Admission Criteria:

An applicant for a Skill Creations, Inc. ICF/ IID facility must meet the current eligibility criteria for this service. Applicants must require active treatment necessitating the ICF/IID level of care; and have a diagnosis of Intellectual Disability or a condition that is closely related to intellectual disability. In addition, the applicant must have it determined by an interdisciplinary team that he/she needs ICF/IID (Intermediate Care Facility for Individual with Intellectual Disability) level of care. The applicant must be qualified to receive Medicaid benefits, or be financially able to pay for private placement at the current daily rate utilized by the facility. The adult applicant must have a legal guardian prior to placement.

The following restrictions may apply:

1. Applicants with severe disruptive, aggressive, and/or destructive behaviors may not be admitted in some locations.
2. Applicants with severe and chronic medical problems requiring significant medical intervention may not be admitted in some locations.
3. In some facilities, clients utilizing wheelchairs must be able to easily transfer from the wheelchair to other chairs, commodes, and automobile seats to be admitted.

The following must be submitted before the Admission Committee will begin considering an applicant:

1. A completed application. Please include Legal Guardianship information and most recent psychological evaluation.
2. A complete medical history preferably prepared by a physician, should be submitted with the application. This history must include an immunization record and current medications.

Application Form and all attached should be submitted (by mail, secure email or fax) to:

Seslie Roughton
Chief Operations Officer
P.O. Box 1664
Goldsboro, NC 27533-1664
seslie.roughton@skillcreations.com
FAX : 919-735-5064

Wait Time Information:

Skill Creations makes every effort to match potential consumers with the most appropriate placement to meet their needs. We will screen potential applicants, as requested for admission upon receipt of the application and requested information. At the time of screening, the admission committee will provide feedback about available beds, the waiting list, expected vacancies, and whether the client is appropriate for services. Please keep in mind that exact wait times are not always known. When admission is not available immediately due to the availability of appropriate vacant beds, Skill Creations is happy to work with you and your MCO

to refer you to other providers that may be able to immediately serve you and your client. Priority may be given to individuals or families with urgent needs or in emergency situations.

Person Centered Planning Process:
Within 30 days of admission, you will be invited to the Annual Habilitation Planning Conference to develop the plan of care for your client. Your input, as well as the participation of the client is very valuable. In preparation for this meeting, Medical, Dietary, Psychological, Education, Social Work, and Self-Care evaluations will be completed to determine your client's strengths, needs, preferences and potential for further development. This meeting is person centered and focuses on the individual needs of your client.

Exit Criteria:
A client will be discharged at any time at the request of the guardian. A two week notice of intent is requested. Discharge may be considered by Skill Creations if it is deemed by the Admission Committee and Interdisciplinary Team that the program no longer successfully meets the person's needs. A 60 day notice prior to ending services will be given to the guardian and MCO unless continuation of services would put the client or others in danger (medical or behavioral issues).

Skill Creations, Inc.
ICF/IID Admission Application

Date application completed: ______________________________MCO:__________________

Applicant's Name: ____ Sex: ________________
Last **First** **Middle**

Applicant's Birthdate: ______________________ County of Residence: _________________

Applicant's Home Address: ____

Home Phone: ________________ Applicant's Social Security #: ______________________

Applicant's Medicaid Number: ____________________ Medicaid County: ______________

Parent or next of kin's name: ____

Next of kin's address: ____

Next of kin's phone: HOME: __________________ WORK: __________________________

Date of Incompetence Adjudication: _______________ County: _______________________

Name & Phone # of Legal Guardian: ____

Legal Guardian's Address: ____

NATURAL FATHER'S NAME:

____

Date of Birth: __________________ County of Birth (if NC): ___________________________

Home Address (If different from applicant): ____
(Street)

Home Phone: ____________________ ____
(Area) **(City)** **(State)**

Marital Status: ____________________________ Education: __________________________

Place of Employment: ____

Working Hours: ________________________ Telephone: _____________________________
(Area)

Skill Creations, Inc.
ICF/IID Admission Application

NATURAL MOTHER'S NAME:

____

First **Maiden** **Last**

Date of Birth: ____________________ County of Birth (if NC): ____________________________

Home Address (If different from applicant): ____
(Street)

Home Phone: _____________________ ____
(Area) **(City)** **(State)**

Marital Status: ______________________________ Education: ____________________________

Place of Employment: ____

Working Hours: __________________________ Telephone: ______________________________
(Area)

Are both parents in the home? ☐ Yes ☐ No If no, please explain: _____________________

____

Names of all children in family: Date of Birth

____

____

____

____

Names of other residing in home: Date of Birth Relationship

____

____

____

____

PHYSICAL/MEDICAL INFORMATION

Please list and explain any physical handicaps and/or severe & chronic medical problems:

____

____

____

____

(Use other side for continuation if needed)

Allergies (food and/or medication) ____

____

List name(s) of all hospitalizations (including birth) or residential placements and reasons. Also include any Centers or programs that have evaluated the applicant: (Use additional sheet, if necessary.)

