

# Resident Admission Procedures: What to do and Why to do it!

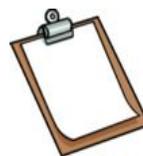
Diane L. Stier, Ph.D.  
Adult Foster Care Licensing Consultant  
Bureau of Children & Adult Licensing



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## Written Assessment

Group Home Rule 301(2)  
Family Home Rule 407(2)



- A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable...



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**ASSESSMENT PLAN FOR AFC RESIDENTS**  
Michigan Department of Human Services  
Bureau of Children and Adult Licensing

**INSTRUCTIONS:**

1. A written assessment plan is required. The licensee is responsible for assuring that a written assessment plan is completed.
2. This form has been approved by the Department of Human Services and contains the information required by administrative rule and Section 3 (9) of 1976 P.A. 218.
3. This form is to be completed by the licensee and resident, or the resident's designated representative. The responsible agency, if any, may assist in this process.
4. Use additional sheets if necessary and **PRINT CLEARLY**.

Name of Resident	Name of Designated Representative (if applicable)	Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F
<b>I. SOCIAL/BEHAVIORAL ASSESSMENT</b>		<b>PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)</b>	
	Yes	No	IF NO, Describe Needs and How They Will Be Met
A. Moves Independently in Community	<input type="checkbox"/>	<input type="checkbox"/>	
B. Communicates Needs	<input type="checkbox"/>	<input type="checkbox"/>	
C. Understands Verbal Communication	<input type="checkbox"/>	<input type="checkbox"/>	
D. Alert to Surroundings	<input type="checkbox"/>	<input type="checkbox"/>	
E. Reads and Writes	<input type="checkbox"/>	<input type="checkbox"/>	
F. Tells Time	<input type="checkbox"/>	<input type="checkbox"/>	
G. Manages Money	<input type="checkbox"/>	<input type="checkbox"/>	
H. Follows Instructions	<input type="checkbox"/>	<input type="checkbox"/>	
I. Controls Aggressive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	
J. Controls Sexual Behavior	<input type="checkbox"/>	<input type="checkbox"/>	
K. Gets Along With Others	<input type="checkbox"/>	<input type="checkbox"/>	
L. Exhibits Self Injurious Behavior	<input type="checkbox"/>	<input type="checkbox"/>	
M. Participates in Social Activities	<input type="checkbox"/>	<input type="checkbox"/>	
N. Smokes	<input type="checkbox"/>	<input type="checkbox"/>	
O. Appropriately Uses Alcohol/Drugs	<input type="checkbox"/>	<input type="checkbox"/>	

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## Is the resident suitable?

- Is the amount of
  - personal care,
  - supervision,
  - and protection

required by the resident available in this home?

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## Is the resident suitable?

- Are the kinds of
  - services,
  - skills, and
  - physical accommodations



needed by the resident available in the home?



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## Is the resident suitable?

- Is the resident compatible with other residents and members of the household?



6

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  - personal care,
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  - and protection



required by the resident available in this home?



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## Personal Care

- Dressing
- Personal Hygiene
- Grooming
- Medications
- Personal & Social Skill Development



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- Does this individual require total assistance with any aspect of hygiene?
  - Do you have more than one staff available to supervise other residents while one staff is totally occupied with this person?
- Does this individual have needs that require two staff?
  - Are you able to provide needed staff on ALL shifts?



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II. SELF CARE SKILL ASSESSMENT      PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)

	Needs Help		IF YES, Describe Needs and How The Will Be Met
	Yes	No	
A. Eating/Feeding	<input type="checkbox"/>	<input type="checkbox"/>	
B. Toileting	<input type="checkbox"/>	<input type="checkbox"/>	
C. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	
D. Grooming (hair care, teeth, nails, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
E. Dressing	<input type="checkbox"/>	<input type="checkbox"/>	
F. Personal Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	
G. Walking/Mobility	<input type="checkbox"/>	<input type="checkbox"/>	
H. Stair climbing	<input type="checkbox"/>	<input type="checkbox"/>	
I. Use of Prosthesis (Dentures, Artificial limbs, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
J. Use of Assistive Devices (explain)	<input type="checkbox"/>	<input type="checkbox"/>	
K. Other (explain)	<input type="checkbox"/>	<input type="checkbox"/>	



