Beacon Specialized Living Services, Inc.

Initial Referral Information

Please send the referral back to Jennifer Milliken at fax number: 269-427-6027

If you have any questions, please call Jennifer's cell phone at 269-365-3815
or email: JMilliken@beaconserv.org

Or you may contact our corporate office at 269-427-8400
or email:

The PDF version is on our website link: http://www.beaconspecialized.org/Contact-1.php

CONFIDENTIAL

Persons completing this document and the Persons receiving the disclosed information may only further disclose consistent with the authorized purpose for which it is intended or disclosed. (MH 1748-[3])

Please answer the following questions related to the Consumer:

FIRST NAME: _____ MIDDLE: _____ LAST:_____

DATE OF BIRTH: _____ SSN:_____ GENDER:_____

RACE:_____ MARITAL STATUS:_____ CLIENT REF#: _____

VETERAN STATUS: _____ IS THERE A SURVIVING SPOUSE/ CHILD OF VETERAN: _____

PRIMARY LANGUAGE:_____

FUNERAL PROVISIONS, if applicable:_____

COURT ORDER?_____ IF SO, TYPE:_____ EXPIRES:_____

COUNTY WHICH ORDER WAS ISSUED?:_____

FUNERAL PROVISIONS AND PREFERENCES:_____

RELIGIOUS PREFERENCE:_____

CURRENT RESIDENCE/ADDRESS/PHONE:_____

_____

REFERRAL SOURCE CONTACT:

Name: _____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone#:_____ Fax#:_____

Email:_____

PHYSICIAN:

Name: _____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone#:_____ Fax#:_____

Email:_____

PSYCHIATRIST:

Name: _____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone#:_____ Fax#:_____

Email:_____

RESPONSIBLE AGENCY:

Name: _____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone#:_____ Fax#:_____

Email:_____

CASE MANAGER:

Name: _____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone#:_____ Fax#:_____

Email:_____

EMERGENCY CONTACT:

Name: _____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone#:_____ Fax#:_____

Email:_____ Relationship: _____

NEXT OF KIN:

Name: _____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone#:_____ Fax#:_____

Email:_____ Relationship: _____

GUARDIAN:

Name: _____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone#:_____ Fax#:_____

Email:_____ Relationship: _____

PAYEE/CONSERVATOR:

Name: _____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone#:_____ Fax#:_____

Email:_____ Relationship: _____

DIAGNOSIS:

Axis I:_____

Axis II:_____

Axis III:_____

Axis IV:_____

Axis V:_____

DIET: _____ **ALLERGIES:** _____

CONTRACTED SERVICES:

☐ **Case Management**

☐ **Psychiatric Services**

☐ **Individual Counseling**

☐ **Dialectical Behavior Therapy**

☐ **Behavior Treatment Plan**

☐ **Group Counseling**

☐ **Enhanced Staffing**

If Enhanced Staffing,
Explain:_____

ADVANCED DIRECTIVES:

Does Individual have an Advanced Directive? YES or NO If Yes, attach a copy.

Is there a Psychiatric Advance Directive? YES or NO If Yes, attach a copy

Does the Individual currently have Medicaid and/or Social Security Benefits? Y or N
(*if the Individual does have Benefits, please include Policy Number & Types of Policies*)

Will Beacon Staff need to assist Individual in applying for Benefits? Y or N

☐ **Medicaid:** **Medicaid Number/Plan:**_____

Spend down? Y or N **If yes, amount?**_____

☐ **Medicare:**

☐ **Part A** _____

☐ **Part B**_____

☐ **Part C**_____

☐ **Part D**_____

☐ **Medicare Advantage Plan:**_____

☐ **Private Insurance** (*name of plan and ID number*):_____

Does this Individual have current insurance cards *(not copies)***? Y or N**

If no, can physical cards be requested? Y or N

Does Individual receive SSI (Supplemental Security Income)? Y or N

If so, how much do they receive a month?:_____

Does this individual have a valid state ID? Y or N

Is Individual under 26 years of age? Y or N

If so, would they be interested in the School Program? Y or N

Current IEP (Individualized Education Program)? Y or N
(please attach copy or give us the last known school attended)

