



Admission Criteria:

An applicant for a Skill Creations, Inc. residential facility must meet the current eligibility criteria for this service.

For ICF admission:

ICF 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. It is preferred that an adult applicant have a legal guardian prior to placement.

For other residential admissions:

Applicants must require the level of care provided in the residential setting and have a diagnosis of Intellectual Disability or a condition that is closely related to intellectual disability. The applicant must be qualified to receive funding to pay for the placement such as Medicaid benefits, or be financially able to pay for private placement at the current daily rate utilized by the facility. It is preferred that an adult applicant have a legal guardian prior to placement.

The screening /admission committee will consider the following factors when determining if individual is appropriate for admission:

1. Applicants with severe disruptive, aggressive, and/or destructive behaviors will be carefully screened and assessed to assure the location can meet their needs and the safety of the other individuals in the home.
2. Applicants with severe or chronic medical problems will be assessed by our medical professionals to assure the location can meet the needs of the individual.
3. Ambulation status may be considered in order to meet the needs of the individual.

Submitting the following information will help the Admission Committee to better process your application:

1. A completed signed application
2. Legal Guardianship information
3. A psychological evaluation within the past 5 years
4. Previous psychological evaluation or historical information to substantiate IDD diagnosis prior to age 18
5. Medical history and a list of current medications
6. Immunization history



Skill Creations, Inc.
Eastern Region Residential Admission Application

Application Form and additional attachments can be submitted (by mail, secure email or fax) to:

Mary Katherine Hackmann
Director of Admissions
P.O. Box 1664
Goldsboro, NC 27533-1664
Admissions@skillcreations.com

FAX: 919-648-2772

Residential 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 current 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 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.

Exit Criteria:

A client will be discharged at any time at the request of the guardian. A two-week notice of intent is requested. Skill Creations may consider discharge 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).

ICF Person Centered Planning Process:

Within 30 days of admission, you will be invited to the Person Centered 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.



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Marital Status: _____ Education: _____

Place of Employment: _____

Working Hours: _____ Telephone: _____
(Area)

NATURAL MOTHER'S NAME:

Date of Birth: _____ County of Birth (if NC): _____
First Maiden Last

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:



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(Use other side for continuation if needed)

Allergies (food and/or medication) _____

List name(s) of all hospitalizations or residential placements and reasons. 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, use additional sheet if necessary)

<u>Name of Medication</u>	<u>Dosage</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 behavioral outbursts? Yes No

If yes, how often? Please describe the outburst _____

Does applicant have behaviors where he/she injures himself? Yes No



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If yes, how often? Please describe the behavior

Is the applicant aggressive toward other individuals? Yes No
If yes, how frequently and what type of behavior?

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:

Table with 5 columns: 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 currently? (i.e. Physical Therapy, Occupational Therapy, Speech Therapy, etc.) 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:



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Does the applicant have Innovations Waiver funding? Yes No

Does the applicant receive other funding or services through the MCO? Yes No

If yes, please include details:



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SELF-HELP INVENTORY

1. **VISION:**

Unknown

Has no useable vision

Unknown, but impairment suspected

Has limited vision

Sees without difficulty

2. **HEARING:**

Unknown

Has no useable hearing

Unknown, but impairment suspected

Has limited hearing

Hears without difficulty

3. **AMBULATION:**

Unable to crawl or walk

Walks with assistance

Crawls or rolls

Walks without assistance

Stands but cannot walk

4. **LOCOMOTION:**

Cannot walk

Can walk-need not be lead

Requires extensive support if moved

Uses adaptive equipment (i.e. Wheelchair, walker, braces, etc.)

Can walk but must be lead

Specify type used: _____

5. **ARM/HAND USE:**

No use of hands/arms

Gross and fine use of one arm/hand

Gross use of one arm/ hand only

Gross and fine use of both arms/hands

Gross use of both arms/hands

6. **COMMUNICATION TO OTHERS:**



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- 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



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- 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 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?



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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#: _____

Name of Care Coordinator: _____

Name of MCO contact (if different): _____

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.

CLIENT OR LEGAL GUARDIAN’S SIGNATURE:

_____/_____
NAME PRINTED SIGNATURE