DHS
Oregon Department of Human Services
Seniors and People with Disabilities

SPECIAL NEEDS RESIDENT ADMISSION REVIEW

Screening date:		License number:	
Licensee:		AFH phone:	
E-mail address:		Cell phone:	
Maximum capacity:		FAX number:	

Proposed residents name: _____ Medicaid number *(if applicable)*: _____

Current location: _____ Proposed admission date: _____

Case manager *(if applicable)*: _____ Phone number: _____

Referral source *(if applicable):* _____ Phone number: _____

Client's profile

Height:	Weight:	DOB:

Diagnosis:	
Cognition:	
Communication:	
Behaviors:	
Mobility/activity:	
Evacuation:	
Treatments:	
Special equip:	
Ventilator info: ☐ Not applicable	Length of time resident has relied on a ventilator: _____ Frequency of vent use: ☐ full time ☐ night time ☐ night only ☐ other_____ Length of time this client can be off the ventilator:

Services:	☐ Nursing	☐ OT/PT	☐ Speech	☐ Hospice
Primary MD:			Phone:	
RN:			Phone:	
RT:			Phone:	
HH/Hospice:			Phone:	

Submit the following supporting documentation:

- ☐ A screening assessment for the proposed resident
- ☐ An evacuation plan including the proposed resident
- ☐ Your most current evacuation drill
- ☐ Care plans for any residents who have not been approved by DHS with this form
- ☐ Physician's orders indicating the resident's medication regimen and current medical diagnosis

Please list all of your current residents:

1) _____ 2) _____ 3) _____
4) _____ 5) _____

Staffing plan: *(attach a separate paper if needed)*

Name of staff	Days scheduled	Time scheduled	Length of time employed
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			

I declare under penalties of perjury this information is true, correct and complete to the best of my knowledge.

_____ _____
Licensee signature Date

To be completed by DHS/SPD Central Office

Name/title: _____ Phone: _____

Placement: ☐ Approved ☐ Denied Date of decision: _____

Case manager: _____ Date notified: _____
Licensor: _____ Date notified: _____
Exceptions: _____ Date notified: _____
Other: _____ Date notified: _____

Print form Reset form