Level of Care Assessment

Resident Name _____ Date _____ ☐Current Resident or ☐New Resident (check one)

Location _____ Completed By _____

	Score		Score
Eating (check all that apply) (0) Independent (no assistance needed) (1) Verbal prompts (reminders to come to meals, chewing, etc.) (2) Extensive assist/special dietary needs (cut up, puree, thicken, etc.) (3) Meals to room (except for short term illness) (6) Special diet purchases (gluten free, vegan, vegetarian, etc.) (6) Total assistance (wouldn't eat without hands-on assistance)		**Mobility and Transferring (check all that apply)** (0) Independent (no assistance needed) (1) Fall risk management (1) Verbal prompts (safety/supervision) (2) Some assistance to steady & side-by-side walking (3) 1 person assistance to transfer (3) 2 person assist or mechanical device needed (6) Total assist (not mobile without assistance)	
Personal Hygiene (check one) (0) Independent (no assistance needed) (1) Verbal prompts (reminders only) (2) Stand-by/some hands-on assistance needed (3) Need physical assistance daily (6) Total assist (dentures, face washed, nails/hair, etc.)		**Bath/Shower (check all that apply)** (0) Independent (no assistance needed) (1) Verbal prompts (reminders only) (2) Stand-by/some hands-on assistance needed (4) 3 or more showers weekly (includes additional for incontinence care) (6) Total assist 2 X's weekly	
Response to Emergency (check one) (0) Independent (recognized & responds to emergencies) (2) Some verbal/ hands on assistance needed (4) Total assistance for safety in an emergency		**Toileting (check one)** (0) Independent (no assistance needed) (2) Occasional incontinence (4) Some hands-on incontinence (Peri-care) (6) Total assistance	
Medications (check all that apply) (1) Bubble Pack Medications (2) Coordination w/outside pharmacy (3) Insulin dependent (4) Self administration of medication requires RN oversite (8) Staff assistance with all medications		**Medical Diagnosis (check all that apply)** (1) Oxygen monitoring (1) Misc._____per event (ex: smoking/ alcohol use) (1) Special medications (nebulizers, c-pap, etc. per product) (2) Coordination with an outside provider ( ) Home Health ( ) Hospice (2) Daily assist with TED hose/braces, etc. (2) Requires bed, chair alarms, bed cane/ rail (4) Ostomy care (4) Foley catheter (4) Wound care	
Dressing (check all that apply) (0) Independent (no assistance needed) (1) Verbal prompts (reminders only) (3) Some hands-on assistance (6) Total assistance for all dressing needs		**Psycho/Social Status (check all that apply)** (0) No behavioral concerns (2) Occasional verbal direction for appropriate social/personal wellness (3) Re-direction for learning and living skills (4) Re-direction due to resistant to cares (4) Behavior plan/monitoring (4) Constant redirection (5) Verbal inappropriate interaction requiring extensive redirection (5) Excessive call bell (5) Intrusive wandering (6) Physical aggressive behaviors (6) High elopement management	
Housekeeping/Laundry (check all that apply) (0) Standard daily room clean/ weekly deep clean (3) Additional housekeeping 2x or more weekly ( )Preference ( ) Incontinence (6) Additional Laundry due to: ( )Preference ( ) Incontinence			
***The grand total point tally will be final upon approval from the Corp Office. LOCA form may be subject to change 30 days after initial move-in and every 90 days thereafter or as needed.**	**Column Total:**	**Notes:** **Room = $_____** **Care = $_____ (total LOCA points x $_____ price per point)** **Other = $_____** **Total = $_____**	**Column Total:**

Grand Total:

Resident/POA Signature _____ Date _____

Home Office Signature _____ Date _____

Administrator Signature _____ Date _____

Rate Effective Date _____