

GOLDEN HEART SENIOR PLACEMENT

Client Needs Assessment



◆ **NV REQUIRED** by Nevada statute (citation shown) ◇ **NV VERIFY** Nevada-specific; confirm current rules Unmarked = professional best practice

1 • CLIENT & DECISION-MAKER

Client name _____ DOB _____ Age _____ Phone _____

Current address _____ City / ZIP _____

Representative / primary contact _____ Relationship _____ Phone / email _____

Who may consent: ☐ Client ☐ Health-care POA ☐ Financial POA ☐ Guardian Advance directive / POLST: ☐ Yes ☐ No ◆ **NRS 449.114(1)(b)**

2 • CURRENT LIVING SITUATION

☐ Own home / apt ☐ Lives alone ☐ With family

☐ Hospital ☐ Rehab / SNF ☐ Assisted living ☐ Other

Discharge / target move date _____

Timeline: ☐ <7 days ☐ ≤30 days ☐ 1–3 mo ☐ Exploring

Falls, last 6 mo # _____ ER / hospital visits # _____

Reason for move _____

3 • LEVEL OF CARE SOUGHT – Select All that Apply

☐ Independent living ☐ Assisted living ☐ Memory care

☐ Skilled nursing ☐ Residential Group Home ☐ Other

◆ **NRS 449.1145(1)(c)–(d)** Refer only to communities that hold any required license and can adequately care for this client.

◇ **NAC 449** Confirm the community's license type and endorsements (e.g., Alzheimer's/dementia) before referring.

5 • MOBILITY & SAFETY

☐ Independent ☐ Cane ☐ Walker ☐ Wheelchair ☐ Bed-bound

Transfers: ☐ Self ☐ 1-person ☐ 2-person ☐ Mech. lift

Can exit unassisted in an emergency? ☐ Yes ☐ No

☐ Hearing aid ☐ Low vision ☐ Night-time care needed

4 • DAILY LIVING SUPPORT (ADL / IADL)

Activity	Indep.	Cue / standby	Hands-on	Total
ACTIVITIES OF DAILY LIVING				
Bathing				
Dressing				
Grooming / hygiene				
Toileting				
Continence (bladder / bowel)				
Eating				
INSTRUMENTAL ACTIVITIES				
Medication management				
Meals / cooking				
Housekeeping / laundry				
Transportation				
Phone / bills				

6 • MEDICAL & COGNITIVE

Primary diagnoses _____

Physician _____ Phone _____

Cognition: ☐ Intact ☐ Mild ☐ Moderate ☐ Severe

☐ Dementia dx ☐ Wandering ☐ Behaviors ☐ Mental-health dx

Meds _____ ☐ Insulin ☐ Other injections ☐ Oxygen

☐ Catheter / ostomy ☐ Wound care ☐ Tube feeding ☐ Dialysis

☐ Hospice ☐ Other skilled need

This is a referral from an Authorized Professional or Hospital:
☐ Yes ☐ No

7 • NEVADA REFERRAL DISCLOSURE & CONSENT — COMPLETE BEFORE ANY REFERRAL ◆ NV REQUIRED

☐ Disclosure statement given: our services, contact info & phone, privacy-policy web address, client's opt-out rights and referral limits, and who pays the referral fee (and amount, if the client pays). Method: ☐ Written ☐ Electronic ☐ Oral — recorded ◆ **NRS 449.114(1)(a)**

☐ Written or recorded consent to receive referrals obtained; disclosure and consent kept at least 3 years ◆ **NRS 449.114(1)(b), (2)**

☐ Told client may stop contact or referrals anytime (we stop within 10 days) and may tell us not to sell personal info ◆ **NRS 449.1145(2)(c)–(e)**

Agency, executive, or family ownership / management interest in a referred community: ☐ None ☐ Yes — written permission first ◆ **449.1145(1)(a), (3)**

☐ Client authorizes sharing this assessment with prospective communities

Professional Signature _____ Professional Accreditation _____

Date _____