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Eating	Y	Staff assist
Bathing	Y	Staff assist

Eating	Y	Choking risk. ½" diced food, staff within arm's reach at meals
Bathing	Y	Verbal prompts only



- What are the person's medical needs?
- Do staff have any special training needed?
- Does the person have a history of non-compliance with medication?
- Do you have all of the person's medications? How do you know?



III. HEALTH CARE ASSESSMENT		PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)	
	Yes	No	IF YES, Describe Needs and How They Will Be Met
A. Taking medication	<input type="checkbox"/>	<input type="checkbox"/>	
B. Special Diets	<input type="checkbox"/>	<input type="checkbox"/>	
C. Physical Limitations	<input type="checkbox"/>	<input type="checkbox"/>	
D. Special Equipment Used (Wheel chair, Walker, Cane, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
E. Other Difficulties (Vision, Weight, Allergies, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
F. Susceptible to Hypothermia or Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>	

V. MEDICATIONS TAKEN AT TIME OF ASSESSMENT		
Name of Medication	Who Prescribed	Dosage

Continued on Next Page



## Protection

- Reasonable action to insure resident health, safety, and well-being
- Protection from physical harm, humiliation, intimidation, and exploitation



## What potential safety issues does this resident pose? – Fire Safety



- Can this resident evacuate independently?
- Will the resident stay at a safe destination?
- If this person requires a two-person transfer, are there two staff on all shifts?
- Will this person's needs change the ability of staff to safely evacuate all residents?



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### F-1 SIDE 2 Worksheet for Rating Residents

Read Instruction Manual before filling out this form.  
Base ratings on commonly observed examples of poor performance.

#### F-1A RATING THE RESIDENT ON THE RISK FACTORS

Rate the resident on each of the factors below by checking the one circle in each risk factor that best describes the resident. For the first six factors, write the scores for the circles you checked in the appropriate score boxes in the far right column. For "response to fire drills," write the three checked scores in the large circles. Write the sum of the 3 scores in the large box on the right.

	Minimal Risk	Risk of Mild Resistance	Risk of Strong Resistance	SCORE BOXES
I. Risk of Resistance (Check only one)	<input type="radio"/> score=0	<input type="radio"/> score=4	<input type="radio"/> score=20	<input type="text"/>
II. Impaired Mobility (Check only one)	Self-Staring <input type="radio"/> score=0	Slow <input type="radio"/> score=2	Needs Limited Assistance <input type="radio"/> score=4	Needs Full Assistance or Very Slow <input type="radio"/> score=20
III. Impaired Consciousness (Check only one)	No Significant Risk <input type="radio"/> score=0	Partially Impaired <input type="radio"/> score=4	Totally Impaired <input type="radio"/> score=20	<input type="text"/>
IV. Need for Extra Help (Check only one)	Needs at Most One Staff <input type="radio"/> score=0	Needs Limited Assistance from 2 Staff <input type="radio"/> score=20	Needs Full Assistance from 2 Staff <input type="radio"/> score=40	<input type="text"/>
V. Response to Instructions (Check only one)	Follows Instructions <input type="radio"/> score=1	Requires Supervision <input type="radio"/> score=3	Requires Considerable Attention/May Not Respond <input type="radio"/> score=10	<input type="text"/>
VI. Making Response to Alarm (Check only one)	Response Probable <input type="radio"/> score=0	Response Not Probable <input type="radio"/> score=4		<input type="text"/>
VII. Response to Fire Drills (Without Guidance or Advice from Staff)	Initiate and Complete Evacuation Promptly	Yes <input type="radio"/> score=0	No <input type="radio"/> score=4	<input type="text"/> + <input type="text"/> + <input type="text"/> = SUM OF THESE THREE ITEMS
	Chooses and Completes Back-up Strategy	Yes <input type="radio"/> score=0	No <input type="radio"/> score=4	
	Stays at Designated Location	Yes <input type="radio"/> score=0	No <input type="radio"/> score=4	

