OCFS-3122 (Rev. 12/00)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

FAMILY TYPE HOMES FOR ADULTS MEDICAL EVALUATION (RESIDENT)

(ALL SPACES MUST BE COMPLETED)

STATEMENT OF PURPOSE

Family Type Homes for Adults provide 24 hour residential care settings for dependent adults. They are not medical facilities. Persons in need of constant medical care and supervision should not be admitted or retained in a Family Type Home for Adults because such a home lacks the staff and expertise to provide needed services. Persons who, by reason of age and/or physical and/or mental limitations, are in need of assistance with the basic activities of daily living can be cared for in Family Type Home for Adults.

The information solicited in this medical evaluation will assist you, the individual, and the operator of a Family Type Home for Adults in determining the level of care needed to assure the health, safety and well-being of the individual. It will become part of the resident's record and subject to review by the State Office of Children and Family Services, which is responsible for supervision of the Family Type Home for Adults Program.

SECTION 1 – PERSONAL

NAME:				DATE OF BIRTH:
ADDRESS:				
CITY:	STATE:	ZIP CODE:	PHONE NUMBER:	SEX *(Check One)* ☐ **M** ☐ **F**

SECTION II – MEDICAL HISTORY

PRIMARY DIAGNOSIS:	**SECONDARY DIAGNOSIS:**
RECENT SURGERY: *(Type of Procedure)* ☐ None Known	**RECENT ACUTE ILLNESS** *(Type and Date)*
DIET:	**ALLERGIES TO:** (List any known) ☐ None Known MEDICATIONS: ☐ None FOOD: ☐ None OTHER: ☐ None ACTIVITY RESTRICTIONS: ☐ None
WEIGHT BEARING: **PARTIAL:** **NONE:**	**CHRONIC ILLNESS, PHYSICAL OR MENTAL LIMITATIONS:** **BLOOD PRESSURE:** **WEIGHT:**

REQUIRED MEDICAL EXAMINATIONS AND/OR COMMUNITY BASED MEDICAL SERVICES

REQUIRED NEED	PROVIDED BY	FREQUENCY

-OVER-

SECTION III: LIST ALL CURRENT MEDICATIONS (Prescriptions and OTC), AND NOTE SPECIAL INSTRUCTIONS

MEDICATION: (Type, Frequency and Dosage):

SECTION IV: OBSERVATIONS OF INDIVIDUAL

IS INDIVIDUAL: *(Please check either Yes or No)*	**Yes**	**No**	**DESCRIBE AS NEEDED**
AMBULATORY?	☐	☐	
CAPABLE OF SELF-ADMINISTRATION OF MEDICATIONS?	☐	☐	
HABITUATED TO DRUGS?	☐	☐	
HABITUATED TO ALCOHOL?	☐	☐	
DANGER TO SELF OR OTHERS?	☐	☐	
INCONTINENT?	☐	☐	

SECTION V: EVALUATION

IN YOUR OPINION CAN THE INDIVIDUAL'S NEEDS BE MET BY THE SUPPORT SERVICES AVAILABLE IN A FAMILY TYPE HOME FOR ADULTS?
☐ YES ☐ NO *(Please Describe – Optional)*

HAS RESIDENT BEEN ADMITTED FROM A: ☐ SNF ☐ OWN HOME ☐ DMH FACILITY
☐ HRF ☐ HOSPITAL ☐ OTHER

If so, is a detailed statement from the referral source included? ☐ YES ☐ NO

DOES THE INDIVIDUAL REQUIRE PLACEMENT IN A NURSING FACILITY? ☐ YES ☐ NO *(If YES, Please give reasons)*

DOES THE INDIVIDUAL HAVE A RELEVANT HISTORY, CURRENT CONDITION OR RECENT HOSPITALIZATION FOR MENTAL ILLNESS?
☐ YES ☐ NO *(If YES, Explain)*

IF YES TO THE ABOVE QUESTION, DOES THE INDIVIDUAL REQUIRE A MENTAL HEALTH EVALUATION? ☐ YES ☐ NO

PHYSICIAN'S SIGNATURE:	DATE OF EXAMINATION:	DATE FORM WAS COMPLETED:
X		