Skill Creations, Inc.
Eastern Region Residential Admission Application

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 and 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

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

Mary Katherine Hackmann
Executive Director of Admissions – East
P.O. Box 1664
Goldsboro, NC 27533-1664

Admissionseast@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 review potential applicants, as requested for admission upon receipt of the application and requested information. At the time of review, 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.

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DATE APPLICATION COMPLETED _______________________MCO:___________________

APPLICANT INFORMATION

Name: ____ Gender: ______________

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)*: ____

PSYCHOLOGICAL TESTING INFORMATION:

Date applicant received their most recent psychological testing: _______________________________

Level of intellectual disability indicated by evaluation: ______________________________________

Location and Physician's Name:____

(Please send copy of the psychological evaluation.)

FATHER'S NAME: _____

Date of Birth: _____________________ County of Birth (if NC): ______________________________

Home Address (If different from applicant):____

(Street)

Phone: ____________________________ ____

(City) **(State)**

Marital Status: ________________________________ Education: _____________________________

Place of Employment: ____

Working Hours: ____________________________ Telephone: ________________________________

MOTHER'S NAME: ____

First **Maiden** **Last**

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

Home Address (If different from applicant): ____

(Street)

Phone: ___________________________ ____

(City) **(State)**

Marital Status: ______________________________ Education: ___________________________

Place of Employment: ____

Working Hours: ___________________________ Telephone: _____________________________

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:

____

____

____

____

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.)*

____

____

Allergies (food and/or medication) ____

____

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 on 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? ____

BEHAVIOR INFORMATION:
Does applicant have behavioral outbursts? ☐ Yes ☐ No
If yes, please describe the frequency and behavior. ____________________________

____

____

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

If yes, please describe the frequency and behavior. ______________________________

____

____

Is the applicant aggressive toward other individuals? ☐ Yes ☐ No

If yes, please describe the frequency and 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 of 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:

____

____

BENEFIT AND FINANCIAL INFORMATION

Is the applicant currently receiving Medicaid benefits? ☐ YES ☐ NO

If no, date of application for Medicaid: ________ County applied in (Social Services): _______

Does the applicant receive any benefits from the Social Security Administration *(i.e. 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, what kind of income and how much per month? ______________________________

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

If yes, please explain: ______________________________

MISCELLANEOUS INFORMATION:

Name of person completing this application: ______________________________

Relationship to applicant: __________________ Phone#: ______________________

Name of Care Coordinator: __________________ Name of MCO contact *(if different):* _____

SELF-HELP INVENTORY CHECKLIST

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

Vision Details:

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

Hearing Details:

3. **AMBULATION:**
   - ☐ Unable to ambulate (skip section 4)
   - ☐ Crawls or rolls
   - ☐ Stands but cannot walk
   - ☐ Walks with assistance
   - ☐ Walks without assistance

Ambulation Details:

4. **LOCOMOTION:**
   - ☐ Cannot walk
   - ☐ Requires extensive support if moved
   - ☐ Can walk, but must be lead
   - ☐ Uses adaptive equipment (wheelchair, walker, braces, etc)
     Specific type used: _____
   - ☐ Can walk without assistance

Locomotion Details:

5. **ARM/HAND USE:**
   - ☐ No use of arms/hands
   - ☐ 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

Arm/Hand Use Details:

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

Communication Details:

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

Place Orientation Details:

8. **ADAPTABILITY:**
   - ☐ Adjusts slowly to new environments
   - ☐ Adjust slowly to new care takers
   - ☐ Adapts quickly to new environments and new care takes

Adaptability Details:

9. COMMUNICATION FROM OTHERS:

- ☐ Does not respond to prompts, gestures, or verbal commands
- ☐ Responds to verbal commands with prompts and gestures
- ☐ Responds to simple verbal commands
- ☐ Understands verbal communication
- ☐ Adapts quickly to new environments and new care takes

Communication Details:

10. BATHING & PERSONAL HYGIENE:

- ☐ Must be bathed
- ☐ Requires help with bathing
- ☐ Bathes Self
- ☐ Must have teeth brushed
- ☐ Requires help with teeth brushing
- ☐ Brushes own teeth/dentures
- ☐ *FEMALES:* Cares for self during menstruation

Hygiene Details:

11. DRESSING

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

Dressing Details:

12. GROOMING:

- ☐ Makes no effort to stay neat and clean
- ☐ Makes little effort to stay neat and clean
- ☐ With prompting, stays neat and clean
- ☐ Without prompting, stays neat and clean
- ☐ Shaves self when needed
- ☐ Takes care of own laundry

Grooming Details:

13. TOILET TRAINING:

- ☐ Physical disability prevents training
- ☐ 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 the day
- ☐ Toilets independently

Toileting Details:

14. EATING SKILLS:

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

Eating Details (include allergies, food likes/dislikes, appetite, special food preparation, feeding techniques, and/or diet consistency):

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: _____

Sleeping Details:

16. LEISURE ACTIVITIES:

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

Leisure Details (Include favorite indoor/outdoor activities):

17. FINANCIAL CAPABILTIES:

- ☐ 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, including spending money

Financial Details:

18. HOUSEHOLD CHORES:

- ☐ Can do simple chores while supervised
- ☐ Keeps own room neat and clean
- ☐ Can prepare a snack for themselves
- ☐ Has no household skills

Household Details:

SELF HELP INVENTORY CHECKLIST COMPLETED BY:
Please Print Name and Relationship:________

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