

Client Name: (last, first, middle)	(maiden)	AKA	Date
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The Enola Group
APPLICATION FOR ADMISSION

Applying for: **Signature Day Program** **Signature Living (AFL)**

Referring Agency: _____

Contact Person: _____ Phone: _____

Current Address:	Contact Numbers:
_____	Home: _____
_____	Work: _____
County: _____	Other: _____

Parent/Guardian Name: _____

Phone: _____ Email address: _____

Address: _____

Age:	DOB:	Gender / Gender Identity:	Race:
SSN:		Medicaid ID:	
Height:	Weight:	Language:	Religious Preference:
Special accommodations (i.e., wheelchair, interpreter, etc.):			

Emergency Contact: _____ Phone: _____

Address: _____

Primary Care Physician: _____

Primary Care Physician Phone: _____

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Current MCO:	Phone:
Current Care Coordinator:	
Care Coordinator Phone:	Email:
List Current Authorizations & Associated Services: (Innovations Waiver, State-Funded, etc.)	

Previous Services / Provider Agencies:

Previous Residences (include names, address, phone numbers):

Natural Supports (include names, address, phone numbers):

Cultural Considerations (religion, language, ethnicity, family composition, socio-economic, etc.):

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SCREENING

Presenting Need: _____ Date of Contact: _____

Current = within 1 year

History of = Documented occurrences prior to 1 year

Current	History of		Current	History of		Current	History of	
		Danger to Self			Danger to Others			Change in Biological Functioning
		None			None			None
		Thoughts of suicide			Thoughts to harm others			Sleep
		Threats of suicide			Threats to harm others			Nightmares
		Plan for suicide			Plan to harm others			Appetite
		Preoccupation with death			Felt like killing someone			Bed Wetting
		Suicide gesture			Attempts to harm others			Bowel Control
		Suicide attempts			Inability to care for dependents			Other:
		Inability to care for self			Legal / law involvement			
		Other:			Other:			
								Substance Abuse
								None
		Affect			Anti-Social Behavior			Alcohol
		Euphoric			Psychotic-like behavior			Other drugs:
		Depressed			Anxiety/Stress			
		Fearful			Manic-like behavior			Date of last use:
		Anxious			Depressive-like behavior			
		Apathetic						
		Flattened						
		Labile			Psychosis			Behavioral Supports
		Angry			None			Formal Behavior Support Plan
		Normal			Hallucinations			Date:
					Delusions			Benign Intervention:
					Formal Thought Disorder			Verbal Correction
		Abuse						Positive Redirection
		None						Specific Guidelines
		Physical			Behaviors of Concern			Restrictive Intervention(s)
		Sexual			Verbal abuse			Physical Restraints
		Emotional			Non-compliance			Psychotropic Medications
		Neglect			Combative			Time-Out
		Domestic Violence			Inappropriate behavior			Rights Restrictions
					Wandering			
		Trauma			Running away			
		Family violence			Injurious to:			
		Assault			Self			
		Severe Accident/Illness			Others			
		Bullying			Property Damage			
		Family hx of suicide						
		System-Induced						
					Other			Other
		Other						

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MEDICAL INFORMATION

Type	Name	Address	Phone
Primary			
Dentist			
(other) Specialist			
(other) Specialist			

Axis	Code	Diagnosis	Indicate Primary with "p"	Date of Onset
I				
II				
III				
IV				
V				

Current Target Population: _____ **Current SNAP Index:** _____ **Current SIS Score:** _____
 (if applicable) (if applicable)

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Medication Name	Dosage & Route	Schedule	Target Symptoms

List all known allergies (food/medication/animals/environmental):

Medical Concerns	Neurological	Adaptive Ability Level	Functional Limitations
Ostomy Care	Convulsions	Mild	
Esophageal Care	Seizures	Moderate	Vision:
History of decubitus ulcers	Grand Mal	Severe	Normal
Contractures	Petit Mal	Profound	Impaired
Diabetes	Frequency:		Blind
Type I		NC SNAP #:	
Type II			Hearing:
Hypertension	Other:		Normal
Insomnia			Deaf
		SIS Score:	Hard of Hearing
Contagious/Communicable Disease(s)?			Other:
If Yes, list:			
Supportive / Protective Devices			
None		Supportive Belts	
Wheelchair		Gait Belt	
Walker / Crutches / Braces		Bed Rails	
Hearing Aid		Lap Trays	
Glasses		Modified Shoes	
Dentures		Mittens / Splints	
Adaptive Clothing			
Adaptive Eating Utensils		Other:	
Helmet			

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ADAPTIVE BEHAVIOR / DAILY LIVING SKILLS

