| Client Name: (last, first, middle) (maiden) | AKA | Date |
|---|---|---|
| | | |

The Enola Group
Adult Services

# 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:

| Client Name: (last, first, middle) (maiden) | AKA | Date |
|---|---|---|
| | | |

| 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.):**

| Client Name: (last, first, middle) (maiden) | AKA | Date |
|---|---|---|
| | | |

# 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 | | | | At risk for trips / falls |
| | | Inability to care for self | | | | Legal / law involvement | | | | Other: |
| | | Other: | | | | Other: | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | **Affect** | | | | **Anti-Social Behavior** | | | | **Substance Abuse** |
| | | Euphoric | | | | Psychotic-like behavior | | | | None |
| | | Depressed | | | | Anxiety/Stress | | | | Alcohol |
| | | Fearful | | | | Manic-like behavior | | | | Other drugs: |
| | | Anxious | | | | Depressive-like behavior | | | | |
| | | Apathetic | | | | | | | | Date of last use: |
| | | Flattened | | | | | | | | |
| | | Labile | | | | **Psychosis** | | | | |
| | | Angry | | | | None | | | | |
| | | Normal | | | | Hallucinations | | | | **Behavioral Supports** |
| | | | | | | Delusions | | | | Formal Behavior Support Plan |
| | | | | | | Formal Thought Disorder | | | | Date: |
| | | **Abuse** | | | | | | | | Benign Intervention: |
| | | None | | | | | | | | Verbal Correction |
| | | Physical | | | | **Behaviors of Concern** | | | | Positive Redirection |
| | | Sexual | | | | Verbal abuse | | | | Requires Specific Guidelines |
| | | Emotional | | | | Non-compliance | | | | Restrictive Intervention(s) |
| | | Neglect | | | | Combative | | | | Physical Restraints |
| | | Domestic Violence | | | | Inappropriate behavior | | | | Psychotropic Medications |
| | | | | | | Wandering | | | | Time-Out |
| | | **Trauma** | | | | Running away | | | | Rights Restrictions: (list) |
| | | Family violence | | | | Injurious to: | | | | |
| | | Assault | | | | Self | | | | |
| | | Severe Accident/Illness | | | | Others | | | | |
| | | Bullying | | | | Property Damage | | | | |
| | | Family hx of suicide | | | | | | | | |
| | | System-Induced | | | | | | | | |
| | | | | | | **Other** | | | | **Other** |
| | | | | | | | | | | |
| | | **Other** | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

| Client Name: (last, first, middle) (maiden) | AKA | Date |
|---|---|---|
| | | |

# 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)**

| Client Name: (last, first, middle) (maiden) | AKA | Date |
|---|---|---|
| | | |

| Medication Name | Dosage & Route | Schedule | Target Symptoms |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |
| | | | |

**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 / AFOs | Bed Rails |
| | Hearing Aid | Lap Trays |
| | Glasses | Modified Shoes |
| | Dentures | Mittens / Splints |
| | Adaptive Clothing | |
| | Adaptive Eating Utensils | **Other:** |
| | Helmet | |
| | | |

| Client Name: (last, first, middle) (maiden) | AKA | Date |
|---|---|---|
| | | |

# 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:** | | Family Supportive | | Type/Dosage: |
| | | | | | Preferred Activities: (list) | | |
| | | | | | | | |
| | | | | | | | **Other:** |
| | | | | | | | |
| | | | | | Activities to Avoid: (list) | | |
| | | | | | | | |
| | | | | | | | |

## Need(s) as perceived by client or others:

| Client Name: (last, first, middle) (maiden) | AKA | Date |
|---|---|---|
| | | |

## 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 ☐ Supported 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:

| Client Name: (last, first, middle) (maiden) | AKA | Date |
|---|---|---|
| | | |

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.***

| Client Name: (last, first, middle) (maiden) | AKA | Date |
|---|---|---|
| | | |

# The Enola Group

## MEDICAL CLEARANCE FORM

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

**MEDICAL HISTORY**

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