

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

For Private Pay Residents of Assisted Living Facilities

Dates: Assessment: ___/___/___
 Reassessment: ___/___/___

1. IDENTIFICATION

Name: _____ Social Security Number: _____
(Last) (First) (Middle Initial)

Current Address: _____
(Street) (City) (State) (Zip Code)

Phone: () _____

Birth date: ___/___/___ Sex: Male ₀ Female ₁
(Month) (Day) (Year)

Marital Status: Married ₀ Widowed ₁ Separated ₂ Divorced ₃ Single ₄ Unknown ₉

2. FUNCTIONAL STATUS (Check only one block for each level of functioning) D = Dependent or Totally Dependent (TD or DD)

	Needs Help?		Mechanical Help Only ^d 10	Human Help Only ^D 2		Mechanical & Human Help ^D 3		Performed by Others ^{D/TD} 40			D/TD Is Not Performed 50
	No 00	If Yes Check Type of Help		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2				
Bathing											
Dressing											
Toileting											
Transferring											
								Spoon Fed 1	Syringe/Tube Fed 2	Fed by IV 3	
Eating/Feeding											
Continenence	Needs Help?		Incontinent ^d Less than weekly 1	Ext. Device/Indwelling/Ostomy Self Care ^d 2	Incontinent ^D Weekly or More 3	External Device ^{D/TD} Not Self Care 4	Indwelling Catheter ^{D/TD} Not Self Care 5	Ostomy ^{D/TD} Not Self Care 6			
	No 0	If Yes Check Type of Help									
Bowel											
Bladder											
AMBULATION	Needs Help?		Mechanical Help Only 10	Human Help Only 2		Mechanical & Human Help 3		Performed by Others 40			Is Not Performed 50
	No 00	If Yes Check Type of Help		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2				
Walking											
Wheeling											
Stairclimbing											
									Confined Moves About		Confined Does Not Move About
Mobility											

2. FUNCTIONAL STATUS *(Continued)*

D = Dependent

IADLS	Needs Help?	
	No ₀	Yes ₁
		D
Meal Prep		
Housekeeping		
Laundry		
Money Mgmt.		

Medication Administration
How can you take your medicine?
<input type="checkbox"/> Without assistance ₀ <input type="checkbox"/> Administered/monitored by lay person ₁ D <input type="checkbox"/> Administered/monitored by professional nursing staff ₂ D
Describe help/Name of helper:

3. PSYCHO-SOCIAL STATUS

Behavior Pattern	Orientation
<input type="checkbox"/> Appropriate ₀ <input type="checkbox"/> Wandering/Passive - Less than weekly ₁ <input type="checkbox"/> Wandering/Passive - Weekly or more ₂ D <input type="checkbox"/> Abusive/Aggressive/Disruptive - Less than weekly ₃ D <input type="checkbox"/> Abusive/Aggressive/Disruptive - Weekly or more ₄ D <input type="checkbox"/> Comatose ₅ D	<input type="checkbox"/> Oriented ₀ <input type="checkbox"/> Disoriented - Some spheres, some of the time ₁ d <input type="checkbox"/> Disoriented - Some spheres, all the time ₂ d <input type="checkbox"/> Disoriented - All spheres, some of the time ₃ D <input type="checkbox"/> Disoriented - All spheres, all of the time ₄ D <input type="checkbox"/> Comatose ₅ D
Type of inappropriate behavior:	Spheres affected:
Current psychiatric or psychological evaluation needed? <input type="checkbox"/> No ₀ <input type="checkbox"/> Yes ₁	

4. ASSESSMENT SUMMARY

Prohibited Conditions
Does applicant/resident have a prohibited condition? <input type="checkbox"/> No ₀ <input type="checkbox"/> Yes ₁ Describe:

Level of Care Approved
1) Residential Living <input type="checkbox"/> 2) Assisted Living <input type="checkbox"/>

Assessment Completed by:			
Assessor	Assessor's Signature	Agency/Assisted Living Facility Name	Date
If the assessor is an assisted living facility employee, the administrator or designee must signify approval by signing below:			
_____ Administrator or Designee Signature	_____ Title	_____ Date	
_____ Administrator or Designee Signature	_____ Title	_____ Date	
Comments:			

032-02-0122-01 (1/10) Note: Form must be filed in private pay resident's record upon completion.