Beacon - Keystone Community Resources, Inc.



***Admission Packet***

**If all required information is not received at least 1 week prior to admission the admission will be postponed by one business day until the information is received.**

*Admissions procedures and the provision of services shall be made without regard to race, color, religious creed, disability, handicap, ancestry, national origin, age, or sexual orientation.*

**Update June 2021:**

*Please note*:

* Unvaccinated individuals: need to be tested for COVID-19 no more than 10 days prior to admission and submit negative results from the lab prior to admission.

NEGATIVE test results will need to be submitted by to pfetterly@keycommres.com AT LEAST 1 day prior to admission or the move in date will be postponed.

* Vaccinated Individuals: please submit a copy of completed CDC Vaccine card. No testing is needed if individual or their caregiver do not report exposure.

**New Jersey Residences Pre-Admission Requirements**

The individual that you have referred to Keystone Community Resources, Inc., has been accepted for admission into our Program. Please complete the following attachments to assist us in meeting admission requirements and to provide appropriate planning for the individual:

**Personal Data Form**: Please complete all sections in full.

**Physical Examination:** Please have the **enclosed** Resident Physical Examination completed in full by physician *(90 days prior)*, including the TB testing by Mantoux method.

**Consent for Hepatitis B Virus Vaccine:** Please have applicable parent/guardian sign. *If the individual has had Hepatitis B Screening and/or the Vaccine Series, please provide documentation.*

**Parents/Guardians will sign the following consents at the time of admission or before:**

1. General Consent and Release
2. Consent for Emergency Hospital Admission:
3. Medical/Dental Consent
4. Consent for Activity Programs, Day Visits & Overnight Leave
5. Consent for Publicity
6. Authorization for Entrustment of Funds
7. Personal Rights Statement
8. Grievance Policy
9. Licensee Rules
10. Free From Communicable Disease
11. List Of Advocates
12. Client Guardian/Parent Information Contact Form
13. Guardian/Family Member Incident Reporting Form
14. Acknowledgement of Notification
15. Consent for Release of Information (for current providers)
16. Authorization for Disclosure of Health Information
17. Authorizations for Release of Record
18. Contribution to Care & Maintenance Under Fee for Service Policy
19. COVID-19 Guardian Consent for Visitation Form
20. Receipt of COVID-19 Information Form
21. COVID-19 Screening Tool
22. Topic: Guidance for Residential Providers on Visits with Family and Friends Acknowledgement

* **Confirmation of Funding Letter. (Only if the person is not currently enrolled in CCP funding).**
* **Birth Certificate** and **Social Security Card**. If the individual was born outside of the U.S. please enclose their Resident Alien Card (copies are acceptable).
* **Health Insurance Card(s).** Please provide a copy now and original card at time of admission.
* **Proof of guardianship**. If individual has a court appointed guardian we require a copy of the court order.
* **Most recent ISP**.
* **Most recent IEP and/or CER for individual under the age of 21** and still enrolled in school.
* **Most recent Psychological Report**, including IQ and level of adaptive functioning.
* **Most recent Psychiatric Evaluation**, including specific psychiatric diagnoses (if applicable).
* **Behavioral support plans** that are in place for the individual.
* **Immunization Record** - A complete and up to date immunization record is required. Tetanus should be current within 10 years as recommended by CDC
* **List of Meds, diagnosis, providers, upcoming apt, current treating physicians, specialists,**
* **A 10-day supply of medication(s) and written prescription(s) from physician treating the individual**.
	1. Obtain hard scripts of medications from prescribing physician to bring at admission and fax copy of that hard script to 570-558-8930
	2. Have prescribing physician fax E-Script of all medications to Prime Care Pharmacy (Adams Ave) Fax: (570) 207-6368 \*Please send email confirmation that these scripts were sent so that we can follow up with our pharmacy

*Admissions procedures and the provision of services shall be made without regard to race, color, religious creed, disability, handicap, ancestry, national origin, age, or sexual orientation.*