_____

Is the Individual a Diabetic? Y N

If Yes, does the Individual have a Guardian? Y N

Any Medication Compliance Issues? Y N

Explain:_____

Is the Individual a Suicide Risk? Y N

Is the Individual a Threat or Danger to others? Y N

Does the Individual have Thoughts of Harm to others? Y N

Has the Individual had any recent Threatening Behaviors? Y N

Is there any presence of other High Risk Behaviors? (ie: cutting, head hanging, elopement, self injurious behavior, poor or dangerous relationships, risk taking, etc…) Y N

_____

Does this Individual appear to be compatible with other individuals in the home?
Are there any foreseeable problems? **Y N**

_____

Does this Individual require continuous nursing care? Y N

_____

Does this Individual require isolation for medial purposes? Y N

_____

Does this Individual require seclusion or restraint? Y N

_____

Does this Individual currently present an immediate danger to themselves or others?

_____

Is this an Individual who requires shelter only? Y N

What amount Personal Care does this Individual need? *Write in the amount of Personal Care the Referral Source indicates the Individual needs.*

_____

What amount of Supervision does this Individual need? *Examples of this would include supervision when in the community, line of sight, one on one*

_____

What amount of Protection does this Individual need? *Include whether the Individual has a high potential of being a victim of abuse.*

_____

What kind of Skills does the home need to have available to meet this Individuals needs?
Examples: nurse, social worker, therapist, gentle teaching, etc...

_____

What kind of Physical Accommodations does the home need to have to be able to meet this Individuals needs? *Examples: alarms, fence, staffing levels, handicap accessibility, etc...*

_____

PLEASE ATTACH THE FOLLOWING REQUIRED DOCUMENTS IF AVAILABLE:

Guardianship Paperwork
Health Care Appraisal
Current Psychiatric Evaluation
Any Psychological Assessments, etc.
Current Prescriptions
Clinical Certifications
Treatment Orders
Current Medication List, if applicable
Current Person Centered Plan
Behavior Plan, if applicable

Applicant Skills Inventory
Transitional Supported Living
(To be completed at referral, intake, and quarterly thereafter)

Applicant:_____ **Date:**_____

Person completing form:_____ **(must be someone other than the Consumer allpyling for services)**

Relationship:_____

Please evaluate the applicant according to his/her current skill level. Use the following scale and indicate one letter per task area.

A = No skill in this area
B = Needs maximum assistance
C = Needs minimum assistance
D = Completes task with reminder, but needs no assistance
E = Completes skill independently
NA – Not Applicable

1. Replaces clean linens on bed properly _____
2. Safe use of knives: carries knife by handle, cuts away from self, selects appropriate knife size _____
3. Safe use of stove and oven: adjusts temperature, arranges racks, turns oven and stove off when not in use _____
4. Daily kitchen clean-up: cleans, washes, dries and puts away dishes ____
5. Cooks food using stove or oven _____
6. Prepares foods that do not requires cooking _____
7. Menu planning: plans meals that are well balanced _____
8. Nutrition: can identify food from each of the four food groups ____
9. Grocery shopping: makes, uses and follows a grocery list _____

Use of the following appliances (electrical and manual):

_____ Coffee pot

_____ Mixer

_____ Toaster

_____ Garbage disposal

_____ Washer & dryer

_____ Can opener ☐ Manual ☐Electric

_____ Lamps

_____ Stereo

_____ Television

_____ Vacuum

_____ Dishwasher

_____ Microwave Oven

When appliances and utilities are not in use, does he/she take responsibility to turn them off? ☐ Y ☐ N

Demonstrates the following housekeeping skills:

_____ Clears clutter from a room

_____ Vacuuming

_____ Defrost the freezer

_____ Outdoor maintenance

_____ Trash disposal

_____ Oven cleaning

_____ Sweeping/Mopping

_____ Cleans inside/outside of toliet

Demonstrates the following safety skills:

_____ Uses key to lock house
- ☐ Dead bolt
- ☐ Chain
- ☐ Door Handle

_____ Uses key to enter house

_____ Lighting pilot in stove

_____ Uses telephone in emergency

_____ Crosses the street safely

_____ Uses cleaning products as labeled

_____ Regulates thermostat

_____ Carries Identification

_____ If smoker, smoking habits safe

Transportation

_____ Walks to/from

_____ Uses public transit

_____ Arrives on time for appointments

_____ Call for a taxi

_____ Drives own vehicle

_____ Bicycle

_____ Requires support for all

Money Management

_____ Knows total monthly income

_____ Handles SS/SSI check

_____Handles paycheck

_____ Maintains savings account

_____ Pays bills on time

_____ Understands budget concept

_____ Spends money on obligations before other items

Health

_____ Recognizes health problems requiring physician care

_____ Schedules and attends appointments as needed

_____ Takes prescription medication as prescribed

_____ Takes over-the-counter medication as labeled

_____ Need for a Special Diet

_____ Physical limitations

_____ Special Equipment (wheelchair, cane, walker, etc..)

_____ Weight Issues

_____ Allergies

_____ Vision problems

Social/Behavioral Needs

Communicates Needs Yes or No
Alert to Surroundings Yes or No
Understands Verbal Communication Yes or No
Reads and Writes Yes or No
Tells Time Yes or No
Follows Instructions Yes or No
Controls Aggressive Behavior Yes or No
Controls Sexual Behavior Yes or No
Gets along with others Yes or No
Exhibits self injurious behavior Yes or No

Appropriately uses alcohol and drugs Yes or No

Self Care Assessment

Needs Assistance with:

Eating Yes or No
Toileting Yes or No
Dressing Yes or No
Personal hygiene Yes or No
Walking mobility Yes or No
Use of prosthesis (dentures, limbs, etc.) Yes or No
Use of assistive devices Yes or No

Social Activities

Participates in religious activities Yes or No
School Yes or No
Hobbies or interests Yes or No
Physical exercise Yes or No
Recreation Yes or No
Workshop or job Yes or No

Please outline the current medication regimen:

Medication Name	Dosage	Time of administration

Last physical _____ Doctor _____

Last psychiatric appointment _____ Doctor _____

The following questions are specifically for family and/or friends of the applicant, these are not applicable for other informants. You will have the opportunity to discuss your answers with program staff.

1. The applicant calls you with a roommate problem and has decided to leave the program because of it. This is the first time you have heard of this issue. What would you do?

2. CM/Supports Staff has asked you to attend a meeting to discuss the need for a birth control method for this trainee. Birth control has never been an issue before, but is being recommended. How would you respond?

3. How would you feel about this person living alone in an apartment after graduation?

4. Are you the legal guardian of this person?_____Payee? _____

5. To the best of your knowledge, has this individual ever participated in one of the following:

   Property damage _____ Physically threatened others _____

   Verbally threatened others _____ Harmed self _____

   Mistreated animals _____

6. Does this individual have any concept of private or personal property?

7. What can the individual tell you about early warning signs/triggers we may see when the Resident is depressed or having other problems that need to be addressed? E.g. withdrawing

Thank you for taking the time to fill out this questionnaire for the applicant.

LIFESTYLES RECOVERY PROGRAM AGREEMENT

Please review these basic rules of the Lifestyles Recovery Program Agreement and the expectations we have of you before you decide to move in and sign this agreement.

