Santa Fe Place ICF-MR Pre-Admission Assessment

Resident Name: _____ Rm. Number: _____

Date: _____ Move-in Date: _____

The assessment of the service needs is based on the resident's capabilities, decisions and preferences in the indicated areas.

Medication Assistance:
❑ Self administers all medications ❑ Needs supervision and reminders for self-medication
❑ Requires all medication to be administered by staff

Pharmacy: _____ Phone: _____

Drug Allergies: _____

Precautions or comments: _____

Toileting:
❑ Independent ❑ Needs minimal assistance with clothing
❑ Needs assistance with continence items ❑ Dependent for all toileting needs

Comments: _____.

Continence:
❑ Continent ❑ Bladder incontinence ❑ Bowel incontinence
❑ Occasionally incontinent of bladder ❑ Occasionally incontinent of bowel
❑ Ostomy ❑ Requires assistance with ostomy care

Special instructions: _____.

Night time preparations: _____.

Hygiene Assistance
❑ Requires assistance with morning dressing
❑ Requires assistance with morning bathing and grooming
❑ Requires assistance with night dressing
❑ Requires assistance with night bathing and grooming
❑ Requires minimal assistance with bathing
❑ Requires full assistance with bathing

Requires assistance with: ❑ Dental Care ❑ Bathing or showering ❑ Hearing aids
❑ Glasses ❑ Dressing ❑ Shaving ❑ Hair care ❑ Nail Care

Escorting: ❑ Independent ❑ Requires reminding to attend meals and activities
❑ Requires escort to meals and activities

Assistive Devices
❑ Hearing Aid ❑ Glasses ❑ Cane ❑ Walker ❑ Wheelchair ❑ Scooter
❑ Splint ❑ Brace

Dietary Needs
❑ No special needs ❑ No concentrated sweets ❑ No added salt ❑ Low fat

❑ Calorie Restrictions: _____
❑ Specific Dislikes: _____.
❑ Food Allergies: _____.
❑ Preferences: _____.

Dining Assistance
❑ Independent ❑ Needs Assistance ❑ Dependent

Safety
Describe any conditions that may require the resident to have an apartment located near an exit:
_____.

Housekeeping and Laundry
❑ Independent ❑ Needs assistance ____ times per week ❑ Dependent

Requires the following assistance: ❑ Bed making daily ❑ Bed linen change____X per week
❑ Sweeping ❑ Vacuum ❑ Mopping ❑ Clean bathroom ❑ Clean kitchen
❑ Complete housekeeping assistance daily

Mental Abilities and Orientation

Indicate any problems, needs, reminders or needs for the staff to monitor specific behaviors (wandering, confusion, etc.)_____

_____.

Health Needs
Describe the level of assistance required for physician appointments, routine medical needs, nursing tasks, etc._____

_____.

Behavior Monitoring Needs. Describe any behavioral characteristics that require monitoring.

_____.

Family Support. List the names and phone numbers of family members likely to visit:

_____ _____

_____ _____

_____ _____

_____ _____

Socialization Habits. Indicate hobbies, special interests and desires to socialize with others: __

_____.

Transportation Needs: _____.
❑ Facility transportation ❑ Public Special Van ❑ Family will transport
❑ Has own car ❑ Arrange with family before other transportation arrangement

Business Management:
❑ Manages all business matters ❑ Family member (name) _____

❑ Advocate (name) _____.

Special Needs: _____.

Life Value Issues:

❑ Full Code ❑ DNR ❑ Living Will ❑ Advance Directives

The resident must comply with all state regulations regarding governing of these medial wishes.

_____ _____
Signature of person completing form Title

STEPS FOR APPLYING FOR SERVICES

1. To be eligible for residential supports, an application with the Social Security Administration is required. The Social Security Administration completes a determination of disability and processes an application for benefits to pay for the cost of residential supports.

   The address for the Social Security office that serves Oklahoma City, Moore, and Norman is:

   200 NE 27th
   Moore, Ok, 73160
   Telephone: (405) 799-0702

2. Contact the Oklahoma Department of Human Services: Developmental Disabilities Services Division to apply for state operated supports at (405) 307-2800.

3. The Oklahoma Area Wide Services Information System (OASIS) serves a clearing house to provide information about a variety of supports that might meet your needs. OASIS telephone number is 1-800-426-2747.

4. Additional information can be obtained from Oklahoma DHS/DDSD at:
   (405) 307-2800

SANTA FE PLACE, LLC.