**PERSONAL DATA FORM**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alias or Name Preferred\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Referral and approximate length of placement desired:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City and State of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religion Preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Citizenship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Language Spoken or Understood: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eye Color: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hair Color: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Height: \_\_\_\_\_\_\_\_\_\_Weight:\_\_\_\_\_\_\_\_

Identifying Marks (Birth marks, scars, tattoos, etc.):
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENTS/GUARDIANSHIP/FAMILY CONTACTS**

Father's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father's Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Are there any guidelines on visitation and/or phone contacts? \_\_\_\_\_\_\_\_*If yes, please enclose legal documents.*

Mother's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Maiden Name (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother's Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any guidelines on visitation and/or phone contacts? \_\_\_\_\_\_\_\_\_ *If yes, please enclose legal documents.*

Siblings or other family members: (Please give names and ages. If continued contact between siblings is desired, please give address and/or phone numbers): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(\*Please include copy of guardianship determination)

Relationship to Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: (if/when the parent/guardian cannot be reached\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASEMANAGEMENT & FUNDING INFORMATION**

Support Coordination Responsibilities(s): Who will be the individual’s Support Coordinator following admission. (If two agencies are involved please include both):

1. Name & Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Name & Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any other agencies/advocates/persons involved with the individual's case?

Name & Relationship to individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Source(s) of income (please list all and include the amount and frequency):

1. SSA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. SSI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Veteran’s: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is currently the individual’s Representative Payee? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Following admission, who will be the individual's Representative Payee? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is responsible for payment of individual's Room and Board? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the individual have a Burial Account? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Insurance Plan and Number (If more than one, please list the primary first):

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EDUCATIONAL/VOCATIONAL**

Name of School last attended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of classroom setting (regular or special education): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREVIOUS PARTICIPATION IN RESIDENTIAL PROGRAMS**

Please begin with most recent.

Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Participation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Discharge: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Participation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Discharge: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BEHAVIORAL HISTORY**

Please describe any maladaptive behaviors:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL INFORMATION**

Medications: Please list any medication currently prescribed and taken by the applicant (please attached an additional page if necessary):

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dose | Time | Reason Prescribed |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Please provide a 10-day supply of medication or original prescription upon admission. If out-of-state, please provide a 30-day supply of medication (out-of-state prescription is not valid).

Is medication self-administered? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL CONTACTS**

**Primary Care Physician**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Next Appointment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychiatrist/Psychologist**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of Next Appointment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychiatrist/Psychologist**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Next Appointment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dentist/Oral Surgeon**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Next Appointment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eye Care Specialist**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Next Appointment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Specialist**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Next Appointment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Specialist:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Next Appointment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skill Assessment**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Disability/Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part I:**
This section has been developed for use in assessing skills and serves as a basis for developing the annual service plan and determining progress and growth in various areas. The assessment results are based on interviews, progress notes, and observations. Prior to admission the Supports Coordinator and or caregiver/legal guardian is responsible for conducting the assessment. Upon admission, Beacon-Keystone Program Specialist will coordinate the re-assessment annually.

**Using the criteria below, rate each behavior on a scale of 1-4. Use an “X” to indicate those items which do not apply.**

1. Total Guidance: Individual requires physical manipulation and is assisted throughout the entire process
2. Partial Guidance: Individual requires gestural (visible signal) or physical prompt (touch) to perform behavior.
3. Verbal Instruction: Individual exhibits behavior given only simple instructions and no other help.
4. Independent: Individual indicates and performs the behavior without a word, gesture, or touch.