Communication	Bathing	Dining	Dressing
Verbal	Independent	Independent	Independent
Non-verbal	Minimal Assistance	Minimal Assistance	Minimal Assistance
Manual Sign Language	Maximum Assistance	Maximum Assistance	Maximum Assistance
Symbol Board	Total Assistance	Must be fed	Total Assistance
Gestural	Resistant	Special diet	Resistant
None	Other:	Parenteral	Other:
Other:		Tube Feed	
		Other:	
Toileting	Ambulation	Activities / Social	Sleeping Habits
Independent	Ambulatory	Passive	Sleeps through the night
Minimal Assistance	Semi-ambulatory	Active	Gets up for bathroom
Maximum Assistance	Propels self in w/chair	Swims	Sleeps some during day
Total Assistance	Dependent wheelchair	Yes	Incontinent at night
Wears diapers / Attends	Confined to bed	No	Difficulty sleeping
Other:	Ambulates w/assistance	Group Participation	Receives meds for sleep
	Other:	Re-socialization	Type/Dosage:
		Family Supportive	
		Activities to Avoid:	
			Other:

Need(s) as perceived by client or others:

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For Signature Living (AFL) only, please complete this page:

Personal Living Preferences: for purposes of determining appropriate match of person with provider family.

1. Are there any special considerations about your residential needs that we should know?

2. Have you ever lived in a group home, Alternative Family Living Home, or apartment?

3. Are you comfortable living with a family with: young children men women cat dog

4. What type of environmental adaptations are needed to make a living space accessible to you? (i.e., ramp, wheelchair-accessible entrance / bathroom / shower, etc.).

5. Do you prefer a private bathroom?

6. What hours of direct supervision will you need?

7. What kind of day services do you prefer:
 School Supplemental Employment Outside Work Signature Day Program

8. Do you have any unusual fears or preferences that might affect your interaction with others?

9. Do you have any specific cultural needs (religion/spirituality, language, ethnicity, socio-economic, etc.)?

10. List preferred contact persons and phone numbers:

11. Approved visitors and their relationship to you:

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With this application and attached Authorization to Use and Disclose Protected Health Information, I grant The Enola Group permission to perform any needed professional evaluations or assessments that may be necessary to meet the admission requirements for my son/daughter/dependent.

Guardian Signature _____ Date _____

The following items **MUST** be returned with this completed application to be considered for admission to The Enola Group services.

- Copy of proof of guardianship
- Current Psychological Evaluation (completed within 3 years)
- Social History / Educational History / Legal History / Trauma & Abuse History
- Medical History (past and present)
- Current Physical Exam (within 1 year prior to date of application) (AFL only)
- Dental Exam (within 6 months prior to date of application) (AFL only)
- Immunization Records (AFL only)
- Signed Authorization to Use and Disclose Protected Health Information
- Copy of complete Person-Centered Plan / Individual Service Plan
- Copy of current Risk Assessment and Crisis Plan
- Copy of current NC SNAP and/or SIS Evaluation
- Copy of current Positive Behavior Support Plan

Another requirement for admission to The Enola Group AFL home is an initial screening within 24-hours prior to admission to identify the need for any immediate medical care and to assess for any communicable diseases.

Attached is a copy of the medical clearance form to be completed by a Licensed Physician 24-hours prior to admission.

If you have any questions regarding this application, please call:

Adult Services Director
 Karin McDaniel, Director
 828-604-4906, ext. 455

Signature Services Director
 Liz Curtis
 828-433-0056

This form was completed by (print name) _____, and is an accurate representation of the applicant.

Signature/Title of Person Completing Form _____ Date _____

**Please return completed application to The Enola Group, PO Box 250, Morganton, NC 28680.
 INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.**

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The Enola Group
MEDICAL CLEARANCE FORM

(MUST be completed by a Licensed Physician 24-hours prior to admission to AFL Home)

MEDICAL HISTORY

<input type="checkbox"/> Surgery:	<input type="checkbox"/> Cancer:
<input type="checkbox"/> Blood Pressure (high, low):	<input type="checkbox"/> Head Injury:
<input type="checkbox"/> Heart Disease / Stroke:	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Liver Disease or damage	<input type="checkbox"/> Sensory Impairments
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Thyroid or Goiter problems	<input type="checkbox"/> Epilepsy / Seizure How often:
<input type="checkbox"/> Infectious disease (HIV, TB)	<input type="checkbox"/> Difficulty Urinating
<input type="checkbox"/> Hepatitis (type):	<input type="checkbox"/> Abuse (Physical/Sexual/Neglect, etc.):
<input type="checkbox"/> Diabetes (type):	<input type="checkbox"/> Special diet (type):
<input type="checkbox"/> Allergies:	<input type="checkbox"/> Other:

Medical concerns that require immediate care:

Any Communicable Diseases? YES NO

If yes, please list:

Current Medications

Name of Medication	Dose	Purpose of Medication

Attach more pages as necessary

Physician's Signature

Date