

# PATHWAYS TO Care

A Healthcare Ministry of  
Catholic Charities of Central Florida

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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 (Version April 2021), based on an exam prior to admission. Please use the following instructions to help you complete the form in its entirety. Following these instructions 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 (nonapplicable) may be recorded in the box.***

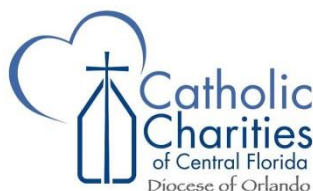
**Page 1/Section 1 Health Assessment:**

- 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.**

**Page2/Section 1 Health Assessment (continued):**

- **Part A** - Activities of Daily Living (ADL): All rows in the INDEPENDENT column must be checked.
- **Part B** - Diets: "Regular" diets are offered to all residents. If your patient requires a specialized diet, it will be the responsibility of the patient to make the best choice for their health condition.
- **Part C** - Questions #1, #2, #4, and #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.
- **Part D** - This box must be checked **YES** to be admitted to an ALF.



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**Page 3/Section 2:**

- **Part A-** Attach discharge medication reconciliation list for the patient.
- **Part B-** Check “Yes” and check box that states “Needs Assistance with Self-Administration”.

**Please be sure to sign, date and include the Examiner's information**



11.8.2021