#### F-1B FINDING THE RESIDENT'S OVERALL NEED FOR ASSISTANCE

Compare the numbers in the 7 score boxes you have filled in. Take the one highest score from the score boxes and write it in this box:  
Life Safety 6090® and 1010® are registered trademarks of the National Fire Protection Association, Inc., Quincy, MA 02268.

EVACUATION ASSISTANCE SCORE



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*What potential safety issues does this resident pose? – Other*

- Can this resident move independently in the community?
- Is this person an elopement risk?
- Does this person pose a threat to any current residents?
- Will this person's needs stretch the ability of staff to provide care to other residents?



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M. Participates in Social Activities	<input type="checkbox"/>	<input type="checkbox"/>	
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- Exploitation

- Does this person have a legal guardian?
- Are there restrictions imposed by the guardian or resident regarding visits, phone calls, or other contact?



IV. SOCIAL AND PROGRAM ACTIVITIES	PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)		
	Yes	No	Explain How These Activities Will Be Provided or Encouraged
A. Participates in Religious Practice	<input type="checkbox"/>	<input type="checkbox"/>	
B. Participates in Household Chores	<input type="checkbox"/>	<input type="checkbox"/>	
C. Adult Activity Program	<input type="checkbox"/>	<input type="checkbox"/>	
D. Senior Center	<input type="checkbox"/>	<input type="checkbox"/>	
E. Workshop or job	<input type="checkbox"/>	<input type="checkbox"/>	
F. School	<input type="checkbox"/>	<input type="checkbox"/>	
G. Hobbies/Special Interest	<input type="checkbox"/>	<input type="checkbox"/>	
H. Recreation	<input type="checkbox"/>	<input type="checkbox"/>	
I. Physical Exercise	<input type="checkbox"/>	<input type="checkbox"/>	
J. Family/Friends (Please Address Any Applicable Visitation Prohibitions and/or Other Considerations)	<input type="checkbox"/>	<input type="checkbox"/>	
K. Other (explain)	<input type="checkbox"/>	<input type="checkbox"/>	



- Exploitation

- Does this individual handle any of his/her own money?



**RESIDENT FUNDS RECORD**  
PART I  
Michigan Department of Human Services  
Bureau of Children and Adult Licensing

Resident Name	
Facility Name	License Number

**INSTRUCTIONS:**

- The licensee is to complete Sections A, B, and C for all residents.
- A Resident Funds Part II (BCAL-2319) or approved substitute, must be completed for:
  - All resident payments for adult foster care services as required by PA420.14102(1)(v)(i), R 400.15102(1)(d)(i)
  - Account(s) managed by the licensee for a resident including:
 

Personal assistance	Workshop checks
Other checks or cash such as gifts	Cash
Interest	Dividends
Stocks, bonds or money market funds	Savings, checking accounts
All other applicable funds	
- The licensee is to keep Resident Funds forms in the resident's record
- The licensee is to give a copy of the Resident Funds forms to the person(s) responsible for managing the resident's funds.
- The licensee shall not commingle resident funds with licensee's funds.

**SECTION A:** The person or persons responsible for the resident's funds is (are):

Resident

Legal Guardian: \_\_\_\_\_



- Exploitation

- Can they "Sign out" cash?



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G. Manages Money	<input type="checkbox"/>	<input type="checkbox"/>	
H. Follows Instructions	<input type="checkbox"/>	<input type="checkbox"/>	
I. Controls Aggressive	<input type="checkbox"/>	<input type="checkbox"/>	



- Exploitation

- Can they "Sign out" cash?

