Washington County

Community Services

WCCS-71980-233 (10-19)

Adult Foster Care

Mobility Access Assessment

Instructions:

- The social worker must complete this form for all individuals before adult foster care placement.
- For current residents, this form needs to be complete if there is a change in mobility, the person develops a seizure disorder, or other disability has developed.
- This form needs to be completed when there is a change in premise of the adult foster care home.
- The adult and/or their legal representative must approve of the home and proposed accommodations prior to placement being finalized.
- **Individuals using a wheelchair must be housed on a level with an exit directly to grade.**

AFC Provider: This assessment must be kept in resident's file and should be used when developing the emergency escape plan for the person.

Check one: ☐ **Initial assessment** ☐ **Reassessment due to changes in mobility** ☐ **Change of premise**

Resident Name	**Date of Assessment**
AFC Provider Name	**Address**

DWELLING INFORMATION

Type of Home
☐ Single Family Home ☐ Duplex/Twin home ☐ Apartment/Condo ☐ Townhome ☐ Mobile Home
☐ Other:
Floors Requiring Resident Access *(*note residents must have access to the living room and dining room)*
☐ Basement ☐ First Floor ☐ Second Floor ☐ Above Second Floor ☐ Garage

RESIDENT INFORMATION

Diagnoses and/or Conditions Causing a Disability
Required Mobility Equipment
Other Functioning Disabilities *check box if the person has special need or disability in this area and explain*
☐ Hand Control/Range of Reach:
☐ Vision:
☐ Hearing:
☐ Temperature/Humidity/Air Quality:
☐ Seizures:
☐ Other:

MOBILITY ACCESS ASSESSMENT CHECKLIST

Is the resident able to safely and independently…	**Yes**	**No**
access the front or back door and enter?	☐	☐
move from the main entry to the main floor?	☐	☐
access any door, enter and move around in the area where meals are served?	☐	☐
access the door, enter, and move around in their bedroom?	☐	☐
access any door and use the closet(s) in their bedroom?	☐	☐
access the door, and enter the bathroom?	☐	☐
access and use the tub/shower?	☐	☐
access and use the sink?	☐	☐
access and use the toilet?	☐	☐
access the kitchen (appliances, sink and storage)?	☐	☐
access any other area not previously identified required?	☐	☐
If no - identify the area and any problems with access to or within this area:		

Other Accessible Needs	**Yes**	**No**
Does the resident need special signaling (ex. visual smoke detector)	☐	☐
If yes – specify:		
Does the resident have a sensitivity requiring temperature/humidity/air quality?	☐	☐
If yes – specify:		

MOBILITY ACCESS ASSESSMENT AGREEMENT

The assessment indicates modifications are needed.
☐ **Yes –** *sign this page* and *continue to pages 3-4.*
☐ **No –** *sign this page and the form is complete.*

Persons who participated in completing this assessment:

Resident _____ Date _____

Resident's Legal Representative _____ Date _____

AFC Authorized Agent _____ Date _____

Social Worker/Care Coordinator _____ Date _____

Other Person - Relationship to Resident: _____ Date _____

COMPLETE THIS SECTION IF MODIFICATIONS ARE REQUIRED (1/2)

Add additional sheets as needed to address additional problem areas.

Problem Area:
Proposed Modification:
Individual(s) Responsible for Modification:
Date for Completion:

Problem Area:
Proposed Modification:
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Date for Completion:

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Problem Area:
Proposed Modification:
Individual(s) Responsible for Modification:
Date for Completion:

COMPLETE THIS SECTION IF MODIFICATIONS ARE REQUIRED (2/2)

Acceptable modifications must be made before the placement can be approved or continued. Depending on the circumstances, these modifications may involve a structural changes, portable equipment, person appliances/aids, personal assistance, or a combination of these resources.

For more information on modifications 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 of local housing authorities or Community Action Program who may have experience in home accessibility remodeling

Modification(s) Agreement

I/We agree to make the modification(s) identified in this assessment by _____ for the
(Date)

placement of _____ in the adult foster care home.
(Resident Name)

_____ _____
AFC Authorized Agent Date

_____ _____
Social Worker/Care Coordinator Date

When the modification(s) identified in this assessment completed, I agree to live in this adult foster home.

_____ _____
Resident Date

_____ _____
Resident's Legal Representative Date