THE TERRACES AT SKYLINE

ASSESSMENT RESULTS

Resident's Name: _____

Currently Living at: _____

LEVEL OF CARE NEEDED:

_____ **Assisted Living** _____ **Catered Assisted Living**

_____ **Memory Support** _____ **Skilled Nursing**

TOTAL CARE FEE POINTS @ $48 per point:_____

Check & Specify Personal Assistive or Medical Devices Needed:

_____**Wheelchair/Size or Consideration**_____

_____**Hospital Bed/Special Bedding** _____

_____**Grab Bars/Location Needed**_____

_____**Overhead Trapeze/Location**_____

_____**Side Bed Pole or Location**_____

_____**Raised Toilet or Any other Needs:**_____

Staff completing assessment: _____

_____ **Date of assessment**

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