New York State
DEPARTMENT OF HEALTH **DSS 4568** (6/97 Rev. 4/14)

## ASSISTED LIVING PROGRAM MEDICAL EVALUATION – INTERIM

**INSTRUCTIONS**: This evaluation must be conducted and completed no less frequently than once every 6 months. If additional space is needed, please use the reverse side. ☐ **6 Month Reassessment**

**Resident Name:**_____ **DOB:**_____

**Address:**_____

**********TO BE COMPLETED BY CHHA, LTHHCP OR LHCSA R.N.**********

1. Describe changes in resident's health or functional status since the last medical evaluation:

2. List current medications (attached medication lists must also be initialed and dated by the resident's physician):

3. Does resident receive skilled services from CHHA or LTHHCP? ☐ Yes ☐ No
   If yes, specify:

Signature/title:_____ Date:_____

**********TO BE COMPLETED BY PHYSICIAN**********

1. Changes in resident's diagnosis, health, mental health, diet, allergies, functional or behavioral status, need for assistance and related information since last evaluation.

2. Changes to medication regimen and orders for skilled services; if none, check here ☐

I have examined this resident and this evaluation accurately describes the resident's medical condition, needs and regimens, including any medication regimen. The resident's condition is stable and the individual is medically appropriate to be cared for in an ALP. I certify that I have reviewed and agree with the UAS-NY Assessment dated _____ (if applicable) and that the uniform assessment and the information provided on this form accurately describes the individual's medical and mental health conditions, needs, and regimens, including any medication regimens.

Date of today's examination:_____ Recommended frequency of medical exams:_____

Signature/title:_____ Date:_____
Nurse Practitioner, Physician's or Specialist's Assistant

Signature/title:_____ Date:_____
Physician (required)