APPRAISAL/NEEDS AND SERVICES PLAN

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

FACILITY NAME	ADDRESS	CHECK TYPE OF NEEDS AND SERVICES PLAN: ☐ ADMISSION ☐ UPDATE

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

Licensing regulations require that an appraisal of needs or a needs and services plan be completed for clients/ residents to identify individual needs or to develop a service plan for meeting client/resident needs. For Residential Care Facilities for the Chronically Ill, licensing regulations require that a Resident Individual Services Plan be completed to document the needs and services of individual residents.

NOTE: For Residential Care Facilities for the Elderly, this form may be completed to assist in developing a plan of action to meet the services needs of individual residents not presently being addressed as specified in California Code of Regulations, Title 22, Section 87457(c)(2).

This form is provided as a courtesy to licensees.

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 adjusting 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