Anne Grady
SERVICES

ICF Admission Checklist

Listed below are the documents that are required to be considered for admission into an ICF residence with Anne Grady. Questions can be directed to Jen Metzger at 419-866-6500 ext. 251 or via email at jmetzger@annegrady.org.

- ☐ Application
- ☐ Admissions Counseling
- ☐ Social Security Card
- ☐ Birth Certificate
- ☐ Guardianship Verification
- ☐ State ID
- ☐ Medicaid Card
- ☐ Medicare Card
- ☐ Individual Service Plan
- ☐ Behavior Support Plans, if applicable
- ☐ Level of Care
- ☐ Diagnosis verification (for level of care)
- ☐ Psychological Evaluation
- ☐ 2-step TB Test or Chest X-Ray
- ☐ Physical Exam
- ☐ Medication list/orders (copy of MARs, if applicable)
- ☐ Immunizations List
- ☐ Specialty notes (i.e. neurologist, endocrinologist, dermatologist, podiatrist, dentist, etc.)

ANNE GRADY SERVICES
1525 EBER ROAD
HOLLAND, OHIO 43528
419-866-6500

ADMISSION APPLICATION

Select service requesting for admission: _____ ICF _____ Respite

Upon return receipt of this application, you will be contacted by a representative to schedule a tour. This process may take up to one hour. Should you have any questions or concerns, please feel free to contact the Anne Grady representative.

I. IDENTIFICATION:

Date of Application:_____

Name:_____ Date of Birth:_____

Address:_____ County of Residence:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Other phone:_____

Race:_____ Religion:_____ Sex:_____ Hair Color:_____

Eye Color:_____ Height:_____ Weight:_____ Language:_____

Identifying marks:_____

II. SUPPORTIVE RELATIONSHIPS:

A. Person/Agency Responsible for Referral:_____

Address:_____ Phone:_____

Email:_____@_____

Reason for Placement:_____

B. Father's name:_____ Phone:_____

Address:_____

Birthdate:_____ Birthplace:_____

Employed by:_____ Phone:_____

Employer address:_____

Email:_____@_____

C. Mother's name:_____ Maiden name: _____

Address:_____ Phone:_____

Birthdate:_____ Birthplace:_____

Employed by:_____ Phone:_____

Employer address:_____

Email:_____@_____

D. Parent's Marital Status: Married Single Widowed Divorced

E. Legally Appointed Guardian:_____

Email:_____@_____

F. Emergency Contacts:

Name:_____ Relationship:_____

Address:_____

Phone:_____ Other phone:_____

Name:_____ Relationship:_____

Address:_____

Phone:_____ Other phone:_____

G. Next of Kin (siblings, grandparents):

Name:_____ Relationship:_____

Address:_____

Phone:_____ Other phone:_____

Name:_____ Relationship:_____

Address:_____

Phone:_____ Other phone:_____

Name:_____ Relationship:_____

Address:_____

Phone:_____ Other phone:_____

III. MEDICAL:

A. Diagnosis/Condition:_____

_____

B. Past Surgeries:_____

_____

C. Medications/Treatments:_____

_____

D. Medical Equipment/Oxygen use:_____

_____

E. Adaptive Equipment: _____

_____

F. Allergies to Medications / Other:_____

_____

G. Physical Limitations:_____

_____

H. Name of Primary Care Physician:_____

Address:_____ Phone:_____

I. Name of Specialist:_____ Specialty:_____

Address:_____ Phone:_____

Name of Specialist:_____ Specialty:_____

Address:_____ Phone:_____

J. Hospital of choice:_____

K. Date of PDD (TB) Test:_____

L. Has the applicant been hospitalized in the past 12 months?_____

IV. FINANCIAL:

_____ SSI - Amount _____ _____ SSA - Amount _____

_____ Waiver - Type:_____ Name of SSA:_____

_____ Other - _____ SSN #:_____

_____ Completed Level of Care - (List Score):_____

Medicaid #:_____ Medicare #:_____

Insurance: _____

V. DEVELOPMENTAL ABILITIES:

Ambulation/Mobility:

_____ walks independently _____ crawls/moves around on floor

_____ walks with assistance _____ uses walker/crutches

_____ sits independently _____ uses wheelchair / moves independently

_____ sits with support in special chair _____ uses wheelchair / needs assistance

_____ assistance with transfers – Explain:_____

_____

_____ assistance with positioning – Explain:_____

_____

Eating:

_____ drinks independently _____ eats with assistance

_____ drinks from cup with assistance _____ needs to be fed

_____ eats independently with utensils _____ chews, eats regular food

_____ eats using fingers/hands _____ drinks from straw

_____ altered food texture – explain:_____

_____ altered fluid consistency – explain:_____

_____ needs special diet – Explain:_____

_____

_____ fed by other than oral means – Explain:_____

_____

Toileting:

_____ uses bathroom independently
_____ indicates need to use bathroom
_____ incontinent - wears Attends
_____ able to use bathroom during day
_____ constipation is a problem
_____ able to use bathroom during night
_____ wipes independently
_____ needs assistance with wiping
_____ uses urinal / bedpan
other:_____

Dressing:

_____ dresses independently
_____ dresses with assistance
_____ needs assistance with fasteners/buttons
_____ needs complete assistance

Personal Hygiene:

_____ bathes/showers independently
_____ brushes teeth independently
_____ shaves independently
_____ needs assistance with bathing/showering
_____ needs assistance with toothbrushing
_____ needs assistance with shaving

Communication:

_____ uses speech to communicate
_____ uses some words/phrases
_____ understands simple phrases
_____ able to notify others when ill
_____ gestures/vocalizes
_____ uses a communication board or device
_____ no effective communication

Sleeping:

_____ sleeps in bed with side rails
_____ sleeps in bed
_____ Other, please explain _____
_____ sleeps through night
_____ does not sleep through night

What supervision level is need in their own home? Please check one for each area:

Kitchen:	_ Visual	_ 5 min. check	_ 10 min. check	_ 15 min. check	_ 30 min. check
Living area:	_ Visual	_ 5 min. check	_ 10 min. check	_ 15 min. check	_ 30 min. check
Bathroom:	_ Visual	_ 5 min. check	_ 10 min. check	_ 15 min. check	_ 30 min. check
Sleeping:	_ Visual	_ 5 min. check	_ 10 min. check	_ 15 min. check	_ 30 min. check

VI. BEHAVIORAL CONCERNS:

Does applicant have any of the following behavioral concerns?

_____ aggression
_____ elopement (leaving the area)
_____ sexual deviance
_____ self-injury
_____ property destruction
_____ other behavioral issues

If you marked any of the above, please explain applicant's behavioral concerns, frequency, and intensity, as well as any interventions used. _____

_____

_____

_____

_____

Does applicant have a behavior program in place? _____ Yes _____ No

VII. **OTHER:**

A. What does applicant do during normal course of day?_____

_____

B. Does applicant attend school, day program, or camp? If so, please include name and location, drop off and pick up times:_____

C. What does applicant enjoy doing?_____

_____

D. What does applicant dislike?_____

_____

E. Does the applicant likes to swim? _____ Are they able to swim?_____

Are they able to use swimming pool? _____ Are they able to use spa? _____

Do they need a life jacket? _____

F. When is the best time to schedule a tour and/or an appointment?_____

_____

G. How did you hear about Anne Grady Services?_____