-chew, thickened liquids or other order. | | | | |
| **Hydration support** | Offer fluids, refill preferred beverages, cue/encourage, track intake when ordered and respond to dehydration risk. | | | | |
| **Meal supervision / feeding** | Pacing, small bites, upright positioning, cueing, direct feeding, aspiration precautions and post-meal monitoring. | | | | |
| **Nutrition monitoring** | Weight, intake, food refusal, swallowing change, constipation, nausea, supplements and provider/dietitian communication. | | | | |

**Please include frequency, duration, level of help, equipment, known triggers, preferred routines, and what support works best.**

**Food allergies, dislikes, cultural/religious needs, diet orders, swallowing history, preferred meal times, supplements and adaptive equipment**

# HOME MANAGEMENT & INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

PRIVATE-PAY ONLY

Please describe household, organization, communication, and community-living support needs.



| Service / need area | Plain-language description and examples | Need? | Frequency | Support level | Details, routines, risks, preferences |
|---|---|---|---|---|---|
| **Housekeeping / room care** | Routine cleaning, trash, bathroom, surfaces, clutter reduction, infection-control precautions and safe organization. | | | | |
| **Laundry / linen service** | Collect, sort, wash, dry, fold, put away, stain/continence handling and bed-linen changes. | | | | |
| **Shopping / personal supplies** | Groceries, toiletries, clothing, incontinence supplies and other personal items; includes list-making and receipt tracking. | | | | |
| **Money / budgeting support** | Budgeting, spending limits, purchases, receipts, communicating with payee/guardian and preventing exploitation; no unauthorized control. | | | | |
| **Appointments / calendar management** | Schedule/reschedule, reminders, forms, records, instructions, follow-up and communication with approved contacts. | | | | |
| **Telephone / communication** | Help making/receiving calls, voicemail, contacts, interpreter access, mail and understanding written information. | | | | |
| **Technology assistance** | Phone/tablet/computer access, charging devices, telehealth setup, passwords through approved process and online safety cueing. | | | | |
| **Personal organization / paperwork** | Room organization, mail, benefits documents, identification, forms, belongings and maintaining a predictable routine. | | | | |
| **Medication organization as an IADL** | When self-managed: pharmacy pickup, pill organizer support or reminders; clinical medication management is recorded separately. | | | | |
| **Other IADL / household support** | Pet-related routine, community errands, clothing repair, personal inventory or another non-clinical task. | | | | |

**Please include frequency, duration, level of help, equipment, known triggers, preferred routines, and what support works best.**

**Identify tasks family will continue, tasks included in the service package, tasks billed separately, spending authority and receipt requirements**

# INDIVIDUALIZED ENGAGEMENT, SOCIALIZATION & COMMUNITY INTEGRATION

PRIVATE-PAY ONLY

Please describe interests, routines, preferred activities, and support needed for meaningful participation.



| Service / need area | Plain-language description and examples | Need? | Frequency | Support level | Details, routines, risks, preferences |
|---|---|---|---|---|---|
| **Individual 1:1 engagement** | Dedicated staff time for conversation, coping, routine-building, hobbies, skill practice, planning or participation that cannot be shared. | | | | |
| **Shared small-group engagement** | Staff-supported activity for approximately 2-5 residents, such as games, music, exercise, cooking, gardening or discussion. | | | | |
| **Community outing support** | Planning, preparation, supervision and participation in preferred outings, recreation, worship, volunteering or community events. | | | | |
| **Relationship / family support** | Help maintaining approved calls, visits, boundaries, calendars, celebrations and communication with important people. | | | | |
| **Daily structure / meaningful routine** | Visual schedule, choices, task initiation, balancing rest/activity and reducing boredom or escalation through predictable engagement. | | | | |
| **Exercise / wellness activity** | Walking, chair exercise, stretching, outdoor time, hydration, relaxation or other non-clinical wellness routine. | | | | |
| **Leisure access / adaptive participation** | Set up TV, music, reading, games, crafts, internet, sensory activities or adaptive materials and cue participation. | | | | |
| **Independent community-safety coaching** | Practice public behavior, money safety, asking for help, street/traffic awareness, boundaries and safe return plan. | | | | |
| **Other person-centered participation** | Education, employment/day program coordination, cultural activity, peer relationship, advocacy or another goal. | | | | |

**Please include frequency, duration, level of help, equipment, known triggers, preferred routines, and what support works best.**

**Interests, preferred activities, dislikes, sensory needs, ideal group size, community goals, day program/employment schedule and behaviors caused by boredom/isolation**

