Submit by Email | Print & Fax/Mail

Level of Care Assessment Form

How to Complete the Form

Online: *For most people this form is easiest completed online. Simply fill-in the form on your screen then click the "Submit by Email" button and follow the instructions.*
By mail or fax: *If you have a printer attached you may print out the form first, hand write your answers, and either mail or fax back to us.*

Please complete the information as best you can as it will help us in providing a more accurate estimation of the cost of care.

Basic Information:

About the Resident:

Prospective Resident's Name:

Age | Female ◯ | Male ◯

Height | Weight

Current Residence:

Other (please write in)

Reason for Moving:

Medical:

Medical Diagnosis

Financial:

Funding Source

Other (please write in)

About You:

Contact Name

Address

City

State

Zip/Postal Code

Relationship

Phone

Cell or other phpne

Email

Activities of Daily Living:

ADL General:

	No Help Needed /Independent	Some Help Needed	Extensive or Total Help
Dressing: Upper Body	◯	◯	◯
Dressing: Lower Body	◯	◯	◯
Hygiene: Hands & Face	◯	◯	◯
Hygiene: Hair, Teeth, MakeUp, Shaving	◯	◯	◯
Hygiene: Using Toilet/Incontinence Issues	◯	◯	◯
Hygiene: Bathing or Showering	◯	◯	◯
Mobility: Getting in or out of Bed/Chair	◯	◯	◯
Locomotion: Needs help with w/chair or walking	◯	◯	◯
Dining: Set Up/Cutting up Food	◯	◯	◯
Dining: Eating and Self Feeding	◯	◯	◯
Bed Mobility: Turning and Positioning in Bed	◯	◯	◯
Uses Walker / Wheelchair / or both	◯ Uses walker	◯ Uses wheel chair	◯ Uses both

ADL's cont.

Bowl & Bladder Function:

	No Help Needed /Independent	Some Help Needed	Extensive or Total Help
Bowel: Continence needs	◯	◯	◯
If incontinent, please indicate the level of frequency			
Urinary: Incontinence needs:	◯	◯	◯
If incontinent, please indicate the level of frequency			

Does the applicant require a catheter? ◯ Yes ◯ No

Mental & Cognitive Status:

Alert & orientated (to time, place and person)	◯ Yes	◯ No	
Memory Loss (short term)	◯ Yes	◯ No	
Disoriented (to time, place and person)	◯ Yes	◯ No	
Memory Loss (long term)	◯ Yes	◯ No	
Depression	◯ Yes	◯ No	
Wanders	◯ Yes	◯ No	if Yes
Exit Seeking?	◯ Yes	◯ No	
Any challenging behaviors?	◯ Yes	◯ No	

This includes things like being disruptive, agitated or aggressive, abusive, demanding and/or requiring frequent staff intervention. Is the resident delusional or does h/she have hallucinations? Please describe the resident's emotional status, personality, and demeanor:

Other Items:

Currently Taking Medication? ◯ Yes ◯ No

Please list medication and any comments

Needs nursing or medical treatments	◯ Yes	◯ No
Needs daily pain managment	◯ Yes	◯ No
Vital signs monitoring	◯ Yes	◯ No

	No Help Needed Independent	Some Help Needed	Extensive or Total Help
Require Injections	◯	◯	◯
Blood glucose monitoring	◯	◯	◯
02 therapy	◯	◯	◯
Need night care	◯	◯	◯

Thank you for taking the time to complete this questionnaire. The quote you will receive is approximate and based on the information you provided above. A more accurate cost quote can be given after a comprehensive assessment by Spada Homes has been carried out.
For mail or fax-back use: Spada Homes 3621 NE 100th St., Seattle, WA 98125 | Fax: 206-729-9049.