ICF Admission Application

Requested Start Date:

Requested Preference of Location:

Name:

Age: DOB:

Sex: M☐ F☐ Other: Race: Prefer not to answer☐

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

Dx Verification Completed: Yes ☐ No ☐

Adopted: Yes ☐ No ☐ If yes: Year: County/State:

Medicaid: Medicare: SS#:

Other Insurance: Burial Plan: Yes ☐ No ☐

Current Residence: Provider: Address:

Contact Name: Phone: Email:

Reason for leaving:

Guardian Contact info: Name: Phone: Email:
Address:

Other Emergency Contact info: Name: Phone:

Email: Address:

SSA: Name: County: Phone:
Email:

Currently Receiving Waiver Service: Yes ☐ No ☐

Level 1 Waiver: ☐ IO Waiver: ☐ Other ☐ :

Medical Information:

Current Height: Current Weight:

Current Medications: (attach list of medications)

Current Dx:

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):

DPT: Polio: Flu: Pneumonia:

Smallpox: Tetanus: MMR:

Chicken Pox: Hep B: TB Test:

Covid-19 vaccine 1: Covid 2: Booster:

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

Seizure D/O: Yes ☐ No ☐ Details: (frequency/duration/PRN):

Vagus nerve stimulator: Yes ☐ No ☐

Tracheostomy: Yes ☐ No ☐

Ileostomy/ Colostomy: Yes ☐ No ☐

PICC line/IV: Yes ☐ No ☐

Skin issues:

Dialysis: Yes ☐ No ☐

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

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

Injection Yes ☐ No ☐ Sliding scale Yes ☐ No ☐

Allergies Yes ☐ No ☐ Details:

O2, CPAP, aerosol treatment, breathing issues? Yes ☐ No ☐ Details:

Ambulation method:

Fall Risk: Yes ☐ No ☐ Details:

Diet type: NPO☐ Pleasure Fed only ☐ Oral☐ Tube Feed☐ Type:

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

ADA☐ NAS☐ Gluten Free☐ Other:

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

Choking risk Yes ☐ No ☐ Details:

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

Adaptive equipment:

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

Continent of Bowel/ Bladder Yes ☐ No ☐ Details:

Catheter Yes ☐ No ☐

Depends/Pull ups use: Yes ☐ No ☐ Size and Schedule:

Residential History

Residence: Provider: Address:

Contact Name: Phone: Email:
Reason for leaving:
Dates: From: To:

Residence: Provider: Address:
Contact Name: Phone: Email:
Reason for leaving:
Dates: From: To:

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.
2.

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.

2.

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

OOD involvement:

Rights Restrictions:

Manual Restriction: Yes ☐ No ☐ Details:

Mechanical Restriction: Yes ☐ No ☐ Details:

Chemical: Yes ☐ No ☐ Details:

Other Restrictions: Yes ☐ No ☐ Details:

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: ☐ Sexual issues: ☐ Cannot be in a co-ed home: ☐ Physical Aggression: ☐
Self-Injurious: ☐ Verbal Aggression: ☐ Property Destruction: ☐ Other:

Give Detail: (include frequency and duration of incidents)

Does the applicant use any of the following?

Drugs/Freq: Alcohol /Freq:

Smoking/Freq: Any Issues with opposite sex:

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:

List any current or pending criminal and/or court hearings/judgments:

Sleeping needs:

Transportation Needs:

Hobbies/Special Interests/Favorite Activities:

Any safety concerns or issues (current or past history): Please describe**:**

Other Pertinent information:

Person completing application: Name: Title/Relationship:

Phone: Email: Address:

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: Address:

Phone: Email:

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