## A. TRANSPORTATION, RIDE COORDINATION & ESCORT SERVICES

| Service / need area | Plain-language description and examples | Need? | Frequency | Support level | Details, routines, risks, preferences |
|---|---|---|---|---|---|
| **Facility vehicle - driver time** | Staff drives for shopping, community activities, errands or other approved trips; include vehicle preparation and return-to-home support. | | | | |
| **Third-party ride coordination** | Staff schedules Lyft, Uber, taxi, public transit or another non-medical ride, confirms pickup, communicates needs and completes safe handoff. | | | | |
| **Door-through-door escort** | Staff accompanies the resident from the residence into the destination and back, including mobility, behavior, safety, and wayfinding support. | | | | |
| **Appointment waiting / accompaniment** | Staff remains during a visit or activity, supports communication, receives instructions when authorized and assists with follow-through. | | | | |
| **Trip preparation / return routine** | Staff helps the resident get ready, gathers required items, confirms medications and equipment, manages transitions, and helps the resident settle afterward. | | | | |
| **Mileage / parking / tolls** | Estimate miles, frequency, parking and tolls; identify whether costs are included, mileage-based or billed as an external pass-through. | | | | |
| **Accessible or specialized transport** | Wheelchair-accessible vehicle, transfer support, oxygen/equipment handling or another accommodation needed for safe transportation. | | | | |

**Please include frequency, duration, level of help, equipment, known triggers, preferred routines, and what support works best.**

**Typical destinations, weekly trip pattern, estimated miles, accessibility needs, required escort, wait-time expectations, and excluded transportation costs**

## A. SUPERVISION & RESPONSE-AVAILABILITY SERVICES

| Service / need area | Plain-language description and examples | Need? | Frequency | Support level | Details, routines, risks, preferences |
|---|---|---|---|---|---|
| **24-hour on-site response availability** | Shared staff presence and response capacity for planned and unplanned needs; this is not automatically dedicated one-to-one staffing. | | | | |
| **Scheduled safety / wellness checks** | Staff checks at defined intervals for location, wellness, fall risk, breathing, behavior, toileting, sleep or another assessed need. | | | | |
| **Close-proximity / line-of-sight supervision** | Staff remains within hearing, immediate reach or line of sight during specified routines, triggers, transitions or high-risk periods. | | | | |
| **Dedicated 1:1 supervision** | One staff member is assigned exclusively to the resident for defined hours, locations, or activities; identify whether the staff member must remain awake. | | | | |
| **Two-person / second-staff support** | A second staff member is required for specified transfers, personal care, behavioral response, transportation or emergency routines. | | | | |
| **Overnight response and monitoring** | Night checks, toileting, insomnia/activity, respiratory or seizure observation, behavior response and unscheduled personal assistance. | | | | |
| **Resident summoning / call device** | A resident call or summoning device will be provided. Assess the resident's ability to understand, access, activate, and wait safely for staff response. | | | | |
| **Emergency / crisis response support** | Staff follows individualized medical, behavioral, elopement, fire, fall or other emergency procedures and contacts 911 or approved persons as indicated. | | | | |

**Please include frequency, duration, level of help, equipment, known triggers, preferred routines, and what support works best.**

**Required check intervals, high-risk times, call-device placement and ability, emergency triggers, de-escalation steps, notification order and when 911 must be called**

# INFORMATION REVIEW, PRIVATE-PAY PROPOSAL & ACKNOWLEDGMENTS



Complete after the provider has reviewed the assessment and prepared the proposed service package



## A. INFORMATION & SERVICE-SCOPE ACKNOWLEDGMENTS

The resident and/or representative provided the information in this form to the best of their knowledge and disclosed known health, medication, cognitive, behavioral, safety, mobility, and support needs.

This preadmission assessment supports screening, service planning, and pricing. It does not replace the provider's required nursing assessment, record review, service plan, admission agreement, or capability determination.

The proposed service package may be revised when records, observation, a nursing assessment, new orders, actual service use, or a change in condition shows that the resident needs more, less, or different support.

Services not included in the signed agreement, services outside the provider's capability, and third-party costs may require a separate arrangement, additional charge, or outside provider.

The resident/representative will promptly report meaningful changes and cooperate with reassessment, care coordination, medication reconciliation, and safety planning.

## B. PROPOSED PRIVATE-PAY TERMS

The daily service rate and monthly room/rent amount shown below are proposals until incorporated into a signed agreement.

The service rate may be reviewed when assessed needs, staffing intensity, one-to-one or second-staff time, nursing oversight, transportation, meals, supplies, equipment, external costs, or legal requirements change.

Third-party charges and services not included in the proposed service package may be billed separately when agreed in writing.

The resident/representative will receive a copy of the final signed agreement and service plan.

Questions about included services, excluded services, payment terms, or rate-review triggers should be resolved before signing.

## C. APPROVAL, SIGNATURES & EFFECTIVE TERMS

**Rate status** ☐

**Proposed daily service rate**

**Separate monthly room/rent**

**Effective date**

**Rate review date / trigger**

**Resident** **Date**

**Representative / support person** **Date**

**RN reviewer** **Date**

**Administrator / authorized reviewer** **Date**

☐ Resident is unable or declines to sign; explanation documented below

☐ Copy provided to resident/representative

**Comments, decision-maker authority, unresolved conditions, or distribution notes**