X. Does Not Apply: Skill is not applicable to the personal needs or care of individual.

|  |  |  |  |
| --- | --- | --- | --- |
| **LEVELS OF SUPERVISION - HOME** | (Pre-Admission) | (Year 2) | ( Year 3) |
| Can locate first aid supplies |  |  |  |
| Knows how to respond to emergency situations (ex. Fire, tornado, bathtub overflow, power outage, etc.) |  |  |  |
| Knows how to evacuate in case of fire |  |  |  |
| Knows how to reach designated contact person if needed |  |  |  |
| Can locate AND dial emergency contact numbers in phone |  |  |  |
| Can lock/unlock exterior doors without assistance |  |  |  |
| Can answer door/phone |  |  |  |
| Can manage leisure time safely in the home |  |  |  |
| Can be alone in the home without supervision or support from staff. *If a “4”, refer to Part III of the Skills Assessment-Unsupervised Time Contingency Plan* |  |  |  |
| Length of time the individual can be alone in the home without supervision from staff: | Time: | Time: | Time: |
| Does the individual require any addition staff support in the home? (YES or NO) |  |  |  |
|  |
| **UNSUPERVISED TIME IN A VEHICLE** | DATE: |  |  |  |
| Has “stranger awareness” (knows not to leave w/ a stranger or let stranger into vehicle |  |  |  |
| Can lock/unlock vehicle door |  |  |  |
| Can hook/unhook seatbelt |  |  |  |
| Knows how to respond to emergency situations/accident while in vehicle |  |  |  |
| Can locate basic first aid supplies in vehicle |  |  |  |
| Ability to open window/door in response to overheating in vehicle |  |  |  |
| Knows how to reach designated contact person in case of emergency |  |  |  |
| Can leave vehicle safely, if needed, to locate assistance |  |  |  |
| Can be alone in a vehicle without supervision from caregiver. If a “4”, refer to PART III – Unsupervised Time Contingency Plan |  |  |  |
| Length of time individual can be alone in vehicle without supervision  |  |  |  |
|  |  |  |  |
| **LEVELS OF SUPERVISION – COMMUNITY or OUTSIDE ON PROPERT OF HOME** | DATE: |  |  |  |
| Knows how to reach designated contact person in case of emergency |  |  |  |
| Able to access community safely (transportation via bus, bicycle, walking, etc.) |  |  |  |
| Knows route to and from home |  |  |  |
| Able to pay for items with money & knows that she/he should get change back |  |  |  |
| Has “stranger awareness” / knows not to leave w/ a stranger or get into a stranger’s vehicle  |  |  |  |
| Knows what to do if someone approaches and he/she does not feel comfortable with that person |  |  |  |
| Knows how to use phone/has access to phone in case of emergency |  |  |  |
| Knows how to find and use public restroom |  |  |  |
| Knows name, home address, & phone number |  |  |  |
| Can manage leisure time safely in the community  |  |  |  |
| Can be alone outside on property of home without supervision from caregiver. If “4”, refer to PART III- Unsupervised Contingency Plan |  |  |  |
| Length of Time individual can be alone outside on property of home without supervision | Time: | Time: | Time: |
| Does the individual require any additional staff support when in the community (YES or NO) |  |  |  |
|  |
| **SAFETY SKILLS** | DATE: |  |  |  |
| Knowledge of danger from heat sources and ability to sense and move away quickly from heat sources that exceed 120 degrees F. and are not insulated |  |  |  |
| Knowledge of water safety |  |  |  |
| Ability to swim |  |  |  |
| Ability to safely use or avoid poisonous material when in their presence |  |  |  |
| Internet safety |  |  |  |
| \*Traffic Safety (Level of Supervision Item-Community & Vehicle) |  |  |  |
| \*Demonstrates awareness of danger from strangers (Level of Supervision Item (home, community, and vehicle) |  |  |  |
| \*Evacuates within 2 ½ minutes in case of fire alarm (level of supervision item- home)  |  |  |  |
| \*Able to care for basic first aid needs (Level of Supervision Item, home, community, vehicle) |  |  |  |
