[ASSISTED LIVING NAME HERE]
[Street Address, City, State, ZIP]
Phone: 123-456-7890 Fax: 123-456-7890 Email: Info@email.com

DETERMINATION AND AUTHORIZATION FOR CONTINUED RESIDENCY

Physician, behavioral health professional or medical practitioner

_____

(Resident Name)

Dear primary care provider: _____

[Physician, behavioral health professional, or other medical practitioner's Name]

The Arizona Department of Health Services requires that the primary care provider or other medical practitioner written authorization to authorize the above named patient to reside or continue to reside in the Assisted Living Facility.

An Assisted Living Facility SHALL NOT ACCEPT OR RETAIN a resident who:

A: Is confined to a bed or chair because of an inability to ambulate even with assistance or
B: Has a stage 3 or stage 4 pressure sore, as determined by a registered nurse or medical practitioner or
C: Requires or receives behavior care/health service or
D: Requires Memory care services.

UNLESS APPROVED BELOW:

Please examine the resident and give us, the Assisted Living Facility, your consent and authorization for continuing residency for this resident. This authorization is required at the onset of the above circled condition or within 30 calendar days before acceptance and at least once every six months throughout the duration of the resident's condition, that the facility can meet the resident's needs within the scope of services of the facility.

I am also aware that I must examine this resident every six months and document my authorization as to the continuing residency of my patient at this facility.

This authorization is valid for the next six months from the date signed.

I have also reviewed the assisted living facility's scope of services and the resident's needs can be met by the assisted living facility within the assisted living facility's scope of services and for retention of a resident.

_____

[Physician, behavioral health professional, or other medical practitioner's Name] [Date]