Take this form to OT / PT Therapist

4 - FA

FUNCTIONAL ASSESSMENT

Dear Applicant:

All prospective residents must be able to live independently upon acceptance into the retirement home. The Functional Assessment evaluates the candidate's Activities of Daily Living (ADL's). The attached assessment must be completed by a LICENSED OCCUPATIONAL THERAPIST (OT) or a PHYSICAL THERAPIST (PT) not a physician, nurse, corpsman or other health care professional. If you have questions regarding this assessment, please contact the Public Affairs Office.

Thank you

AFRH

RETURN ASSESSMENT TO:

ARMED FORCES RETIREMENT HOME
PUBLIC AFFAIRS OFFICE #584
3700 NORTH CAPITOL ST, NW
Washington, DC 20011-8400
Fax Number: (202) 541-7519
Telephone: (800) 422-9988 opt. 1

If FAXING documents to AFRH, please make a black & white copy before sending the fax so that it will be legible when it arrives. Please call and let us know to look for the documents to come through as well – Thank you for your help! We want to prevent any delays in processing applications.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C 136, Under Secretary of Personnel and Readiness; 24 U.S.C. 401, Armed Forces Retirement Home; DoD Directive 5124.09 Assistant Secretary of Defense for Personnel and Readiness Force Management; DoD Instruction 1000.28, Armed Forces Retirement Home (AFRH); and E.O. 9397 (SSN), as amended.

PURPOSE: To determine and verify eligibility for admission to the AFRH.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, the records contained herein may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: To the Federal Reserve for processing the debt on the resident account; To authorized contractors or vendors for the purpose of providing medical services to the residents of the Armed Forces Retirement Home; To any Federal agency which provides medical services to residents of the Armed Forces Retirement home; To the Inspector General of the Department of Defense or his/her designee, for conducting inspections of AFRH records; To a Federal agency, or an organization or person contracting with the AFRH for information needed in the performance of official duties related to reconciling or reconstructing data files, compiling descriptive statistics, and/or making analytical or financial studies to support the function for which the records were collected and maintained; Law Enforcement Routine Use; Congressional Inquiries Disclosure Routine Use; Disclosure of Information to the National Archives and Records Administration Routine Use; Disclosure to the Merit Systems Protection Board Routine Use; and Data Breach Remediation Purposes Routine Use.

The applicable system of records notice is DPR 38 DoD, Armed Forces Retirement Home electronic Resident Information System (eRIS) and is available at: (ADD LINK WHEN PUBLISHED).

DISCLOSURE: Voluntary; however, failure to provide the required information may result in the delay or denial of admission.

ARMED FORCES RETIREMENT HOME

Functional Assessment

Form Completed by a Licensed Occupational or Physical Therapist

4 - FA

Last Name _____ First Name _____ MI _____ Birthdate _____

Street Address _____ City _____ State _____ Zip Code _____

This assessment is required for all applicants seeking admission to the Armed Forces Retirement Home and must be completed and signed **ONLY by a licensed occupational or physical therapist: NOT by a doctor, nurse, or other healthcare practitioner, or the resident candidate**. Please answer the following questions based on your professional judgment, observation and functional tests administered during the applicant's visit and initial each page of the assessment. Answers are subject for verification for accuracy purposes and all "Yes" answers need to be explained. "Yes" answers may or may not affect you application approval.

The following responses are to be completed by a LICENSED PHYSICAL THERAPIST or OCCUPATIONAL THERAPIST only. Provider please give a full explanation of ANY positive response to the following:

1. Requires and/or receives assistance using the telephone? (Such as: dialing, receiving, calling 911) _____ _____ _____ _____	○ Yes ○ No
2. Requires and/or receives assistance with transportation? (such as: planning, driving, bus, plane, taxi usage) _____ _____ _____ _____	○ Yes ○ No
3. Requires and/or receives assistance on incline, decline, or curbs? _____ _____ _____ _____	○ Yes ○ No
4. Requires and/or receives assistance shopping? (Such as: clothes, hygiene, grooming products) _____ _____ _____ _____	○ Yes ○ No
5. Requires and/or receives assistance to recall current events, locations, dates, or names? _____ _____ _____ _____	○ Yes ○ No

Last Name _____ First Name _____ MI _____ Birthdate _____

Street Address _____ City _____ State _____ Zip Code _____

○Yes ○ No	6. Requires and/or receives assistance with meals? (i.e. feeding, carrying tray, diet management)
○Yes ○ No	7. 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	8. Requires and/or receives assistance with personal hygiene? (Such as: bathing, grooming, dressing) Please indicate specific needs such as a grab bar, bath stool, supervision, or otherwise.
○Yes ○ No	9. Requires and/or receives therapy services? (to address weight, pain, cognition, ADL, wound care)
○Yes ○ No	10. Requires and/or receives assistance of a mobility device? (Such as: wheelchair, person, cane, walker, etc.)

