

## SUGGESTED NEEDS ASSESSMENT FOR RESIDENTS OF LTC FACILITIES

1. What caused your move to a nursing home?
2. Who made the decision for your move to a facility?
3. Did you use long-term care services prior to moving to the nursing home?

Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered "Yes", which services did you use?

Case management	_____	Adult Day Health Care	_____
In-Home Supportive Svcs	_____	Adult Day Care	_____
Transportation	_____	Home-delivered meals	_____
Housekeeping Services	_____	Other	_____

Were you satisfied with the quality of services you received?  
If no, why not?

Did the services meet your needs?  
If no, why not?

Did you know about the long-term care services in your community?  
Could you afford the services you needed?

4. Do you have long-term care insurance?  
If yes, did it pay for the services that you thought it would?
5. Do you belong to a Health Maintenance Organization (HMO)?  
Are you getting the services you thought you would?
6. Has a doctor visited you since your move to this facility?  
If yes, how often?
7. Do you have family and friends in the area that visits you?  
If yes, how often?
8. Does your facility have a resident council?  
If yes, do you attend the meetings?

If not, why not?

9. Does your facility have a family council?  
If yes, do members of your family attend?
10. Please rate your quality of life (1 - lowest; 10 - highest)

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1    2    3    4    5    6    7    8    9    10