Washington State Department of Social & Health Services
Transforming lives

Assisted Living Facility (ALF) Dementia Screening Tool

Name of individual: _____

The individual named on this form has been assessed and found to exhibit:

1. Evidence of short-term memory loss: ☐ Yes ☐ No
   (If there is no evidence of short-term memory loss, the assessor may go to **4.b**, and skip 2 and 3.)

And

2. **One** or more of the following conditions: (Check all that apply.)
   - ☐ Is not oriented to place or time.
   - ☐ Has limited ability to make him or herself understood through speech, writing, sign language or any other method the individual uses to communicate.
   - ☐ Requires hands-on assistance with eating or drinking.

   (If there is no evidence of one of these conditions, the assessor may go to **4.b**, and skip 3.)

And

3. ☐ One or more of the following behaviors or symptoms which has been exhibited by the individual within the last thirty days: (Check all that apply.)
   - ☐ Ability to make decisions about daily life is poor; requires reminders, cues and supervision in planning daily routines
   - ☐ History of physical injury to staff / others
   - ☐ Combative
   - ☐ Resistive to care
   - ☐ Sexual acting out (does not victimize others)
   - ☐ Seeks vulnerable or unwilling sexual partners
   - ☐ Agitated or wanders at night
   - ☐ Eats non-edible things
   - ☐ Inappropriate screaming, yelling or verbal noises
   - ☐ Has left home and gotten lost when trying to return
   - ☐ Repetitive physical movement / pacing, hand-wringing, fidgeting
   - ☐ Leaves stove on after cooking
   - ☐ Aggressive / intimidating
   - ☐ Exit seeking behaviors
   - ☐ Easily irritated / upset / agitated
   - ☐ Seeks / demands constant attention / reassurance
   - ☐ Pattern of inability to control own behaviors
     Specify: _____
   - ☐ Unrealistic fears or suspicions
   - ☐ Inappropriate toileting activity
     Specify: _____

   (If there is no evidence of one of these conditions, the assessor may go to **4.b**)

4.a ☐ The individual named on this form has identified characteristics of dementia in categories 1, 2, and 3 above. Therefore:

(1) The staff of any assisted living facility in which the named individual resides must meet the dementia specialty training requirements specified in Washington Administrative Code 388-112A, and

(2) The assisted living facility must obtain the assessment information for the individual as specified in WAC 388-78A-2370.

4.b ☐ This individual does not meet the screening criteria for dementia identified on this form.

_____ _____
QUALIFIED ASSESSOR SIGNATURE DATE