Name of Peer: _____ Date: _____

This skill development training program is based on the concept that you are coming to live here to help yourself start/continue the process of Recovering. RECOVERY means something different for each person. To live at the Lifestyles Recovery Program you need to agree to participate in the program which will be individualized to meet your needs. You will have a great deal of input into what you will work on during your stay at the program. The length of this program is flexible to address your individual needs.

This is not a permanent program for you to be in. The skills training you will receive at Lifestyles Recovery Program will help you learn how to live as independently as possible in the community. The following are some of the basic rules of the Lifestyles Recovery Program.

METHOD OF PAYMENT ACCEPTED: Checks Or Money Orders Only. No Cash _____

PAYMENT TO BE SENT TO: Beacon Specialized Living Services, P.O. Box 69, Bangor, MI 49013 or other designated Lessor's as established by the Apartment Complex.

_____

- The Enhanced Supported Living program does not provide meals. As part of the skill development program, you will be budgeting for and purchasing your own food, preparing your own meals and cleaning up.

  _____

- You will also be asked to purchase your own linens and launder them when needed. _____
- You will be asked to learn to use public transportation (bus, taxi). Staff will assist you in learning how to use this transportation. _____
- Transportation will be provided by staff for major medical/dental/optical and psychiatric appointments ONLY. Transportation will also be offered twice weekly to complete major grocery shopping and for any pre-planned group outings. You should plan to use public transportation for all other appointments/errands.

  _____

- The campus has 24 hour staffing. You can access staff by going to the office or calling the office number. Staff may not be physically present in the office, but will be available by phone. _____
- You are urged to take medications as prescribed by your doctor. Refusal to take medications as prescribed will be reported to your team of caregivers and may be grounds for dismissal from the program. Staff may need to assist you, and/or educate you in maintaining your medication regimen.

  _____

- Part of building your level of independence is learning about and administering your own medications. Upon completing (30) consecutive days of participation in the program, your treatment team will assess your readiness to begin the Self Administration Program. Your progress in the self administration program will depend greatly upon your willingness to work with staff to learn about each of your medications as well as

their uses, dosages, and potential side effects. Consistent medication compliance will also be closely monitored at each step of the Self Administration Program to determine your readiness to advance to the next level. **You may NOT begin the Self Administration Program until your ENTIRE treatment team has agreed that you are ready. Signatures must be obtained from BOTH your psychiatrist and your primary care physician PRIOR to beginning this process.**

_____

- Drinking alcohol or taking drugs is contraindicated with most medications. Alcohol or drug consumption can also lead to behavior that is not conducive to a training environment and that is not acceptable in the community at large. It is in your best interest to avoid alcohol/drug consumption while residing at the Enhanced Supported Living Program. _____
- Illegal activities such as theft, drugs, or underage drinking will not be tolerated. **Suspected illegal activities will be reported to local law enforcement authorities including possession of weapons.** Suspected drug or alcohol use/abuse will be reported to the appropriate member(s) of your treatment team and may be grounds for dismissal from the program. _____
- We expect you to **show respect** for your roommate, other residents of the programs, and other members of the community at large. Check with your roommates before inviting a guest(s) into your apartment. We ask that you not exceed (3) guests at any time unless you have obtained prior approval from management for a special circumstance. **No guest is permitted to stay overnight at your apartment more than (3) times in any (7) day period.** In addition, if you must leave while you have company, your guest **MUST** go with you. Your guest(s) may not be left in your apartment while you are gone.

_____

- Leave of Absences (LOA) for overnight must be planned at least 48hrs ahead of time so the treatment team has time to review your plans and have your medications prepared. LOA's must be approved by your case manager and guardian (if applicable).
- Individual training with a staff is provided Monday through Friday. You will need to provide your staff with an accurate schedule of your appointments and commitments. Your staff will work with you to schedule mutually agreed upon appointment times for individualized "training". **Participation in training activities is a mandatory component of this program.** Any exceptions must be cleared in advance with the Supervisors. **At any point where you have not made these arrangements with staff or do not respond to a phone call or a knock on the door the staff will enter with a master key to ensure that you are safe and not any type of crisis.** _____
- Your staff will expect you to be in you apartment, ready and motivated to participate in training, on time. It is also expected that the relationship between the staff and the trainee be courteous and respectful.

