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Dear Healthcare Provider,

The State of Florida regulations that govern Assisted Living Facilities require a COMPLETED Agency for Healthcare Administration (AHCA) Health Assessment form 1823, based on an exam prior to admission. Please utilize the following instructions to complete the form in its entirety. By following these instructions, this will minimize any follow up phone calls or correspondence needed to comply with the regulatory standards.

Please note the following when completing this form for your patient:

There cannot be any blanks on the form. If the box does not apply, then N/A (non-applicable) may be recorded in the box.

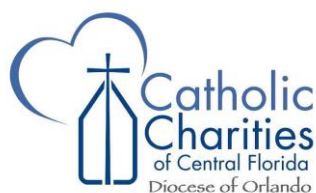
Page 1:

- Allergies: Food allergies, if any, are important information for dietary staff. If there are no allergies, then please put NONE in the box.
- A current height and weight are required.

NOTE: Not all your patients have physical or sensory limitations; require nursing, treatment, therapy, or special precautions. If this does not apply, then N/A is acceptable. Please NO blanks.

Page 2/Part 1:

- **Section A** – Activities of Daily Living (ADL): If supervision or assistance is checked off, it is required to write a brief description in the comment section.
- **Section B** – Diets: Most ALF's do not provide specialized diets, so "regular" diets are preferred. If your patient requires a specialized diet, please check with your patient to be sure they want to comply. It is a resident right to refuse a therapeutic diet.



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- **Section C** – Questions #1, #2, #4, #5 must be answered **NO** to qualify for admission to ALF. Question #3-a person with a stage 2 pressure sore may be admitted under certain conditions. Please note that #5, 24-hour Nursing or Psychiatric Care means your patient requires skilled nursing care or mental health treatment to a crisis stabilization unit.
- **Section D** – This box must be checked **YES** in order to be admitted to an ALF.

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- **Section A** – Ability to perform self-care tasks: If supervision or assistance is checked off, it is required to write a brief description in the comment section
- **Section B** – General Oversight: If “O” is checked off then please write a brief description in the comment section.

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- **Section A** – Please attach an order sheet for your patient’s current medications. Please include quantities and refills so that the pharmacy can fill medications accordingly. Also include any hard scripts written for controlled medications.
- **Section B** – Please check the appropriate box indicating your patient’s ability to manage their medications. If assistance is checked off for any medications, then note that unlicensed/trained personnel may be providing this service. If medication administration is required, then only a Nurse may do so in an ALF.
- **Section C**- This is for additional comments, if any. If your patient is on a medication and self manages then you may indicate so here. For example, Oxygen or Over-The-Counter (OTC) medications.

Please be sure to sign, date and include the Examiner’s information.

