

ARMED FORCES RETIREMENT HOME



Functional Assessment

This assessment is required for all applicants seeking admission to the Armed Forces Retirement Home and must be completed and signed by a licensed Occupational or Physical Therapist. Please answer the following questions based on your professional judgement, observation and functional tests administered during the applicant's visit. Answers are subject to verification for accuracy purposes and all "Yes" answers need to be explained. "Yes" answers may or may not affect your application approval.

Applicant Name: _____
Last Name First Name Middle Initial

Activities of Daily Living (ADL)

1. Requires and/or receives assistance using the phone? (such as: Dialing, receiving, calling 911)

Yes No

If yes, explain: _____

2. Requires and/or receives assistance traveling? (such as: Planning, driving, bus, plane, taxi usage)

Yes No

If yes, explain: _____

3. Requires and/or receives assistance on incline, decline or curbs?

Yes No

If yes, explain: _____

4. Requires and/or receives assistance shopping? (such as: Clothes, hygiene, grooming)

Yes No

If yes, explain: _____

5. Requires and/or receives assistance to recall current events, locations, dates,

Yes No

If yes, explain: _____

6. Requires and/or receives assistance with the preparation and intake of

Yes No

If yes, explain: _____

7. Requires and/or receives assistance with meals: (ie. Feeding, carrying tray,

Yes No

If yes, explain: _____

Specific needs (adaptive equipment): _____

8. Requires and/or receives assistance with maintaining/cleaning living quarters and personal laundry?(such as: Sweeping/vacuuming, making bed, cleaning bathroom, washing garments)

Yes No

If yes, explain: _____

9. Requires and/or receives assistance with personal hygiene? (such as: Bathing, grooming,

Yes No

If yes, explain: _____

Specific needs (grab bar, bath stool, supervision, etc): _____

10. Requires and/or receives therapy services (to address weight, pain, cognition, ADL, wound

Yes No

If yes, explain: _____

11. Requires and/or receives assistance of a mobility device? (such as: Wheelchair, person, cane, walker,

Yes No

If yes, specify type: _____

Applicant name: _____

Last Name

First Name

Middle Initial

12. Requires and/or receives assistance with toileting? (i.e. Transfer, removing/re-applying clothes)

Yes No

If yes, explain: _____

Specific needs (colostomy, ileostomy, catheter, raised seat, grab bar, bed pan, incontinent supplies, _____

13. Requires and/or receives assistance with transfers? (from chair, bed, bath, vehicle, etc.)

Yes No

If yes, explain: _____

Specific needs (mechanical device, grab bars, lift system, etc.) _____

14. Requires and/or receives assistance for daily decision making? (such as: Cues, supervision)

Yes No

If yes, explain: _____

15. The individual currently lives or has lived in the past 6 months? (Check all that apply)

| | | |
|--------------------|--------------------------|--------------|
| Alone | Assisted Living Facility | Apartment |
| With Family Member | Nursing Home | House |
| With Caretaker | Senior Housing | Other: _____ |

16. The individual uses the following mobility devices on a daily basis? (Check all that apply)

| | | |
|--|------------------------------|---|
| Wheelchair (manual) | Raised Toilet Seat | Escort |
| Wheelchair/Scooter/ Battery Powered Vehicle (electric) | Grab Bar | Recliner Chair that lifts one to their feet |
| Cane/ Walker/Crutch | Shower Chair / Bathing Stool | Other: _____ |

17. Furthest distance walked during this session? (can include resting periods)

| | | |
|------------|-------------------|----------------|
| 150+ feet | 51-149 feet | 26-50 feet |
| 10-25 feet | less than 10 feet | Unable to walk |

Explain, if needed: _____

Applicant name: _____
Last Name First Name Middle Initial

18. Walking support used during this demonstration? (Check all that apply)

| | | |
|---------------|--------------------|-----------------------------|
| None | Cane/Walker/Crutch | Oxygen/ breathing equipment |
| Parallel Bars | Prosthesis | 1-2 persons assisting |
| | Seeing-eye Dog | Other: _____ |

Assessment Information

19. Who participated in this assessment? (Check all that apply)

| | | |
|------------|---------------|-------------------|
| Individual | Family Member | Significant Other |
| Caretaker | Friend | Other: _____ |

Your signature indicates that you have assessed this individual and the answers to the questions are accurate based on your professional judgement.

Signature of Occupational/ Physical Therapist (sign on above line)

Print Name

License Number/State

Date Assessment Completed

Telephone Number: _____

Email Address: _____

Return to:

Armed Forces Retirement Home
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