1000 S. Santa Fe
Moore, OK, 73160
Phone: (405) 912-5377
Fax: (405) 912-5382

APPLICATION FOR RESIDENTIAL TREATMENT

GENERAL INFORMATION ABOUT APPLICANT

Name:		Date:
Address:		
City:	State:	Zip:
Phone: (home)	(other)	
Date of Birth:	Age:	Marital Status: S M D W
Social Security Number:		
Medicaid Number:		Medicare:
Case Manager:		
IQ:	Religious Preference:	

INCOME/RESOURCES

SSI Amount:	Social Security Amount:
AID/Disabled Amount:	Public Assist Amount:
Private Trust: Y N	
Other income/resources: (stocks, bonds, life insurance, checking/savings account, etc.)	
Who serves as Rep Payee?	
Private Insurance:	Group #:
Health Ins.: Y N	Life: Y N Pre Paid Burial: Y N
Legal Guardian: Y N	If "Yes" whom?
(If so please enclose copy of legal decree)	

Primary Family Contact

Name:		Relationship:
Address:		
City:	State:	Zip:
Phone: (home)	(other)	

PRIOR RESIDENTIAL CARE/HOSPITALIZATIONS

Facility Name:
Address:
City: County: State: Zip:
Reason for Admission:
Dates of Service:

Facility Name:
Address:
City: County: State: Zip:
Reason for Admission:
Dates of Service:

Facility Name:
Address:
City: County: State: Zip:
Reason for Admission:
Dates of Service:

SOCIAL SERVICES RECEIVED

Types of Services:

Dates of Services:

Types of Services:

Dates of Services:

Types of Services:

Dates of Services:

PHYSICIAN CARE

Name:
Address:
City: County: State: Zip:
Dates of Service:
Phone :

Name:
Address:
City: County: State: Zip:
Dates of Service:
Phone :

Name:
Address:
City: County: State: Zip:
Dates of Service:
Phone :

Medications being taken:

1._____ 2._____
3._____ 4._____
5._____ 6._____

PHYSICAL/MEDICAL STATUS

Height: Weight: General Health:

Eyesight: (circle one) Good Fair Glasses Legally Blind

Seizure/Epilepsy: Y N Type & Frequency:

Cause of Mental Retardation:

Physical Limitations:

Allergies:

Diseases/Disabilities

SCHOOLS/EDUCATION

Name of School: Dates Attended:
Address:
City: County: State: Zip:

Name of School: Dates Attended:
Address:
City: County: State: Zip:

Name of School: Dates Attended:
Address:
City: County: State: Zip:

VOCATIONAL TRAINING/WORK EXPERIENCE

Name
Address:
City: County: State: Zip:
Dates Attended:
Type of training/experience/position:
Hours worked per week:
Reason for leaving:

Name
Address:
City: County: State: Zip:
Dates Attended:
Type of training/experience/position:
Hours worked per week:
Reason for leaving:

Name
Address:
City: County: State: Zip:
Dates Attended:
Type of training/experience/position:
Hours worked per week:
Reason for leaving:

Documentation Needed

Birth Certificate
Social Security Card
Medicaid Card
Medicare Card
Private Insurance
State Issued ID Card
All Medical Records
Psychological Assessment
Legal Guardianship Papers

FUNCTIONING AND/OR ABILITIES				
FUNCTION	**UNABLE TO DO**	**REQUIRES PHYSICAL OR VERBAL ASSISTANCE (indicate which)**	**CONSISTENTLY INDEPENDENT**	**N/A**
Grooming Habits				
Keeps hands and face clean				
Bathes (shower or tub)				
Shampoo Hair				
Brushes Teeth or Dentures				
Changes clothes daily				
Selects weather appropriate clothing				
Shaving				
Cares for menstrual needs				
Meal Time Skills				
Eats with proper utensils				
Can prepare simple foods (coffee, cereal, soup, etc.)				
Uses stove or microwave				
Can follow & use recipes				
Washes Dishes				
Cleans kitchen				
Housekeeping				
Makes bed				
Uses washer/dryer				
Changes bedding routinely				
Keeps room neat				
Helps with general housework				
Community interaction skills				
Tells time				
Uses public transportation				
Uses community resources (library, stores, church)				
Can manage money				
Knows coin and bill value				
Shops for personal needs				
Social activity w/ family				
Social activity w/ friends				
Structures leisure time				
Has a hobby				
Rides a bicycle				
Entertains self w/ hobby, TV, books, etc.				
Emergency knowledge				
Can use phone to call 911				
Knows severe weather procedures.				

FUNCTIONING AND/OR ABILITIES continued				
Social Behavior	**Rarely**	**Sometimes**	**Always**	**Comments**
Respects authority				
Accepts criticism				
Asks for help when needed				
Accepts responsibility				
Helps others				
Listens & follows directions				
Completes tasks				
Works well with others				
Respects other's property				
Shares and takes turns				
Controls temper				
Well mannered				
Appropriate sexual behavior				
Awareness of strangers				
Destructive to property				
Harms others physically				
Has outbursts of temper				
Runs away				
Can safely stay alone				
Other				
Other				