



**FAX #: 563-659-1120**  
**PHONE #: 563-659-4100**

### **ICF/MR REFERRAL PACKET:**

Community Care, Inc. is a rehabilitation treatment services for persons with mental disabilities. Policies for admission to these services are the same for everyone, without regards to race, color, sex, religion, or national origin. Each candidate will be assessed in regards to their specific needs and the available openings. Any appropriate candidate not immediately admitted will be placed on a waiting list.

Persons appropriate for the services offered by Community Care, Inc. ICF/MR services must be at least 18 years of age and have a primary diagnosis of Mental Retardation.

Prior to admission the candidate must have submitted a referral packet, which is FULLY completed. It is important that the packet be fully completed in order for our admissions committee to have a clear and full picture of the candidate. The candidate must have a physical (including tuberculosis screening) and a psychology report within 30 days of admission. Funding is also an important part of an admission. If making a self-referral, please contact your county of legal settlement.

Thank you, for your cooperation and assistance. We will contact you following the discussion of the packet by our admissions committee. Please return the referral packet, and direct any questions or concerns you may have regarding the referral and admissions process to the ICF/MR Director.

PRE-ADMISSIONS  
FUNDING INFORMATION

COMMUNITY CARE, INC.  
108 E. Industrial St.  
DeWitt, IA. 52742  
Ph#: 563-659-4100  
Fax#: 563-659-1120

Date: \_\_\_\_\_  
Full Name: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_  
County of Legal Settlement: \_\_\_\_\_ State Case:  YES  NO  
Voluntary Admission:  YES  NO \_\_\_\_\_  
Signature of person completing \_\_\_\_\_ date \_\_\_\_\_

INSURANCE INFORMATION:

DOES CANDIDATE HAVE INSURANCE:  YES  NO  
IF YES PLEASE INCLUDE THE FOLLOWING INFORMATION:

MEDICAID #: \_\_\_\_\_ MEDICARE #: \_\_\_\_\_

OTHER: \_\_\_\_\_

DOES CANDIDATE HAVE A PAYEE:  YES  NO

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

DOES CANDIDATE HAVE A CONSERVATOR/ TRUSTEE:  YES  NO

DOES CANDIDATE HAVE A GUARDIAN:  YES  NO

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_



MEDICAL INFORMATION

LEVEL OF MENTAL RETARDATION:

MILD     MODERATE     SEVERE     PROFOUND

PLEASE LIST ALL OTHER DIAGNOSIS:

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PHYSICIAN NAME, ADDRESS AND PHONE NUMBER:

DENTIST NAME, ADDRESS AND PHONE NUMBER:

OPTOMETRIST NAME, ADDRESS AND PHONE NUMBER:

PHARMACY NAME, ADDRESS AND PHONE NUMBER:

ATTORNEY NAME, ADDRESS AND PHONE NUMBER:

MORTICIAN NAME, ADDRESS AND PHONE NUMBER:

PSYCHIATRIST NAME, ADDRESS AND PHONE NUMBER:

PSYCHOLOGIST NAME, ADDRESS AND PHONE NUMBER:

EMERGENCY CONTACT NAME, ADDRESS AND PHONE NUMBER:

OTHER FAMILY & FRIENDS



SOCIAL HISTORY INFORMATION:

REFERRAL SOURCE: \_\_\_\_\_

REASON FOR ADMISSION: \_\_\_\_\_

DESCRIPTION OF CURRENT/PREVIOUS LIVING ARRANGEMENT: \_\_\_\_\_

DESCRIPTION OF SIGNIFICANT MEDICAL/PSYCHIATRIC/BEHAVIORAL CONDITIONS:

- ALLERGIES             YES  NO
- ILLNESSES            YES  NO
- SUBSTANCE ABUSE    YES  NO
- HOSPITALIZATION    YES  NO
- BEHAVIOR THERAPY    YES  NO
- SPECIAL DIET         YES  NO

PLEASE EXPLAIN ANY YES BOXES:

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IS CANDIDATE ABLE TO AMBULATE INDEPENDENTLY:  YES  NO

IF NO, PLEASE EXPLAIN LIMITATIONS:

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DOES CANDIDATE HAVE ANY MUSCULO-SKELETAL DISABILITY:  YES  NO

IF YES, PLEASE EXPLAIN:

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IS CANDIDATE ABLE TO PERFORM ADL'S INDEPENDENTLY:  YES  NO

IF NO, PLEASE EXPLAIN LIMITATIONS:

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IS CANDIDATE CONTINENT OF BOWEL AND BLADDER:  YES  NO  
IF NO, PLEASE EXPLAIN LIMITATIONS:

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IS CANDIDATE ABLE TO EAT INDEPENDENTLY:  YES  NO  
IF NO, PLEASE EXPLAIN LIMITATIONS:

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DOES CANDIDATE HAVE ANY SENSORIMOTOR PROBLEMS:  YES  NO  
IF YES, PLEASE EXPLAIN LIMITATIONS:

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DOES CANDIDATE HAVE ACADEMIC SKILLS:  YES  NO  
IF YES, PLEASE LIST ABILITIES:

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DOES CANDIDATE HAVE VOCATIONAL SKILLS:  YES  NO  
IF YES, PLEASE LIST ABILITIES:

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DOES CANDIDATE HAVE COMMUNITY/SOCIAL SKILLS:  YES  NO  
IF YES, PLEASE LIST ABILITIES:

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DOES CANDIDATE HAVE MALADAPTIVE BEHAVIORS:  YES  NO  
IF YES, PLEASE CHECK APPROPRIATE BOX AND EXPLAIN:

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| <input type="checkbox"/> SIB           | <input type="checkbox"/> AGGRESSION TOWARDS OTHERS | <input type="checkbox"/> DESTRUCTION         |
| <input type="checkbox"/> DISRUPTION    | <input type="checkbox"/> REPETITIVE BEHAVIOR       | <input type="checkbox"/> ANTISOCIAL BEHAVIOR |
| <input type="checkbox"/> NONCOMPLIANCE | <input type="checkbox"/> HABITUAL RUNAWAY          | <input type="checkbox"/> SEXUAL BEHAVIOR     |
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PLEASE CHECK ALL BOXES THAT APPLY:

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|---|---|
| <input type="checkbox"/> SEIZURE DISORDER     | <input type="checkbox"/> URINARY TRACT PROBLEMS           |
| <input type="checkbox"/> CARDIAC PROBLEMS     | <input type="checkbox"/> EVIDENCE OF COMMUNICABLE DISEASE |
| <input type="checkbox"/> RESPIRATORY PROBLEM  | <input type="checkbox"/> WEIGHT PROBLEM                   |
| <input type="checkbox"/> SKIN RELATED PROBLEM | <input type="checkbox"/> OTHER MEDICAL PROBLEMS           |
| <input type="checkbox"/> GI DISORDERS         | COMMENT ON REVERSE:                                       |

PLEASE LIST RELATIONSHIP WITH FAMILY AND FRIENDS:

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DOES CANDIDATE ATTEND CHURCH:  YES  NO

IF YES, PLEASE LIST FAITH:

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WHAT ARE SOME REC/LEISURE ACTIVITIES CANDIDATE LIKES TO DO:

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WHAT ARE SOME DISLIKES:

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ANY ROUTINE THAT WOULD BE IMPORTANT TO MAINTAIN:

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ANY OTHER PERTINENT INFORMATION THAT WOULD BE BENEFICIAL IN DETERMINING APPROPRIATENESS FOR THIS ICF/MR LEVEL OF CARE:

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