_____

- Throughout the week, there are mandatory skill-building group sessions held in the program. These include but are not limited to Medication Education, Coping Skills, Money Management, Grocery Shopping & Meal Planning, Recovery Training, Anger Management, Bus Training, and Community Safety Awareness. You will need to allow time in your schedule for routine participation in group sessions.

_____

- We expect that you will resolve any conflicts with peers and staff in an appropriate manner. If you are having difficulties with a roommate or other program participant, you will be encouraged to talk out any problems in a "mediation-meeting" with staff present. _____
- You are expected to act and relate with others in an adult and responsible way. Be a good roommate, a good neighbor and a good citizen in your community. _____
- Regular meetings between yourself, staff and other members of your team are an important part of this program. Your input in these meetings is a valuable step in your recovery. _____

Disregarding any of these rules may result in your termination from this program and/or legal action.

_____

All the rules presented in this Program Agreement have been reviewed with me. I have initialed each section as an indication that I understand what is expected of me, and I agree to abide by the program rules as outlined here. My signature below, or that of my guardian/legal representative, indicates my understanding and willingness to participate in the Lifestyles Recovery Program.

Printed Name	Signature & Date
Printed Name of Guardian/Legal Representative	Signature of Guardian/Legal Representative & Date
Payee - Printed Name	Payee – Signature & Date
Staff - Printed Name	Staff – Signature & Date

LIFESTYLES RECOVERY PROGRAM
ITEMS PROVIDED

Beacon Specialized Living Services Inc., will provide the following items in our supported apartment programs:

- Sofa
- Dining Room Table and Chairs
- End Tables
- Refrigerator
- Stove
- Microwave
- Lamps for living room and bedrooms

There will be 2 of the following supplied if the apartment is a two bedroom:

- Chairs
- Twin Bed
- Headboard
- Mattress
- Dresser

Residents are responsible for all other furnishings/ supplies, including food and a cell phone, prior to moving in to the apartment. It is recommended that residents have bedding and toiletries upon moving into their apartment.

RESIDENT ADMISSION CHECKLIST

Please ensure the following items are accounted for at time of pick-up.

Resident Name: _____ Weight_____ Height_____

☐ Photo ID
☐ Insurance Cards and/ or Copy of Insurance Cards

Medications:
☐ Copy of Prescriptions ☐ Epi-Pen (if applicable)
☐ Attach Medication List
Name of Pharmacy where Prescriptions were filled

_____

Medical Equipment:
☐ C-Pap or Bi-Pap

If Diabetic:
☐ Glucometer ☐ Test Strips ☐ Lancets
☐ Needles/ Syringes
Who supplies this equipment? (Local Pharmacy, Binsons, Healthy Living, etc.)

_____

If on Oxygen:
☐ Concentrator ☐ Back-up Tank ☐ Tubing
☐ Mask and/ or Nasal Cannula

If has Nebulizer:
☐ Nebulizer ☐ Tubing ☐ Mask
☐ Medication for Nebulizer

Assistive Devices:
☐ Walker ☐ Cane ☐ Wheelchair
☐ Crutches ☐ Shower Chair ☐ Eye Glasses
☐ Dentures ☐ Incontinence Supplies (Adult Diapers, etc.)
☐ Gait Belt

Who is the supplier of the incontinence products?_____

Has individual been using a hospital bed? ☐ Yes ☐ No

Does this individual use a hoyer, and if so do they have one of their own?
☐ Yes ☐ No

☐ Other Equipment/ Medical Supplies:_____

_____

Are there Prescriptions/ Order to use these supplies? ☐ Yes ☐ No

Case Manager Signature: _____ Date: _____