ICF Admission Application

Requested Start Date: _____

Requested Preference of Location: _____

Name: _____ Age: _____ DOB: _____

If under 18 is the guardian willing to agree to a waiver allowing the minor to room with someone above the age of 18?
Yes ☐ No☐

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 Services: 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 Feed 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☐ Sexually 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/judgements _____

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: _____

Email: Elaine Bertolette at: ebertolette@gatewaystbl.com Fax: 330-792-3386 Phone: 330-792-2854 ext. 232