Adult Foster Care

Mobility Access Assessments

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 resident's needs, whether accessibility aides or modifications to the residence are needed. (MN Rule Part 9555.5605 Subp. 2)

This 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 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 Resident's 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 (MN Part 9555.6225 Subp. 5H)

Part 1:

Name of Adult: _____

Date of Review: _____

Assessor: _____

PART 2: 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 3: 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 consult with your local public health department or adult's physician.

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 on the adult
- An occupational therapist (O.T.R.)
- A registered physical therapist (R.P.T.)

PART 4: CHECKLIST

This checklist will assist in reviewing the home on an area-by- area basis to determine if the adult will or does not have mobility, control, or safety problem. If the person uses a wheelchair, walker, or other similar equipment, pay close attention to the dimension 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. Consult with your local health department or health care provider for information related to the use of different types of mobility equipment.

CAN THE PERSON SAFELY AND INDEPENDENTLY:	Yes	No
Get up to the front or back door? (If a resident must have a ramp or similar modification to enter and exit, only one doorway has to be 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.)	☐	☐
Comfortably pause, open the door, and enter?	☐	☐
Move from the entry to the main floor?	☐	☐
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? (MN Part 9555.5605 Subp. 2 requires that a person using a wheelchair must be housed on a level with an exit directly to grade.)	☐	☐
Open any door and use the closet(s) in his/her bedroom?	☐	☐
Approach, open the door, and enter the bathroom?	☐	☐

	Yes	No
Approach, transfer to, and/or use: The tub shower? The sink? The toilet? The medicine cabinet?	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
If kitchen access is required by the Individual Services Plan, Individual Habilitation Plan, Individual Resident Placement Agreement other than for meals, can the person safely and independently use the appliances, sink, storage?	☐	☐
Is access to any other area not previously identified required? If so, identify the area and any 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? Specify:	☐	☐

PART 5: ACCESSIBILITY AGREEMENT

If the checklist indicates any area(s) where the adult will or does encounter accessibility problems in the home, acceptable accommodation must be made before the placement can be approved or continued. Depending on the circumstances, these accommodations may involve a structural modification, portable equipment, person appliances/aids, personal assistance, or a combination of these resources. The agreement becomes part of the adult's Individual Resident Placement Agreement.

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 of local housing authorities or Community Action Program who may have experience in home accessibility remodeling

Note: Minnesota Rule Parts 9555.5606 Subpart 2 requires that a person using a wheelchair must be housed on a level with an exit directly to grade.

CHECK HERE IF NO MODIFICATIONS OR ACCOMMODATIONS ARE NEEDED:

☐ This assessment has been reviewed and at this time no modifications or accommodations are identified as being needed.

COMPLETE THIS SECTION IF MODIFICATIONS OR ACCOMMODATIONS ARE REQUIRED

Add additional sheets as needed to address additional problem areas.

Problem Area:
Proposed Accommodation:
Individual Responsible for Modification:
Date for Completion:

Problem Area:
Proposed Accommodation:
Individual Responsible for Modification:
Date for Completion:

Problem Area:
Proposed Accommodation:
Individual Responsible for Modification:
Date for Completion:

Problem Area:
Proposed Accommodation:
Individual Responsible for Modification:
Date for Completion:

Any other notes or information explaining needed accommodations:

Accommodations noted above should be reflected in the Program Abuse Prevention Plan.

**Note: Residents should be reassessed when there is reasonable cause to believe a mobility access, seizure, or disability problem has developed.*

PERSONS WHO PARTICIPATED IN COMPLETING THIS ASSESSMENT.
If not providing a signature, note how they participated.

Adult foster home license holder

Other (include title, credentials, or relationship to adult)

Resident

Other (include title, credentials, or relationship to adult)

Adult's Legal Representative

Other (include title, credentials, or relationship to adult)

Case Manager/Social Worker/Care Coordinator

Other (include title, credentials, or relationship to adult)

ASSURANCES

I/We agree

☐ *to make the accommodation(s) identified above by* _____
Date

☐ *no accommodations are needed*

for the placement of _____ *in the adult foster home.*
Name of Adult

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

Signed:

_____ _____
Adult Foster Home Operator Date

_____ _____
Social Worker/Care Coordinator Date

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

_____ _____
Person Date

_____ _____
Person's Legal Representative Date