**RESIDENT FUNDS**  
**PART B**  
 Michigan Department of Human Services  
 Bureau of Children and Adult Licensing

This form or an approved substitute is to be used to record all resident care payments for adult foster care services.

**INSTRUCTIONS:**  
 Please use a separate BCAL 2919 - Resident Funds - Part B for each savings, checking, or other account. One form may be added to account for each and for payment of adult foster care services. Please attach additional pages as necessary.

Type of Account:  SAVINGS  CHECKING  CASH  RESIDENT FOR ADULT FOSTER CARE SERVICES  OTHER (Specify) \_\_\_\_\_

Date	Reason for Transaction	Resident or Designated Representative Signature	Signature of Designer Signature	Deposit Amount (\$)	Withdrawal Amount (\$)	Balance	Forwarded



# Supervision

- Guidance in the activities of daily living:
  - Maintaining medication schedule
  - Carrying out important activities
  - Keeping appointments
  - Being aware of whereabouts





- Whereabouts
  - Can this person be outside unsupervised?
  - Is the resident an elopement risk?



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## Is the resident suitable?

- Are the kinds of
  - services,
  - skills, and
  - physical accommodations



needed by the resident available in the home?



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## Is the resident suitable?

- Is the resident compatible with other residents and members of the household?



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- Will this person be the only one of his/her age group or gender?
- Will this person have "peers" in the home?
- Does this person enjoy going on outings, or will he/she insist on staying home?
- Will this person be a potential aggressor toward other residents? Can the other residents protect themselves?
- Will this person be a potential victim of current residents?

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M. Participates in Social Activities	<input type="checkbox"/>	<input type="checkbox"/>	
N. Smokes	<input type="checkbox"/>	<input type="checkbox"/>	
O. Appropriately Uses Alcohol/Drugs	<input type="checkbox"/>	<input type="checkbox"/>	

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See Page 4 for Non-discrimination and ADA statement

Continued on Next Page



**MEDICAL OR DENTAL FOLLOW-UPS NEEDED (i.e., check-ups, regular appointments, etc.)**

**VI. RELEASE OF INFORMATION – RESIDENT OR LEGAL GUARDIAN SIGNATURE ONLY**

"By signing this form, I understand that I am authorizing the release of medical information concerning me, including information regarding Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV), if applicable, to the licensee and licensee's staff, the responsible agency and the Michigan Department of Human Services, Bureau of Children and Adult Licensing, for the purpose of providing appropriate care to me and determining compliance with licensing rules."

Signature of Resident or Legal Guardian	Date
---	------

**VII OTHER INFORMATION**

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**VIII. ASSESSMENT PLAN COMPLETION**

Date Assessment Plan Was Completed	Name(s) and Position(s) of Person(s) Who Completed Assessment
------------------------------------	---

**IX. PLACEMENT OBJECTIVE**

<input type="checkbox"/> A. Delay/prevent deterioration and movement to a more restrictive setting. <input type="checkbox"/> B. Encourage movement to a less restrictive setting.
--

**X. SIGNATURES**

Signature of Resident or Designated Representative	Date	Signature of Licensee	Date
Signature of Responsible Agency (if applicable)	Date		

† Department of Human Services (DHS) will not discriminate against any



## Health Care Appraisal – Rule 301(10)

- Protect yourself – you need the information
- CHECK the information against what else you have
- Call if you're not sure





## Resident Information Record

- Be sure it's COMPLETE
- Keep it current
- Complete an Inventory of Valuables



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## Medication Record

- Initial at the time meds are given
- Record any PRNS, with time and reason
- Record any refusals, contact health care professional, and record and follow instructions



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## Physician Contacts –

Rules 301(11) & 316(iii, iv)  
407(7) & (8)

- Provides clear and timely documentation
- Provides “history” of a resident’s care



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## Moving a Resident

- Just like a new admission
- Must have signed agreement for the move
- PCP must be updated



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## Odds & Ends

- Website: [michigan.gov/afchfa](http://michigan.gov/afchfa)
- Request technical assistance when you need it
- Be patient!

