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 22
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.

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.

Date application completed _____MCO:_____

APPLICANT INFORMATION

Name: _____ Sex: _____
Last First Middle

Birthdate: _____ County of Residence: _____

Home Address: _____

Home Phone: _____ Social Security #: _____

Race: _____ Religious Preference: _____ Place of Birth: _____

Medicaid Number: _____ Medicaid County: _____

Medicare Number: (if applicable) _____

Parent/Guardian or Next of Kin's name: _____

Guardian/ Next of Kin address: _____

Guardian/Next of Kin's phone: HOME: _____ WORK: _____

Date of Incompetence Adjudication: _____ County: _____

Name of Legal Guardian (if different from above): _____

Legal Guardian Phone (if different from above): _____

Legal Guardian's Address (if different from above): _____

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)

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 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)

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 behavioral outbursts? ☐ Yes ☐ No
If yes, how often? Please describe the outburst _____

_____

_____

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

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:

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:

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:

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 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#: _____

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