Last Name _____ First Name _____ MI _____ Birthdate _____

Street Address _____ City _____ State _____ Zip Code _____

11. Requires and/or receives assistance with toileting? (i.e. transfer, removing/reapplying clothes) If so, describe any specific requirements or equipment necessary (colostomy, ileostomy, catheter, raised toilet seat, grab bar, bed pan, incontinent supplies, etc.)

_____

_____

_____

_____

○ **Yes** ○ **No**

12. Requires and/or receives assistance with **transfers**? (From chair, bed, bath, vehicle, etc.)

_____

_____

_____

_____

○ **Yes** ○ **No**

13. Requires and/or receives assistance for daily decision making? (Such as: cues, supervision) If so, describe cognitive abilities and limitations.

_____

_____

_____

_____

○ **Yes** ○ **No**

14. Does the individual have difficulty walking distances over 50 feet (with or without resting periods)?

Please indicated the Furthest Distance walked during this session: (Select One)

☐ Over 150 Feet ☐ 26-50 Feet ☐ Less than 10 Feet

☐ 51-149 Feet ☐ 10-25 Feet ☐ Unable to Walk

○ **Yes** ○ **No**

15. Was there any walking support used during this demonstration: (If so, select all that apply)

☐ Cane / Walker / Crutches ☐ Parallel Bars ☐ Oxygen / Breathing Equipment

☐ Prosthesis ☐ Seeing Eye Dog ☐ 1-2 persons assisting

☐ Leaning on something in area ☐ Other: _____

○ **Yes** ○ **No**

16. Requires and/or uses mobility devices on a regular basis: (select all that apply)

☐ Wheelchair (manual) ☐ Raised Toilet Seat ☐ Escort

☐ Powered Wheelchair / Scooter ☐ Shower chair / Bathing Stool ☐ Grab Bars

☐ Cane / Walker / Crutches ☐ Powered Recliner / Lifting Chair ☐ Other: _____

○ **Yes** ○ **No**

Functional Assessment

Form Completed by a Licensed Occupational or Physical Therapist

4 - FA

Last Name _____ First Name _____ MI _____ Birthdate _____

Street Address _____ City _____ State _____ Zip Code _____

○ Yes ○ No	17. Requires assistance and/or experiences falls when transferring from mobility device to toilet, bed, bath, etc.? _____ _____ _____
○ Yes ○ No	18. Requires and/or currently lives in a situation where some assistance is provided (within past 6 months)? Select the living situation/s which best describes the individual's recent accommodations: **Independent Living Situations:** ☐ Homeowner (House, Condo, etc.) ☐ Renting or Leasing (Apartment, etc.) ☐ Independent Senior (over 50) Living Community ☐ Independent – Traveling, RV, or Nomadic Lifestyle ☐ Other: _____ **Living Situations with some assistance given:** ☐ At Home, with some aid from Family or Caretaker ☐ Receiving Home Health Care in Home/Apartment ☐ Assisted Living Facility ☐ Nursing Home ☐ Other: _____
○ Yes ○ No	19. Does this person currently with a family member or somebody else? If so, with whom (response is optional)? ☐ Lives Alone ☐ Lives with Family or Spouse ☐ Lives with a roommate or friend Name: _____ Relationship: _____
	20. Who participated in this assessment? ☐ Applicant ☐ Family Member ☐ Significant Other / Spouse ☐ Caretaker ☐ Friend ☐ Other: _____

Your signature below indicates that you have assessed this individual and the answers to the questions are accurate based on your professional judgement as a LICENSED OCCUPATIONAL OR PHYSICAL THERAPIST

Please Print (Stamp is acceptable)	
Therapist Name	
Title:	
Street Address	
City, ST ZIP	
Phone Number	
Fax Number	

Signature and License Number Required

Signature Date

☐ Occupational Therapist ☐ Physical Therapist

License Number State

END