ICF Admission Application

Requested Start Date: Click or tap to enter a date.

Requested Preference of Location: Click or tap here to enter text.

Name:Click or tap here to enter text.

Age:Click or tap here to enter text. DOB: Click or tap to enter a date.

Sex: M☐ F☐ Other:Click or tap here to enter text. Race:Click or tap here to enter text. Prefer not to answer☐

DD/ID Diagnosis: Mild ☐ Moderate ☐ Severe ☐ Profound ☐

Dx Verification Completed: Yes ☐ No ☐

Adopted: Yes ☐ No ☐ If yes: Year:Click or tap here to enter text.County/State:Click or tap here to enter text.

Medicaid: Click or tap here to enter text. Medicare: Click or tap here to enter text. SS#: Click or tap here to enter text. Other Insurance: Click or tap here to enter text. Burial Plan: Yes ☐ No ☐

Current Residence: Provider: Click or tap here to enter text. Address: Click or tap here to enter text.

Contact Name: Click or tap here to enter text. Phone: Click or tap here to enter text. Email: Click or tap here to enter text. Reason for leaving: Click or tap here to enter text.

Guardian Contact info: Name: Click or tap here to enter text. Phone: Click or tap here to enter text. EmailClick or tap here to enter text. Address: Click or tap here to enter text.

Other Emergency Contact info: Name: Click or tap here to enter text. Phone: Click or tap here to enter text. EmailClick or tap here to enter text. Address: Click or tap here to enter text.

SSA: Name: Click or tap here to enter text. County: Click or tap here to enter text.Phone: Click or tap here to enter text. EmailClick or tap here to enter text.

Currently Receiving Waiver Services: Yes ☐ No ☐

Level 1 Waiver ☐ IO Waiver ☐ Other☐ :Click or tap here to enter text.

Medical Information:

Current Height: Click or tap here to enter text. Current Weight: Click or tap here to enter text.

Current Medications: (attach list of medications)Click or tap here to enter text.

Current Dx: Click or tap here to enter text.

How do they complete medication administration? Independent ☐ Verbal prompts☐ Total assist☐

Medication Route (check all the apply) – Oral☐ Topical ☐ Injection ☐ Gastronomy ☐

Has the individual had any of the following (if currently has please add *):
Pleurisy ☐ Diabetes☐ Diphtheria☐ Malaria☐ Venereal Disease☐ Meningitis☐ Pneumonia☐
Typhoid Fever☐ Scarlet Fever☐ Rheumatic Fever☐ Chicken Pox☐ Shingles☐ Hepatis B☐ Broken Bones ☐ Covid☐ Sexually Transmitted Diseases: ☐ Small Pox:☐

Immunization Records (include dates):

DPTClick or tap to enter a date. PolioClick or tap to enter a date. FluClick or tap to enter a date.PneumoniaClick or tap to enter a date.SmallpoxClick or tap to enter a date.Tetanus: Click or tap to enter a date.MMRClick or tap to enter a date.
Chicken PoxClick or tap to enter a date.Hep BClick or tap to enter a date.TB testClick or tap to enter a date.
Covid-19 vaccine 1Click or tap to enter a date.Covid 2Click or tap to enter a date.BoosterClick or tap to enter a date.

Advanced Directives: DNR Yes ☐ No ☐ DNRCC: Yes ☐ No ☐ If yes, attach documentation

Seizure D/O: Yes ☐ No ☐ Details: (frequency/duration/PRN): Click or tap here to enter text.

Vagus nerve stimulator: Yes ☐ No ☐

Tracheostomy: Yes ☐ No ☐

Ileostomy/ Colostomy: Yes ☐ No ☐

PICC line/IV: Yes ☐ No ☐

Skin issues: Click or tap here to enter text.

Dialysis: Yes ☐ No ☐

Diabetic: Yes ☐ No ☐ How is the Diabetes treated?

Diet/exercise only Yes ☐ No ☐ Finger stick? Yes ☐ No ☐ Oral medications Yes ☐ No ☐ Finger stick Yes ☐ No ☐ Injection Yes ☐ No ☐ sliding scale Yes ☐ No ☐

Allergies Yes ☐ No ☐ Details: Click or tap here to enter text.

O2, CPAP, aerosol treatment, breathing issues? Yes ☐ No ☐ Details: Click or tap here to enter text.

Ambulation method: Click or tap here to enter text.

Fall Risk: Yes ☐ No ☐ Details: Click or tap here to enter text.

Diet type: NPO☐ Pleasure Feed only ☐ Oral☐ Tube Feed☐ Type:Click or tap here to enter text.

Diet Texture: Regular ☐ Chopped☐ Chopped/ Ground Meat ☐ Ground☐ Puree ☐

ADA☐ NAS☐ Gluten Free☐ Other:Click or tap here to enter text.

Beverage Thickness: Regular thin☐ Nectar☐ Honey☐ Puree☐

Choking risk Yes ☐ No ☐ Details: Click or tap here to enter text.

Feeding Assistance Needed: independent ☐ Verbal/Physical Assistance☐ Total Feed☐

Adaptive equipment: Click or tap here to enter text.

Toileting Assistance Needed: Independent ☐ Verbal/Physical Assistance☐ Total Assist☐

Continent of Bowel/ Bladder Yes ☐ No ☐ Details: Click or tap here to enter text.

Catheter Yes ☐ No ☐

Depends/Pull ups use: Yes ☐ No ☐ Size and Schedule: Click or tap here to enter text.

