LEVEL OF CARE EVALUATION FOR ADULT RESIDENTIAL CARE HOME RESIDENTS

Resident Name SSN_________________________

Activities of Daily Living	Need for Verbal Reminders/Encouragement (Level /Points 1)	Need for Some Physical Assistance (Level /Points 2)	Need for Ext. /Total Assistance (Level /Points 3)
A. Eating/Feeding	1	2	3
B. Bathing	1	2	3
C. Dressing/Grooming	1	2	3
D. Mobility	1	2	3
E. Transfers	1	2	3
F. Toileting	1	2	3
G. Incontinence-Urine/Feces/Both (Circle appropriate one)		1 x /Month 2	2 x /Month 3

Total Circled Level Points ____________

(If more then 10 points, reassess in total for ARCH level of care.)

Supervision, Behavior Management	NEED FOR OPERATOR ASSISTANCE / INTERVENTION / CONTROLS		
	Less then weekly but at least 1x / month	At least 4x / month	At least 6x / month
A. Impaired communications	1.5	3	4.5
B. Impaired Judgment	1.5	3	4.5
C. Agitated/Hostile	1.5	3	4.5
D. Hallucinates	1.5	3	4.5
E. Depression	1.5	3	4.5
F. Assaultive/Destructive	1.5	3	4.5
G. Abusive (verbal)	1.5	3	4.5
H. Withdrawn/Regressive	1.5	3	4.5
I. Wanders	1.5	3	4.5
J. Other-Specify: ______________________	1.5	3	4.5

Total Circled Level Points ________________________

(If more then 5 points, reassess in total for ARCH level of care.)

Health-Related Services - Per doctor's orders	NEED FOR OPERATOR ASSISTANCE		
	1x / Day	2-3x / Day	4+ x / D
A. Oral Medication	1	2	3
B. Non-Oral Medication/Dressing/Treatment	1	2	3
C. Special Diet	1	2	3
D. Medical or Psychiatric Appointments/ Transportation/Escort Services	1x / Month 1	2-3x / Month 2	4+x / Month 3

Total Circled Level Points __________________________

(If more then 6 points, reassess in total for ARCH level of care.)

LEVEL OF CARE ASSESSMENT

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ADULT RESIDENTIAL CARE HOME LEVEL	**INTERMEDIATE NURSING CARE LEVEL**	**SKILLED NURSING CARE LEVEL**

(See instructions for Form OHCA ARCH N 2)

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Signature of Physician/APRN Date

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