____

____

Immunizations: Are they up to date? ☐ Yes ☐ No
(Please send copy of immunization record)
Does the applicant have seizures? ☐ Yes ☐ No
If yes, are they under control? ☐ Yes ☐ No
How many average per week/month? ____________________________

Is the applicant presently on any medication? ☐ Yes ☐ No If yes, what medication and why? (Please list below)

Name of Medication	Dosage	Reason

Current Physician Name and Address: ____

____

DENTAL INFORMATION:

Name and address of applicant's dentist: ____________________________________
When was the last time the applicant was seen by the dentist? ____________________
Was all work done which the dentist recommended? ☐ Yes ☐ No
If no, what work needs to be done? ____

INFORMATION ON BEHAVIOR:

Does applicant have temper tantrums? ☐ Yes ☐ No
If yes, how often and what does he/she do to hurt himself? _______________________

____

____

Is the applicant aggressive toward other children or adults? ☐ Yes ☐ No
If yes, how frequently and what type of aggressive behavior does he/she have? ____________

____

____

Does the applicant run away? ☐Yes ☐ No If yes, how frequently? _______________
Describe any other inappropriate behaviors the applicant may have: ________________

____

____

COMMUNITY INVOLVEMENT:

Does the applicant attend any programs in your community? ☐ Yes ☐ No
If yes, complete the following:

Name of Program	Address	Type of Program	Hours Per Day	Number Mo.'s per Year

Does the program(s) meet all of the applicant's needs? If no, what needs does it not meet?

____

____

Is the client receiving any professional treatment (i.e. Physical Therapy, Occupational Therapy, Speech Therapy, etc.) now? ☐ Yes ☐ No
If yes, list names of therapists, their address, and specialty:

____

____

____

Does the client have any criminal offenses on their record? ☐ Yes ☐ No

Is the client in an active relationship with the court system? ☐ Yes ☐ No

If yes, please include details:

____

____

SELF-HELP INVENTORY

1. **VISION:**
   - ☐ Unknown
   - ☐ Unknown, but impairment suspected
   - ☐ Has no useable vision
   - ☐ Has limited vision
   - ☐ Sees without difficulty

2. **HEARING:**
   - ☐ Unknown
   - ☐ Unknown, but impairment suspected
   - ☐ Has no useable hearing
   - ☐ Has limited hearing
   - ☐ Hears without difficulty

3. **AMBULATION:**
   - ☐ Unable to crawl or walk
   - ☐ Crawls or rolls
   - ☐ Stands but cannot walk
   - ☐ Walks with assistance
   - ☐ Walks without assistance

4. **LOCOMOTION:**
   - ☐ Cannot walk
   - ☐ Requires extensive support if moved
   - ☐ Can walk but must be lead
   - ☐ Can walk-need not be lead
   - ☐ Uses adaptive equipment (i.e. Wheelchair, walker, braces, etc.) Specify type used: _____

5. **ARM/HAND USE:**
   - ☐ No use of hands/arms
   - ☐ Gross use of one arm/ hand only
   - ☐ Gross use of both arms/hands
   - ☐ Gross and fine use of one arm/hand
   - ☐ Gross and fine use of both arms/hands

6. **COMMUNICATION TO OTHERS:**
   - ☐ No meaningful communication recognized
   - ☐ Communicates by signs and sounds
   - ☐ Speech somewhat difficult to understand
   - ☐ Communicates well enough to make needs known

7. **PLACE ORIENTATION:**
   - ☐ Would be lost if left on own in living area
   - ☐ Knows way around home
   - ☐ Can go about home alone
   - ☐ Can leave home alone

8. **COMMUNICATION FROM OTHER:**
   - ☐ Does not respond to prompts, gestures, or verbal commands
   - ☐ Responds to verbal commands with prompts and gestures
   - ☐ Responds to simple verbal commands
   - ☐ Understands verbal communications

