**\*\*Confidential\*\***

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**CIRCLE OF LIFE ALZHEIMER'S HOMES, L.L.C.**

**Susan E. Wielechowski, Director**

**5620 West Corliss Circle Prescott, AZ, 88305**

[**(928) 237 4795 susan@circleoflifecare.com**](mailto:susan@circleoflifecare.com) [**www.circleoflifecare.com**](http://www.circleoflifecare.com/)

Resident’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESIDENT’S SERVICE PLAN**

(Circle of Life Alzheimer's Homes, L.L.C. hereinafter referred to as "COLAH, L.L.C.")

**Date of Plan Preparation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Resident Involved\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Brief description of their medical history/emotional, behavioral and physical issues, functional limitations, functional capabilities, ability to handle cash resources and perform simple homemaking tasks, likes and dislikes, etc.**

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**Plan Details by Element**

**Socialization Plan Element**

**Initial or Update?\_\_\_\_\_\_\_\_\_\_\_\_**

**Socialization Plan Detailed Description**

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**Time Frame**

**From\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To\_\_\_\_\_\_\_\_\_\_\_\_**

**Team Member Responsible for Socialization Plan Implementation**

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**Methodology to Evaluate Plan’s Success\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Date for Re-evaluation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emotional Plan Element**

**Initial or Update?\_\_\_\_\_\_\_\_\_\_\_\_**

**Emotional Plan Detailed Description**

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**Time Frame**

**From\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To\_\_\_\_\_\_\_\_\_\_\_\_**

**Team Member Responsible for Emotional Plan Implementation**

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**Methodology to Evaluate Plan’s Success\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Date for Re-evaluation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mental Plan Element**

**Initial or Update?\_\_\_\_\_\_\_\_\_\_\_\_**

**Mental Plan Detailed Description**

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**Time Frame**

**From\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To\_\_\_\_\_\_\_\_\_\_\_\_**

**Team Member Responsible for Mental Plan Implementation**

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**Methodology to Evaluate Plan’s Success\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Date for Re-evaluation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physical/Health Plan Element**

**Initial or Update?\_\_\_\_\_\_\_\_\_\_\_\_**

**Physical/Health Detailed Description**

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**Time Frame**

**From\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To\_\_\_\_\_\_\_\_\_\_\_\_**

**Team Member Responsible for Physical/Health Plan Implementation**

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**Methodology to Evaluate Plan’s Success\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Date for Re-evaluation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Functional Plan Element**

**Initial or Update?\_\_\_\_\_\_\_\_\_\_\_\_**

**Functional Plan Detailed Description**

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**Time Frame**

**From\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To\_\_\_\_\_\_\_\_\_\_\_\_**

**Team Member Responsible for Functional Plan Implementation**

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**Methodology to Evaluate Plan’s Success\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Date for Re-evaluation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ATTESTATIONS**

**Signature of Report Preparer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**