| \*Able to safely use electrical appliances- identify specific appliances below (Level of Supervision Item- home) |  |  |  |
| \*Adjusts water temperature (Level of Supervision Item-Home) |  |  |  |
| \*Carries Photo ID in the community (Level of Supervision Item- Community) |  |  |  |
| Safety Skills Comments Section:Pre-Admission:Year: Year: |
| **SELF CARE SKILLS: PERSONAL HYGIENE & GROOMING** | DATE: |  |  |  |
| Daytime toileting |  |  |  |
| Nighttime toileting |  |  |  |
| Combs/brushes hair |  |  |  |
| Washes hair |  |  |  |
| Oral care: teeth and/or gums |  |  |  |
| Nail care |  |  |  |
| Nasal hygiene (wiping, blowing nose, etc.) |  |  |  |
| Shaving |  |  |  |
| Menstrual care |  |  |  |
| Skin care |  |  |  |
| Dressing |  |  |  |
| Undressing |  |  |  |
| Drinking |  |  |  |
| Feeding him/herself |  |  |  |
| Ambulation (walking |  |  |  |
| Functional transfers (ex. Getting out of bed) |  |  |  |
| Able to use adaptive equipment for mobility, as applicable  |  |  |  |
| \*Bathing or showering (Level of Supervision Item- Home) |  |  |  |
| SELF CARE SKILLS COMMENTS SECTION: Pre-admission: Year 2: Year 3: |
| **INSTRUMENTAL ACTIVITIES OF DAILY LIVING (ADLs)** | Date: |  |  |  |
| Able to safely avoid foods which trigger allergic symptoms |  |  |  |
| Uses appropriate table manners |  |  |  |
| Clothing care/laundry routine |  |  |  |
| Able to complete simple household chores (ex. Dusting, mopping, etc.) |  |  |  |
| Shopping (groceries, clothing, personal items) |  |  |  |
| Telephone use |  |  |  |
| Technology use (iPad, computers, laptops) |  |  |  |
| Able to identify own medication by dosage |  |  |  |
| Able to identify own medication by name |  |  |  |
| Able to identify own medication administration time(s) |  |  |  |
| Able to identify own medication by right route |  |  |  |
| Recognized that money has value |  |  |  |
| Managing money |  |  |  |
| Individual can handle the following amount of money at a time: |  |  |  |
| \*Able to tell time on a digital clock (Level of Supervision Item- Community) |  |  |  |
| \*Able to tell time on an analogue clock (Level of Supervision Item- Community) |  |  |  |
| \*Able to Self-Medicate (Level of Supervision Item- Home, Community) |  |  |  |
| \*Simple Meal Preparation (Level of Supervision Item- Home) |  |  |  |
| ADLs COMMENTS SECTION Pre-Admission: Year 2: Year 3:  |
| **COMMUNICATION SKILLS** | DATE: |  |  |  |
| Communicates verbally with others |  |  |  |
| Communicates primarily using gestures and/or sign language |  |  |  |
| Use of assistive technology (as applicable- describe below) |  |  |  |
| COMMUNCATION COMMENTS SECTION Pre-Admission: Year 2: Year 3:  |
| **SOCIALIZATION SKILLS** | DATE: |  |  |  |
| Appropriately expresses emotions (happiness, sadness, anger, etc.) |  |  |  |
| Carries on conversation |  |  |  |
| Careful with property of others |  |  |  |
| Maintains appropriate physical distance in social situations |  |  |  |
| Recognizes need for own personal privacy |  |  |  |
| Understands privacy needs of others |  |  |  |
| Distinguishes between friends and acquaintances  |  |  |  |
| Understands concepts and consequences of owning, borrowing, & lending |  |  |  |
| Appropriately greets and says goodbye to others |  |  |  |
| Able to self-advocate |  |  |  |
| SOCIALIZATION COMMENTS SECTION Pre-Admission: Year 2: Year 3:  |
| **LEARNING SKILLS** | DATE: |  |  |  |
| Processes information independently (understands & remembers info given or spoken) |  |  |  |
| Reads |  |  |  |
| Writes |  |  |  |
| Reasons independently |  |  |  |
| Problem Solves (thinks through problems & can identify solutions) |  |  |  |
| Makes decisions independently  |  |  |  |
| Recognizes numbers |  |  |  |
| Counts in sequential order |  |  |  |
| SOCIALIZATION COMMENTS SECTION Pre-Admission: Year 2: Year 3:  |