9. **ADAPTABILITY:**

- ☐ Adjusts slowly to new environments
- ☐ Adjusts slowly to new people caring for him/her
- ☐ Adapts quickly to new environments and new care takers

10. **BATHING & PERSONAL HYGIENE:**

- ☐ Must be bathed
- ☐ Must have teeth brushed
- ☐ Requires help (bathing)
- ☐ Requires help (teeth)
- ☐ Bathes self
- ☐ Brushes own teeth/dentures
- ☐ Cares for self during menstruation

11. **DRESSING**

- ☐ Must be dressed
- ☐ Requires much help
- ☐ Requires little help
- ☐ Dresses self except for buttons, zippers, or laces
- ☐ Dresses self completely

12. **GROOMING:**

- ☐ Makes no effort to stay neat and clean
- ☐ Makes little effort to stay neat and clean
- ☐ Will stay neat and clean if prompted
- ☐ Stays neat and clean without prompting
- ☐ Shaves when needed
- ☐ Can take care of own laundry

13. **TOILET TRAINING:**

- ☐ Physical disability prevents training
- ☐ Not in training for reasons other than physical disability
- ☐ In training-does not make needs known
- ☐ In training-makes needs known
- ☐ Trained for bowel movements
- ☐ Trained for urination
- ☐ Wears diapers
- ☐ Wears training pants
- ☐ Wets self at night
- ☐ Wets self during day
- ☐ Toilets independently

14. **EATING SKILLS:**

- ☐ Feeds self with spoon
- ☐ Feeds self with spoon & fork
- ☐ Drinks from cup alone
- ☐ Drinks from cup using straw
- ☐ Uses all eating utensil appropriately

SPECIFY:

Food allergies: ______________________________
Food preferences: ____________________________
Food Dislikes: _______________________________
Describe applicant's appetite: _________________

Specify feeding techniques or problems such as special preparation of food, special positioning : ________
Special diet: ________________________________

15. **SLEEPING:**

- ☐ Sleeps in room alone
- ☐ Sleeps in room with others
- ☐ Usually sleeps soundly
- ☐ Usually wakes up at night (specify # of times per Night and length of time Awake each time): ____

16. **LEISURE ACTIVITIES**

- ☐ Stays to himself
- ☐ Prefers being alone, but will interact with others
- ☐ Interacts only when others initiate it
- ☐ Enjoys being with others

SPECIFY:
Favorite indoor activities: ____________________
Favorite outdoor activities: ____________________

17. **FINANCIAL CAPABILITIES:**

- ☐ Can identify coins and bills
- ☐ Knows value of coins and bills
- ☐ Can make change
- ☐ Handles own personal spending money
- ☐ Needs assistance in caring for personal finances, to include spending money

18. **HOUSEHOLD SKILLS:**

- ☐ Can do simple chores when supervised
- ☐ Keeps own room neat and clean
- ☐ Can prepare a snack for himself/herself
- ☐ Has no household skills

CHECKLIST COMPLETED BY: ____
PLEASE PRINT NAME/RELATIONSHIP

BENEFIT AND FINANCIAL INFORMATION

Is the applicant currently receiving Medicaid benefits? ☐ Yes ☐ No

If yes, please provide Medicaid number and County: ________________________________

If receiving Medicare, provide number: ____

If applicant is not receiving Medicaid, date of application for Medicaid: __________________

County applied in (Social Services): ____

Does the applicant receive any benefits from the Social Security Administration (example: Survivor benefits, Supplementary Security Income)? ☐ Yes ☐ No

If yes, please tell us the type and amount of the benefit: ____________________________

Does the applicant receive any other income? _____________________________________

If yes, how much per month? $____

What kind of income is it?

____

Does the applicant have a savings account, trust account, or other type of asset? ☐ Yes ☐ No

If yes, please explain: ____

MISCELLANEOUS INFORMATION:

Date applicant received psychological testing: ______________________________

Level of intellectual disability indicated by evaluation: ______________________________

Name of person completing this application: ______________________________

Relationship to applicant: ____________________ Phone#: ______________________

I give voluntary consent to Skill Creations, Inc. to share this application and information with the Managed Care Organization (MCO/ LME) that covers the county of residence.
My signature below indicates consent to share this information.

LEGAL GUARDIAN'S SIGNATURE: ______________________________

WITNESS: ______________________ /______________________
NAME PRINTED SIGNATURE

I give voluntary consent to Skill Creations, Inc. to share this application and information to Rubicon Management, Inc. (an administrative service organization) that covers the county of residence. Sharing of the information will allow for consideration for services by other providers that may have openings. I fully understand that refusal to share the application and information will not impact consideration of my application for services with Skill Creations, Inc.
My signature below indicates consent to share this information.

