



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: Email:

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