**Part II – Assessment Results**

1. **As a result of the assessment are additional evaluations needed?**

Pre-Admission Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] YES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] NO

Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] YES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] NO

Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] YES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] NO

1. **Does the individual have a need for additional staff support? If so, describe the individuals needs and the additional staffing support necessary for the individual’s health and safety:**

Pre-Admission Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] YES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] NO

Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] YES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] NO

Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] YES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] NO

1. **As a result of the assessment the following list of strong likes, dislikes, strengths, and needs have been developed:**

Pre-Admission Date: \_\_\_\_\_\_\_\_\_\_\_\_\_
Please list:

Year (Date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_
Please list:

Year (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list:

1. **As a result of the assessment, the following recommendations for specific areas of training, program planning, and services have been made:**

Pre-Admission Date: \_\_\_\_\_\_\_\_\_\_\_\_\_
Please list:

Year (Date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_
Please list:

Year (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list:

1. **The Skills Assessment was completed by the following individuals**:

|  |
| --- |
| Pre-Admission Completion Date: |
| Printed Name | Signature | Relationship |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Year 2 Completion Date: |
| Printed Name | Signature | Relationship |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |
| Year 3 Completion Date: |
| Printed Name | Signature | Relationship |
|  |  |  |
|  |  |  |
|  |  |  |

***My*25 Choice House & Consumer Pre-Admission Form**

New Admissions: Please fill out this form in its entirety.

**Client’s Initials Height & Weight**

**Medical/Dietary Issues:** (*if diabetic indicate if on insulin & # of carbs/day)*

**Does the client have calorie restrictions as prescribed by their health care professional/physician?**

[ ] **NO** [ ] **YES**

**IF YES:** Please expand on this by individual and the calorie restriction prescribed by their health care professional.

**Do any residents have missing teeth, making chewing difficult?**

**Dysphagia:** [ ] **NO** [ ] **YES**

**IF YES:** Please expand on any dysphagia needs and which level of mechanical soft is prescribed.

**GERD:** [ ] **NO** [ ] **YES**

**IF YES**: Please expand on any GERD issues noted above; we need to know the explicit foods/beverages not allowed.

**Lactose Intolerance:** [ ] **NO** [ ] **YES**

**IF YES:** Please expand on any lactose intolerance issues noted above; we need to know the explicit foods/beverages not allowed.

**Food Allergy:** [ ] **NO** [ ] **YES**

**IF YES:** Please expand on any allergy issues noted above.

**PKU or ESRD:** [ ] **NO** [ ] **YES**

For individuals with PKU or ESRD, we will need to have a conversation to better understand the unique needs of the individual(s). Please reach out to us at least four weeks prior to first menus being delivered to arrange for this important discussion. Contact information is noted below.

**Food Likes, including vegetables and fruits**

**What are some of the most favorite snacks?**

**Food Dislikes, including vegetables and fruits**

**Eating Habits/Routines**

Are there any unique eating habits/routines for this person?

**\*Beacon Residential Staff**: Please use the information collected on this form to update MY25’s official Intake Packet. Send to amy@my25.com as **a Word document**, please. Thank you.

**STATE OF NEW JERSEY**

**DEPARTMENT OF HUMAN SERVICES – DIVISION OF DEVELOPMENTAL DISABILITIES**

**MEDICAL FORM FOR ADULTS**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) MALE ( ) FEMALE

HEALTH INSURANCE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EXAM DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. HISTORY:
2. Indicate any present and past medical condition (include communicable disease history):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Previous hospitalizations/surgery:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Immunizations:

Adult Diphtheria/Tetanus-Date:\_\_\_\_\_\_\_\_\_\_\_\_(Document date of last booster or administer if more than 10 years ago)

Hepatitis B Immunization (if given) Date: (1) \_\_\_\_\_\_\_\_\_\_\_ (2) \_\_\_\_\_\_\_\_\_\_\_ 3)\_\_\_\_\_\_\_\_\_\_\_

1. LABORATORY TESTS:
2. Mantoux Test yearly if non-reactor or chest x-ray if indicated. Past or current results must be documented.

Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_

 Tine test is not acceptable. Positive Mantoux reactor should never be retested.

1. Hepatitis B Profile: Initial (repeat at physician’s discretion).

Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_

 (Past or current results must be documented).

