FUNCTIONAL CAPABILITY ASSESSMENT

Licensees of Adult Residential and Social Rehabilitation Facilities must obtain the following information prior to placement. The Licensee can obtain this assessment from the applicant or his/her authorized representative. Adult Day Care Facilities and Adult Day Support Centers may use this from to identify the functional ability of the applicant as required. The Licensee must maintain this information in the client's file as a part of the Needs and Services Plan.

Note: Residential Care Facilities for the Elderly may use this form to assess the person's functional capabilities as required in Section 87584 of the regulations.

CLIENT'S NAME	DATE OF BIRTH	AGE	SEX ☐ MALE ☐ FEMALE

Check the box that most appropriately describes clients ability:

BATHING
- ☐ **Does not bathe or shower self.**
- ☐ **Needs help with bathing and showering.**
- ☐ **Bathes or showers without help.**

DRESSING:
- ☐ **Does not dress self.**
- ☐ **Needs help with dressing.**
- ☐ **Dresses self completely.**

TOILETING:
- ☐ **Not toilet trained.**
- ☐ **Needs help toileting.**
- ☐ **Uses toilet by self.**

TRANSFERRING:
- ☐ **Unable to move in and out of a bed or chair.**
- ☐ **Needs help to transfer.**
- ☐ **Is able to move in and out of a bed or chair.**

CONTINENCE:
- ☐ **No bowel and/or bladder control.**
- ☐ **Some bowel and/or bladder control.**
- ☐ **Use of assistive devices, such as a catheter.**
- ☐ **Complete bowel and/or bladder control.**

EATING:
- ☐ **Does not feed self.**
- ☐ **Feeds self with help from another person.**
- ☐ **Feeds self completely.**

GROOMING:
- ☐ **Does not tend to own personal hygiene.**
- ☐ **Needs help with personal hygiene tasks.**
- ☐ **Handles own personal hygiene.**

Check the box that most appropriately describes clients ability:

REPOSITIONING
- ☐ **Unable to reposition.**
- ☐ **Repositions from side to side.**
- ☐ **Repositions from front to back and back to front**

WHEELCHAIR:
- ☐ **Unable to sit without support.**
- ☐ **Sits without support.**
- ☐ **Uses wheelchair.**
- ☐ **Needs help moving wheelchair.**
- ☐ **Moves wheelchair by self.**

VISION:
- ☐ **Severe vision problem.**
- ☐ **Mild/moderate vision problem.**
- ☐ **Wears glasses to correct vision problem.**
- ☐ **No vision problem.**

HEARING:
- ☐ **Sever hearing loss.**
- ☐ **Mild/moderate hearing loss.**
- ☐ **Wears hearing aid(s).**
- ☐ **No hearing loss.**

COMMUNICATION:
- ☐ **Does not express verbally.**
- ☐ **Expresses by facial expressions or gestures.**
- ☐ **Expresses by sounds or movements.**
- ☐ **Expresses self verbally.**

WALKING:
- ☐ **Does not walk.**
- ☐ **Walks with support.**
- ☐ **Uses walker.**
- ☐ **Walks well alone.**

(over)

Describe client's medical history and/or conditions:

List prescription medicine:	List non-prescription medicine:

Describe mental and/or emotional status:

Able to follow instructions? ☐ YES ☐ NO	Confused/disoriented? ☐ YES ☐ NO
Participates in social activities? ☐ YES ☐ NO	☐ Active ☐ Withdrawn

Is there a history of behaviors resulting in harm to self or others that require supervision? ☐ YES ☐ NO
If YES, provide date _____ and describe last occurrence:

Does he/she have ability to manage own finances and cash resources?	☐ YES ☐ NO
Is there any additional information that would assist the facility in determining client's Suitability for admission? If YES, describe:	☐ YES ☐ NO

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE	DATE COMPLETED
SIGNATURE OF LICENSEE OR FACILITY REPRESENTATIVE	DATE COMPLETED