Residential History

Residence: Provider: Click or tap here to enter text. Address: Click or tap here to enter text.

Contact Name: Click or tap here to enter text. Phone: Click or tap here to enter text. Email: Click or tap here to enter text. Reason for leaving: Click or tap here to enter text.
Dates: From: Click or tap to enter a date. To: Click or tap to enter a date.

Residence: Provider: Click or tap here to enter text. Address: Click or tap here to enter text.
Contact Name: Click or tap here to enter text. Phone: Click or tap here to enter text. Email: Click or tap here to enter text. Reason for leaving: Click or tap here to enter text.
Dates: From: Click or tap to enter a date. To: Click or tap to enter a date.

Education: List schools currently attending or attended (include district or city). List dates and indicate if regular or special classes. List the current or most previously attended school first.

1.Click or tap here to enter text.

2. Click or tap here to enter text.

Employment and/or Day Programming: List all work experience. Include dates and whether sheltered or competitive. List the current employer first and provide the name and phone number of someone to contact. Any whether they receive Day Hab or Voc Hab Services.

1. Click or tap here to enter text.

2. Click or tap here to enter text.

Acuity/AAI Score: **A** ☐ **A1** ☐ **B** ☐ **C**☐

OOD involvement: Click or tap here to enter text.

Rights Restrictions:

Manual Restriction: Yes ☐ No ☐ Details: Click or tap here to enter text.

Mechanical Restriction: Yes ☐ No ☐ Details: Click or tap here to enter text.

Chemical: Yes ☐ No ☐ Details: Click or tap here to enter text.

Other Restrictions: Yes ☐ No ☐ Details: Click or tap here to enter text.

Supervision level needed during:

Eating:	Independent☐	Auditory ☐	Visual ☐	Total ☐	1:1 ☐
Personal hygiene:	Independent☐	Auditory ☐	Visual ☐	Total ☐	1:1 ☐
Community:	Independent☐	Auditory ☐	Visual ☐	Total ☐	1:1 ☐
At home in bedroom:	Independent☐	Auditory ☐	Visual ☐	Total ☐	1:1 ☐
At home in common area:	Independent☐	Auditory ☐	Visual ☐	Total ☐	1:1 ☐

Communication: Verbal☐ Sign Language☐ Written ☐ Vocalizations ☐ Non-Verbal☐

Behavioral Concerns:

Elopement☐ Sexually issues ☐ Cannot be in a co-ed home☐ Physical aggression☐

Self-Injurious☐ Verbal Aggression☐ Property destruction☐ Other:Click or tap here to enter text.

Give Detail: (include frequency and duration of incidents) Click or tap here to enter text.

Does the applicant use any of the following?

Drugs/Freq: Click or tap here to enter text. Alcohol /Freq: Click or tap here to enter text. Smoking/Freq: Click or tap here to enter text. Any Issues with opposite sex: Click or tap here to enter text.

Does the applicant have PRN medication given for behavioral concerns: Yes ☐ No☐

Police and/or court contact; include dates and brief descriptions of each contact: Click or tap here to enter text.

List any current or pending criminal and/or court hearings/judgements Click or tap here to enter text.

Sleeping needs:Click or tap here to enter text.

Transportation Needs: Click or tap here to enter text.

Hobbies/Special Interests/Favorite Activities: Click or tap here to enter text.

Any safety concerns or issues (current or past history): Please describe**:** Click or tap here to enter text.

Other Pertinent information: Click or tap here to enter text.

Person completing application: Name: Click or tap here to enter text. Title/Relationship: Click or tap here to enter text. Phone: Click or tap here to enter text. EmailClick or tap here to enter text. Address: Click or tap here to enter text.

I understand that the information provided in this document will be used by Gateways to Better Living, Inc. to evaluate whether the referred individual is appropriate for placement into the agency. I understand that Gateways may offer technical assistance and consultation to the referring entity prior to any admission. Any admission to Gateways is considered a temporary placement and subject to receiving all available information as requested.

Please attach the following documents to this application:

- ☐ The most recent psychological evaluation or update
- ☐ Immunization records (TB, Rubella, Polio, Tetanus, Hep B, Pertussis, Diphtheria, Influenza, Pneumonia ALSO COVID-19 VACCINATION STATUS)
- ☐ Copy of current plan, if applicable
- ☐ Copy of restrictive measures
- ☐ Any pertinent medical records including current medications, most recent physical exam, and psychiatric diagnosis
- ☐ Copy of OEDI
- ☐ Copy of FED
- ☐ Diagnosis Verification
- ☐ Behavioral Data last 6months
- ☐ Previous Level of Care, if applicable
- ☐ Release of Authorization for specific medical or other information

Once approved for admission but prior to admission date:

- ☐ Copy of guardianship papers, if applicable prior to admission
- ☐ Copy of Medicaid card prior to admission as long as number is on application
- ☐ Copy of Social Security card prior to admission as long as number is on application
- ☐ Copy of birth certificate prior to admission as long as info is on application
- ☐ Copy of Life Insurance Policy, if applicable
- ☐ Copy of Burial Contract, if applicable

Who should we notify if about admission committee decision? (GTBL will review within 30 days of receipt)
Name: Click or tap here to enter text. Address: Click or tap here to enter text. Phone: Click or tap here to enter text. EmailClick or tap here to enter text.

Please send to: Kristie Rossi krossi@gatewaystbl.com Fax: 330-792-3386 Any questions call: 330-792-2854 ext. 238