1. Lead Poisoning: Blood Lead Level is required:
2. For individuals with known Pica behavior, test annually, or according to guidelines for elevated lead levels
3. Prior to discharge from developmental center (within 3 months of discharge).
4. For all new admissions to Division residential services (within 3 months prior to admission or within 10 days

after admission).

Blood lead level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_

1. SMAC, initial (repeat at physician’s discretion): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Complete Blood Count, initial (repeat at physician’s discretion): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Urinalysis, initial (repeat at physician’s discretion): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Serology, initial (repeat at physician’s discretion): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Pap Smear (follow American Cancer Society Guidelines): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. EKG, initial at age 40 (repeat at physician’s discretion): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. OTHER MEDICAL CONDITIONS/NEEDS:
8. 1. Seizures ( )Yes ( ) No Frequency and type, if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Special Dietary Needs ( ) Yes ( ) No (Attach prescription): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Allergies, sensitivities (foods, drugs, others): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Mental Health problems (behavioral, psychiatric disorders): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. MEDICATION:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage:­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_Frequency\_\_\_\_\_\_\_\_\_\_\_Indication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage:\_\_\_\_\_\_\_\_\_\_\_\_Frequency\_\_\_\_\_\_\_\_\_\_\_Indication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage:\_\_\_\_\_\_\_\_\_\_\_\_Frequency\_\_\_\_\_\_\_\_\_\_\_Indication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage:\_\_\_\_\_\_\_\_\_\_\_\_Frequency\_\_\_\_\_\_\_\_\_\_\_Indication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage:\_\_\_\_\_\_\_\_\_\_\_\_Frequency\_\_\_\_\_\_\_\_\_\_\_Indication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage:\_\_\_\_\_\_\_\_\_\_\_\_Frequency\_\_\_\_\_\_\_\_\_\_\_Indication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. CLINICAL EXAMINATION;
2. Height: \_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_Temp.: \_\_\_\_\_\_\_\_ Pulse: \_\_\_\_\_\_\_\_ B/P: \_\_\_\_\_\_\_\_
3. Sensory (Indicate any impairment and extent):

Eyes: Vision (glasses, etc.):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hearing (aides, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3. ENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 4. Teeth & gums: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 5. Neck: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 6. Breast (follow American Cancer Society guidelines for Mammography):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. 7. Lymphatic System:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Respiratory System: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Cardiovascular System: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 10. Gastrointestinal System: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Genitourinary System: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 12. Prostate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Muscular System: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. Skeletal System: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15. Neurological System: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. ADDITIONAL INFORMATION OR RECOMMENDATIONS:

Please indicate if there are limitations or restrictions regarding physical activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please issue prescriptions for medications, diet, adaptive equipment, procedures and therapies.

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE RETURN COMPLETED FORM TO: Paige Della Camera (Admissions Coordinator) Fax: (570) 702-8093**

**FREE FROM COMMUNICABLE DISEASE FORM**

Date: \_\_\_\_\_\_\_\_\_\_

Individual’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Based upon the individual’s: (check as appropriate)

 [ ]  Current Physical Evaluation

 [ ]  Provider Information

 [ ]  Family Information

 [ ]  Current Medical File

 [ ]  Other

**There appears to be no contagious disease.**

This form provides certification from a physician stating the individual is free of communicable disease and shall be provided to the licensee within 72 hours of admission.

This statement is signed with the full understanding that my awareness whether this client is ‘free from’ or has been exposed to contagious disease is limited to mere observation and the accuracy of information shared by others.

**Physician Signature & DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Thank you for all your assistance in completing and submitting these documents promptly prior to admission. If the packet is not completed in full and submitted at least a week prior to admission, the move in date will be delayed by an additional business day until all pre-admission documents are submitted.

**Please send requested documents as you complete them so the Admissions Coordinator can add them to the client’s intake file.**

Three options to submit documents to Admissions Coordinator:

|  |  |  |
| --- | --- | --- |
| \***Email** **Scanned Copies**: Pfetterly@keycommres.com(fastest option) | **Fax Copies:**Attn: Paige Della Camera(570) 702-8093 | **Mail:** Beacon-Keystone Community Resources100 Abington Exec. Park, Suite B, Clarks Summit, PA18411 |