

## ADULT FOSTER HOME MOBILITY ACCESS ASSESSMENT

**INSTRUCTIONS:** Before placement, or after placement if the local agency has reasonable cause to believe a mobility access, seizure, or disability problem has developed, the social worker shall determine, in consultation with the adult and the adult's legal representative and any other person knowledgeable about the adult's needs, whether accessibility aids or modifications to the residence are needed (Adult Foster Care Services Rule Part 9555.5605 Subp. 2). The checklist should be used for an adult who:

1. Must use a wheelchair most of the time or;
2. Has great difficulty with the motions required for walking or climbing or;
3. Has poor balance/coordination or;
4. Has a seizure disorder or;
5. Lacks strength and endurance.

If the assessment is completed with the adult present at the initial evaluation, the adult and/or the legal representative must approve of the home and proposed accommodations prior to placement being finalized.

If the adult's needs can be accommodated and placement approved or continued, the results of the evaluation must be:

1. Incorporated into the Individual Residential Placement Agreement,
2. Maintained in the operator's records on the adult and,
3. Used in preparing the fire safety emergency escape plan required for the person.

### PART 1 - FOSTER HOME INFORMATION

Operator's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

#### Home Layout:

Number of stories: \_\_\_\_\_

Main floor rooms: \_\_\_\_\_

Any upper floor rooms: \_\_\_\_\_

Any Lower floor rooms: \_\_\_\_\_

### PART II – INFORMATION ON ADULT

Condition causing disability (e.g. polio): \_\_\_\_\_

Present since: \_\_\_\_\_

Required mobility equipment: \_\_\_\_\_

Other disabilities or special needs:

Hand control/range of reach: \_\_\_\_\_

Vision: \_\_\_\_\_

Hearing: \_\_\_\_\_

Temperature/humidity/air quality: \_\_\_\_\_

Seizures: \_\_\_\_\_

Other: \_\_\_\_\_

If more general information is needed on various disabilities, review Appendix A.

If more specific information is needed to evaluate the adult's capabilities and limitations, consult with:

\* A family member, a friend or advocate, a staff or household member of the adult's current or most recent placement, a professional providing health care services to the adult, any medical or rehabilitation reports available on the adult, an occupational therapist (O.T.R.), a registered physical therapist (R.P.T.).

**PART III – CHECKLIST**

This checklist will assist in reviewing the home on an area-by-area basis to determine if the adult will or does have a mobility, control or safety problem. If the person uses a wheelchair, walker or similar equipment, pay close attention to the dimensions and space requirements of his or her particular equipment to make sure that doors and halls are wide enough and fixtures can be readily approached. Appendix B contains information related to the use of different types of mobility equipment.

CAN THE PERSON SAFELY AND INDEPENDENTLY: (X)	YES	NO
Get up to the front or back door? *	_____	_____
Comfortably pause, open the door and enter?	_____	_____
Move from the entry to the main floor?	_____	_____
Approach, open any door, and move around in the living room?	_____	_____
Approach, open any door, enter and move around in the area where meals are served?	_____	_____
Approach, open the door, enter and move around in his/her bedroom? *	_____	_____
Open any door and use the closet(s) in his/her bedroom?	_____	_____
Approach, open the door, and enter the bathroom?	_____	_____

Approach, transfer to, and/or use the tub/shower? \_\_\_\_\_

the sink \_\_\_\_\_

the toilet \_\_\_\_\_

the medicine cabinet \_\_\_\_\_

If kitchen access is required by the Individual Service Plan & Individual Habilitation Plan other than for meals, can the person Safely & independently use the appliances, sink, storage? \_\_\_\_\_

Is access to any other area not previously identified required? \_\_\_\_\_  
If so, identify area: \_\_\_\_\_  
Are there problems with access to or within this area? \_\_\_\_\_

Does the person need special signaling (e.g. visual smoke detector)? \_\_\_\_\_

Specify \_\_\_\_\_

Does the person have a special sensitivity that requires temperature/humidity/air quality controls? \_\_\_\_\_

\* (If a resident must have a ramp or similar modification to enter and exit, only one doorway has to be made accessible. Arrangements for emergency exit through the home's other exterior door(s) can be covered in the resident's required fire safety emergency escape plan)

\* (Part 9555.5605, subp. 2 requires that a person using a wheelchair must be housed on a level with an exit directly to grade.)

#### PART IV - ACCESSIBILITY AGREEMENT

If the checklist indicates any area(s) where the adult will or does encounter accessibility problems in the home, acceptable accommodations must be made before the placement can be approved or continued. Depending on the circumstances, these accommodations may involve a structural modification, portable equipment, personal appliances/aids, personal assistance, or a combination of these resources. If the adult foster home operator accepts responsibility for making specific changes and/or arrangements outline below. This agreement becomes a part of the Individual Residential Placement Agreement.

This section identifies what problems must be accommodated by which means.

If you need more information on possible options, consult with:

\* an occupational therapist (O.T.R.), a registered physical therapist (R.P.T.), architects or persons who have special training in accessible residential design, local contractors, home remodelers, or staff or local housing authorities or Community Action Programs who may have experience in home accessibility remodeling, Appendix C which has information on how a range of structural modification can be done.

Persons who participated in completing this assessment:

Adult foster home operator: \_\_\_\_\_

Adult: \_\_\_\_\_

Adult's legal representative: \_\_\_\_\_

Social Worker: \_\_\_\_\_

Other Persons contributing:

Name	Title or relationship to adult
_____	_____
_____	_____
_____	_____
_____	_____

Problem areas (describe)	Proposed accommodation	Date to be completed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other notes or information explaining needed accommodations:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Assurances:

*I/we agree to make the accommodation(s) identified above for the placement of \_\_\_\_\_*

*\_\_\_\_\_ in this adult foster home by \_\_\_\_\_*

*(date)*

*If personal aids/appliances are needed to finalize this placement, I/we understand that the service agency will provide assistance in obtaining them.*

SIGNED

Operator \_\_\_\_\_ Date \_\_\_\_\_

Social Worker \_\_\_\_\_ Date \_\_\_\_\_

With the accommodations cited above, I agree to live in this adult foster home.

Adult \_\_\_\_\_ Date \_\_\_\_\_

Adult's Legal Representative \_\_\_\_\_ Date \_\_\_\_\_