LEGAL GUARDIAN'S SIGNATURE: ______________________________

WITNESS: ______________________ /______________________
NAME PRINTED SIGNATURE

****

TO BE COMPLETED BY CHAIRMAN OF SCI ADMISSION COMMITTEE ONLY

Date reviewed by Admission Committee: ______________________________

☐ Admission Approved ☐ Admission Denied

Reason for approval of Denial:______________________________

____

Chairman's Signature: ______________________ Date: ______________

ADMISSION DATE:______________________ (IF APPLICABLE)

CLIENT RIGHTS AND RESPONSIBILITIES

Each client receiving care from Skill Creations shall have the following rights:

1. To be fully informed, at the time of admission and annually thereafter, of services available from Skill Creations and of any charges for service. This includes full information about client rights which are available for review at all times, with clarification as needed.
2. To participate in the development and future changes in his/her plan of care.
   a. To have a plan that is age appropriate, by asking appropriate QP..
   b. To have an individual plan of care written and implemented within 30 days of admission.
   c. To be provided with a copy of his/her plan of care.
   d. To meet as requested with the agency or individuals/agencies of their choice in regards for provision of services.
3. To be fully informed, in advance, of any changes in the services to be provided by Skill Creations.
4. To voice grievances/complaints about his/her care and not be subject to discrimination or reprisal for doing so.
5. To accept or refuse treatment to the extent permitted by law and to be informed of the consequences of such refusal.
6. To be assured confidential treatment of personal and service records and to approve or refuse their release to any individual outside the agency.
7. To be treated with respect, consideration and full recognition and individuality, including privacy in treatment and in care for personal needs.
8. To be assured that the personnel who provide care are qualified through education and experience, to carry out the services for which they are responsible.
9. To be notified of the services to be provided and the schedule of services.
10. To formulate advance directives that describe the clients desires relating to his/her medical care.
11. To be fully informed about any changes for services to be provided and about expected payments from other sources.
12. To be informed of the process for acceptance and continuance of service and eligibility determination.
13. To be informed of the agency's on call system.
14. To be informed of supervisory accessibility and availability.
15. To be advised of the agency's procedures for discharge.
16. To manage his/her personal financial affairs or request assistance in writing when necessary.
    a. To make purchases.
    b. To withdraw and deposit money.
    c. To have assistance and support to invest money.
17. To be free from abuse, neglect, mistreatment and unauthorized restraint.
18. To have dignity, humane care, and freedom from mental and physical abuse, neglect, and financial or other exploitation.
19. To be free from performing services that does not qualify as training activities.
20. To receive or refuse visitors at any time.
21. To live in an unlocked environment in SCI residential programming.
    a. To have the freedom to decorate a living area in accordance with facility rules.
    b. To have quiet atmosphere in order to rest.
    c. To have the choice of visits in the community.

   d. To have access to exercise options.
   e. To have rights to have proper daily hygiene.
   f. To have the right for proper hair care.
   f. To have daily provisions for linens, appropriate supplies and hygiene products that are needed to meet the individual's needs (toothpaste, hair products, shaving cream, feminine products, etc.)
   g. Adequate bathroom facilities for all client needs.
   h. To have efforts made on your behalf to protect your personal clothing and possessions from theft, destruction, loss, or misplacement.

22. To be free from exclusion of ongoing programming as a result of inappropriate behavior.
23. To be free of cruel and unusual punishment.
24. To make and receive confidential telephone calls; to receive and send mail that is not censored and have access to writing materials, postage, and staff assistance when needed.
25. To have access to individual locked storage space in residential facilities if requested.
26. To participate in co-educational programs.
27. To have the right to marry, divorce, procreate and raise children.
28. To be free from any loss of meal for programmatic or other reasons.
29. To receive the telephone number and contact for the Disability Rights North Carolina (DRNC): 1-877-235-4210.
30. To receive explanation of Client Rights and Responsibilities in a manner consistent with comprehension.
31. To have the right of freedom of speech and expression. .
32. To have the right to equal employment opportunities.
33. To have the right to vote.
34. To contact legal counsel of choice.
35. To dispose of property
36. Execute documents
37. Enter contracts
38. To be assured of the right to dignity and humane care in the provision of personal health, hygiene and grooming.
39. To have choice of providers and adequate prevention and treatment interventions for all mental and physical ailments.
40. To be free from unnecessary medications and for medications not to be used for punishment or staff convenience.
41. To have an opportunity for an education and employment opportunities.
42. Right to have copy of discharge plan at time of discharge with any recommendations as needed.
43. Right to freedom from retaliation of expressing opinions, concerns, complaints, or making any statements about your rights/desires, and services.
44. To be free from humiliation.

