Assisted Living Individualized Service Plan (ISP)

Resident Name: _____ ❑ Female ❑ Male

Date: _____ **For:** ❑ Initial ❑ Six months ❑ Other _____

Note: Services to be provided and by whom: *Any additional information or change of service on this ISP must be indicated in bold type, capital letters, or by using a different color ink and dated.* ***Indicate the reason for any change in service in the last column, and the date of the change.***
Key: N/A = Not Applicable, RA = Resident Aide, N = Nurse, P = Physician, L = Lab Tech, T = Therapist, O = Other

Part 1 – Care Needs

Activity – Check all applicable	Services to be provided:	Frequency	By Whom	Changes/Comments
Medical - Nursing				
❑ Lab Test				
❑ Pacemaker				
❑ Dialysis				
❑ Skilled Nursing, Treatments &/or Education	❑ Injection ❑ Insulin ❑ Other – Type _____ ❑ Dressing ❑ Other _____			
❑ Specialists (eg podiatrist, chiropractor)	Specify_____ _____			
❑ Medical Equipment	❑ Independent ❑ Type _____ ❑ 1+ Assist *(requires more than intermittent assistance with equipment – EALR required)*			
❑ Pain Management				
❑ Other	❑ health prevention ❑ aide-level health related activities ❑ other – specify_____ _____			
Rehabilitation	❑ PT ❑ OT ❑ Speech Therapy ❑ Other: _____			
Nutritional				
Diet – Meal Assist	❑ Regular ❑ NAS ❑ NCS ❑ Chopped as needed ❑ Soft ❑ Dietary Supplement Specify: _____	❑ Meals ❑ Snacks		❑ Chewing Difficulty ❑ Swallowing Difficulty ❑ Other: _____

Activity – Check all applicable	Services to be provided:	Frequency	By Whom	Changes/Comments
Fluid Restrictions/ Encouragement	❑ None ❑ Dietary Supplements _____ ❑ Other Specify: _____			

Functional				
Personal Hygiene	❑ Independent ❑ Shower ❑ Bath ❑ Equipment			
	❑ Hearing Aide: ❑ R ❑ L ❑ Eyeglasses ❑ Reading ❑ Always			
	Hair: ❑ Shampoo ❑ Grooming ❑Shave			
	❑ Teeth Care ❑ Denture Care			
	❑ Nail Care ❑ Foot Care			
Continence	❑ Independent ❑ Assist with bathroom ❑ Assist with protective garment change ❑ Ostomy Care ❑ Chronic unmanaged incontinence *(chronically unwilling or unable to participate, with help from staff, so that cleanliness and sanitation can be maintained - EALR required)*			
Skin Care	❑ None ❑ Location & Type: _____			
Dressing	❑ Independent ❑ Coordinate ❑ Upper ❑ Lower ❑ Other _____			
Medications	❑ Self ❑ Assist			
Transfer	❑ Independent ❑ 1+ Assist *(chronically chairfast and/or chronically needs one person assist to transfer – EALR required)*			
Mobility	❑ Independent ❑ Walker ❑Cane ❑ Wheelchair ❑ Crutches ❑ Escort: _____ ❑ 1+ Assist *(chronically needs one person to assist to walk or to climb/descend stairs- EALR required)*			
Falls Risk Reduction	❑ No Known History ❑ Other: _____			
Respiratory Therapy & Oxygen	❑ None ❑ Self-managed ❑ Type: _____			
Equipment	❑ None ❑ Self-managed ❑ Prosthesis ❑ Braces ❑ Other _____			

