This assessment must be completed at initial placement and be reviewed annually. If the resident develops difficulties with mobility during placement, the assessment must be completed.
This assessment must be completed for the resident who: 1) must use a wheelchair most/all of the time or; 2) has great difficulty walking or climbing or; 3) has poor balance/coordination; or 4)has a seizure disorder.
**If the resident must have a ramp or similar modification to enter/exit, only one doorway need be accessible.
**Residents using wheelchair MUST be housed on a level with an exit directly to grade.

ADULT FOSTER CARE
MOBILITY ACCESS ASSESSMENT

Resident_____AFC Provider_____

Date Completed_____ Assessor's Initials_____

☐ Does Not Apply/No Mobility Concerns

PART I - RESIDENT INFORMATION

Condition causing disability (polio, cerebral palsy, etc.):_____Date of onset (if known):_____
Required mobility equipment:_____
Hand control/range of motion:_____
Vision:_____
Hearing:_____
Temperature/humidity:_____
Seizures (type, duration, etc.):_____
Other:_____
** Attach any relevant reports from PT, OT, physician, etc.

PART II - CHECKLIST

CAN THE RESIDENT SAFELY AND INDEPENDENTLY:		YES	NO
1. Get up to the front/back door?		___	___
2. Comfortably pause, open the door and enter?		___	___
3. Move from the entry to the main floor?		___	___
4. Approach, open door and move around in the living room?		___	___
5. Approach, open door and move around in the area where meals are served?		___	___
6. Approach, open door and move around in his/her bedroom?		___	___
7. Approach, open door and use the closet in his/her bedroom?		___	___
8. Approach, open door and enter the bathroom?		___	___
9. Approach, transfer to and/or use:	the tub/shower?	___	___
	the sink?	___	___
	the toilet?	___	___
	the medicine cabinet?	___	___
10. If kitchen access is required by the ISP for other than meals, can the resident safely and independently use the sink, storage, etc.?		___	___
11. Is access to any other area not previously identified required?		___	___
If so, identify area:			
Are there problems with access to or within this area?		___	___
12. Does the resident have a special sensitivity that requires temperature/ humidity controls?		___	___

PART III - ACCESSIBILITY PLAN AND AGREEMENT

Identify specific areas where changes to the adult foster care home must be completed for placement to be approved or continued, and give detailed instructions for changes. If accepting a placement, the license holder is responsible for cooperating with the plan to make the residence safe for that specific resident.

2. Problem Area: _____
   Proposed Change: _____
   _____
   _____
   Completion Date: _____
   Person Responsible: _____

3. Problem Area: _____
   Proposed Change: _____
   _____
   _____
   Completion Date: _____
   Person Responsible: _____

4. Problem Area: _____
   Proposed Change: _____
   _____
   _____
   Completion Date: _____
   Person Responsible: _____

5. Problem Area: _____
   Proposed Change: _____
   _____
   _____
   Completion Date: _____
   Person Responsible: _____

6. Problem Area: _____
   Proposed Change: _____
   _____
   _____
   Completion Date: _____
   Person Responsible: _____

7. Problem Area: _____
   Proposed Change: _____
   _____
   _____
   Completion Date: _____
   Person Responsible: _____

8. Problem Area: _____
   Proposed Change: _____
   _____
   _____
   Completion Date: _____
   Person Responsible: _____