As a client of Skill Creations, you have a responsibility to:

1. Provide accurate and complete information about your condition and needs as well as an accurate financial history regarding ability to pay for services.
2. Notify the agency of any changes in situation that will affect the agreed upon services you are receiving.
3. Notify a Skill Creation agency representative at 1-877-377-3112 (toll free) of any

problems, concerns or complaints with services. Unresolved complaints may be reported to the Division of Health Service Regulation complaint hotline at (919) 855-4500 or 1-800-624-3004 (within NC).

4. Comply with the care plan that was jointly developed.
5. Notify the agency of any advance directive or changes in these documents.
6. Request information and ask questions.
7. Provide and maintain a safe home environment.

SIGNATURE of RECEIPT & AWARENESS of THESE RIGHTS AND RESPONSIBILITIES

___________________________	___________________________
Client or Legal Guardian of the Client	Witness
___________________________	___________________________
Printed Name of Above Signature	Printed Name of Above Signature
________________	________________
Date	Date

Client Rights - Page 3 of 3

1001 CLIENT/GUARDIAN GRIEVANCE PROCEDURE

A. Skill Creations defines a grievance as an issue which is brought forth to any Skill Creations employee for clarification or correction. This grievance is something that is voiced in communication and not formally documented in writing. These grievances may come from clients, guardians, family members, employees, stakeholders and other community members.

B. Skill Creations defines a formal complaint as an issue or problem that is brought forth to any Skill Creations employee for correction in writing. This writing can be through email, letter or a formal statement after a conversation. These complaints may come from clients, guardians, family members, employees, stakeholders, regulatory agencies and other community members.

C. At any time a Skill Creations staff receives a grievance or a formal complaint the appropriate staff (ICF- Facility Director, Comm Ops- Executive Director, COO-Child Development) will respond within 24 hours of receiving the complaint or grievance. At that time information of the grievance or complaint will be documented on a log for tracking purposes.

D. If the individual making the grievance or complaint is not satisfied with the Response, then contact (either verbal or in writing) to the Chief Operations Officer for Corporate Relations. The Chief Operations Officer shall respond to the individual making the complaint within 24 hours. The Chief Operations Officer can be reached by calling 919-734-7398 extension 1227 or in writing at:

   Skill Creations
   Attn: COO Corporate Relations
   PO Box 1664
   Goldsboro, NC 27533-1664

E. If the individual making the grievance or complaint is not satisfied with the response they shall send written communication to the Chief Executive Officer who will respond within 24 hours after receipt of the complaint. Written communication can be sent to:

   Skill Creations
   Attn: CEO
   PO Box 1664
   Goldsboro, NC 27533-1664

F. If the individual making the grievance or complaint is not satisfied with the response they shall send written communication/ appeal to the Chairperson of the Board of Directors. All actions/decisions of the Board are final. Written communication can be sent to:

   Skill Creations
   Attn: Board of Directors
   PO Box 1664
   Goldsboro, NC 27533-1664

G. A copy of this policy section shall be given to all clients and/or guardians.

H. A copy of the Clients Rights and Responsibilities policy is also given to all clients and/or guardians.

I. At any point during this process, the individual making the grievance or complaint has the right to contact the Division of Health Service Regulation complaint hotline at 919- 855-4500, or 1-800-624-3004 (within NC) to voice any issues.

J. At any point during this process, the individual making the grievance or complaint has the right to request the availability of local advocates or other assistance. Disability Rights NC can be contacted at 1-877-235-4210.

K. The initial point of contact will follow the formal complaint through this process, and document on appropriate form. This form will be submitted to the Quality Management Department to be reviewed quarterly to identify trends/patterns and to identify areas needing performance improvement. Review of these items will be documented in Quality Management minutes and sent to Management for review. A yearly analysis of complaints will be compiled by Quality Management and submitted to Management. This analysis will include whether formal complaints were received, trends/patterns identified, areas that needed performance improvement, and the actions taken or changes made to improve performance. This analysis is available for external review.

L. It is the responsibility of Skill Creations to protect individuals served from retaliation. Skill Creations will not allow retaliation towards an individual for making any complaint, grievance, or for voicing an opinion or concerns.