Activity – Check all applicable	Services to be provided:	Frequency	By Whom	Changes/Comments
Cognitive				
Orientation	❑ N/A ❑ Remind ❑ Cue ❑ Supervise ❑ Accompany			
Specialized Services	❑ N/A ❑ Dementia Care, Secured Unit *(requires SNALR)* ❑ Environmental modifications ❑ Supervision/Monitoring			
Sensory	❑ None ❑ Hearing ❑ Vision ❑ Speech ❑ Other: _____			
Mental Health	❑ Diagnosis: _____ ❑ Treatment Required ___Yes ___No ❑ Substance Abuse ❑ Coordination with SA provider_____			
Social				
Education & Employment	Desire for continued or future education: ❑ Yes ❑ No If yes, specify: _____ Desire to work or volunteer ❑ Yes ❑ No If yes, specify: _____			
Intellectual	Desire for new or continued intellectual activity ❑ Yes ❑ No If yes, specify: _____			
Recreational	Desire for new or continued recreational activity ❑ No ❑ Yes, Specify: _____ ❑ Need assistance of ALR staff Specify: _____			
Spiritual	Desire for new or continued spiritual activity ❑ No ❑ Yes, Specify: _____ ❑ Need assistance of ALR staff Specify: _____			
Cultural	Desire for new or continued cultural activity ❑ No ❑ Yes, Specify: _____ ❑ Need assistance of ALR staff Specify: _____			
Financial	Assistance with access to financial benfits (i.e. Medicare, Medicaid, Social Security, Veteran's Admin., Pensions, etc.) ❑ Managed Independently ❑ Assistance of family, resident rep. or legal rep. Specify: _____ ❑ Need assistance of ALR staff Specify: _____			

Other Comments: _____

Print Name, Title and Organization of Individuals Participating

Resident

Resident's Representative

Resident's Legal Representative (if applicable)

ALR Provider's Representative

Was the Resident's Primary Physician Consulted?
❑ Yes Indicate physician's name and date: _____ _____
❑ No

Home Care Services Agency Rep. Signature (if applicable)	**ALR Provider's Representative Signature**	**Date**

Documentation of ISP Review: *For 6-month ISP reviews please consider and review any changes in the following areas: Communication/Dental/Vision/Hearing; Customary Routine, Continence Status/Management, Physical Function, Cognitive Impairment Screen, and Admission Decision.*

❑ I am confirming the ISP services as listed above, including any changes that have been made since the last review.

❑ I have reviewed the ISP services as listed above and recommend the following change(s) in service: _____

_____

Name	Title	Date	Signature

Documentation of ISP Review: *For 6-month ISP reviews please consider and review any changes in the following areas: Communication/Dental/Vision/Hearing; Customary Routine, Continence Status/Management, Physical Function, Cognitive Impairment Screen, and Admission Decision.*

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_____

Name	Title	Date	Signature

Attach Documentation of additional ISP Reviews as Necessary

Assisted Living Individualized Service Plan
Addendum for Enriched Housing Program/Assisted Living Residences
(If applicable)

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The following information pertains to additional tasks not included on the ISP relating to the enriched housing program functional assessment

Activity	Services to be provided:	Frequency	By Whom	Changes/Comments
Instrumental Activities of Daily Living				
❑ Transportation	❑ independent, drives own car or accesses transportation on own & chooses to do so ❑ wants or needs someone to drive them, but does not require an escort ❑ must be accompanied by an escort ❑ requires special transportation specify _____			
❑ Laundry	❑ is able & chooses to do own laundry ❑ is able & chooses to do light laundry, but wants/needs assistance with heavy laundry ❑ needs or chooses ALR to do all laundry			
❑ Housekeeping	❑ is able & chooses to do all housekeeping tasks in room/apartment ❑ is able & chooses to do light housekeeping, but wants/needs assistance with heavier cleaning tasks Specify _____ ❑ needs or chooses ALR to do all housekeeping			
❑ Shopping	❑ is able & chooses to shop on their own & carry or transport packages on their own ❑ is able & chooses to do light shopping on their own, but wants/needs assistance with major shopping Specify _____ ❑ needs or chooses ALR staff or other person (i.e. family member) to do all of their shopping			
❑ Ability to use telephone	❑ Independent-has phone & dials numbers and answers calls without assistance ❑ has specially adapted phone and dials numbers and answers calls without assistance ❑ chooses or needs ALR staff to help them make calls or make the calls on their behalf			