BEACON
Specialized Living
KEYSTONE

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.comAT 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. All documents must be received before an admission date will be set:

Personal Data Form: Please complete all sections in full.

Physical Examination: Please have the **enclosed** Resident Physical Examination completed in full by physician, including the TB testing by Mantoux method. Will not be accepted with any blank sections.

Most Recent Dental, Vision Hearing Reports

Immunization Record - A complete and up to date immunization record is required. Tetanus should be current within 10 years as recommended by CDC

Social Security Awards Letter

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/Evaluation, including IQ and level of adaptive functioning, including specific psychiatric diagnoses (if applicable)..

Behavioral support plans that are in place for the individual.

A 10-day supply of medication(s) and written prescription(s) from physician treating the individual.

a. Obtain hard scripts of medications(oral, topical, etc) from prescribing physician to bring at admission and fax copy of that hard script to 570-558-8930

b. Have prescribing physician fax E-Script of all medications to V Care Pharmacy (362 South Main St., Phillipsburg, NJ) Fax:(908) 454-0795 *Please send email confirmation that these scripts were sent so that we can follow up with the 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: _____

Social Security #: _____ Medicaid # : _____

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.):

_____

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

1. SSA: _____
2. SSI: _____
3. Veteran's: _____
4. Other: _____

Name/Address/Phone number of Rep Payee:

_____

_____

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

1._____

2._____

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.*

Legal Guardian Name: (if applicable) _____

(*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: _____

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: _____

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MEDICAL INFORMATION

Current Medications: Please list any medication currently prescribed and taken by the applicant (please attached an additional page if necessary): This list should include all medications given orally, topically, injections, nasal sprays etc.) ****All medications on this Current list of medications requires a current prescription from the doctor, or Beacon/Keystone cannot administer. Please remember that this includes pills, creams, nasal sprays, cough syrup, allergy pills, medications given for behaviors, nebulizers, PRNS (as needed meds) etc. ***

Medication	Dose	Time	Reason Prescribed

Is medication self-administered? _____

BEACON Specialized Living KEYSTONE

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

2. **Does the individual have a need for additional staff support? If so, describe the individual's 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

3. **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:

4. **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:

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

Pre-Admission 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**

Food Likes, including vegetables and fruits

What are some of the most favorite snacks?

Food Dislikes, including vegetables and fruits

Does the resident have missing teeth, making chewing difficult?

Eating Habits/Routines

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

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.

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.

***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

BEACON Specialized Living KEYSTONE

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: _____

A. HISTORY:

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

_____

2. Previous hospitalizations/surgery:_____

_____

3. 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) _____

B. LABORATORY TESTS:

1. 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.

2. Hepatitis B Profile: Initial (repeat at physician's discretion).

   Results:_____Date:_____
   (Past or current results must be documented).

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

4. SMAC, initial (repeat at physician's discretion): _

5. Complete Blood Count, initial (repeat at physician's discretion): _____

6. Urinalysis, initial (repeat at physician's discretion): _

7. Serology, initial (repeat at physician's discretion): _

8. Pap Smear (follow American Cancer Society Guidelines): _____

9. EKG, initial at age 40 (repeat at physician's discretion): _

C. OTHER MEDICAL CONDITIONS/NEEDS:

D. 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): _____

E. 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_____

F. CLINICAL EXAMINATION;

1. Height:_____ Weight:_____Temp.:_____ Pulse:_____B/P:_____

2. Sensory (Indicate any impairment and extent):

Eyes: Vision (glasses, etc.): _____

Hearing (aides, etc.): _____

3. ENT: _____

4. Teeth & gums: _____

5. Neck: _____

6. Breast (follow American Cancer Society guidelines for Mammography):_____

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: _____

G. 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: _

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Individual's Name: _____

DIET ORDERS

Check all that apply

- ☐ REGULAR
- ☐ REDUCED CALORIE (SPECIFY CALORIES) _____
- ☐ LOW FAT
- ☐ LOW CHOLESTEROL
- ☐ DIABETIC
- ☐ LOW SODIUM
- ☐ HIGH FIBER
- ☐ DASH
- ☐ RESTRICT FLUIDS _____ CC/DAY
- ☐ SNACKS / DIET SUPPLEMENTS Specify supplements and times: _____

_____

Texture /Consistency - Solids

- ☐ REGULAR
- ☐ CUT UP / BITE SIZED (1"x 1")
- ☐ CHOPPED (½ " x ½ ")
- ☐ GROUND (¼ "x ¼ "
- ☐ FORK MASHED
- ☐ MOISTENED
- ☐ PUREED
- ☐ OTHER (SPECIFY)

_____

Thicken Fluids To:

- ☐ THIN LIQUIDS (REGULAR)
- ☐ NECTAR CONSISTENCY
- ☐ HONEY CONSISTENCY
- ☐ PUDDING CONSISTENCY

- ☐ OTHER (SPECIFY)

_____

"DIET ORDER SCRIPTS are required in addition to this form."

Orders are considered valid for 1 year unless otherwise specified.

_____ _____

DATE PHYSICIAN'S SIGNATURE

DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES
COMMUNITY SERVICES
OVER THE COUNTER MEDICATION ORDERS FORAS NEEDED USE
(GOOD FOR ONE YEAR)

Name of Client: _____ **Allergies:** _____

Doctor's Signature: _____ **Date:** _____

REASON	MEDICATION	DOSAGE	FREQUENCY	MAX. AMT. IN 24 HOURS
Headache/Pain -toothache, earache, muscle ache	Tylenol / Acetaminophen	(2) - 325 mg tablets	Every 4 hours	Max: 8 Tablets
Diarrhea (More than 5 times/day see doctor)	Imodium AD	2 mg tablet	2 Tablets STAT, then 1 tablets after each BM	Max: 4 Tablets
Constipation (3 days or longer see doctor)	Milk of Magnesia	(1)- tablespoon	Every 24 hours	Max: 1 tablespoon per 24 hour period (for 3 days)
Cold Symptoms-Including cough (If cough lasts longer than 3 days see doctor)	Robitusin DM	(2) – teaspoons	Every 4 to 6 hours	Max: 4 doses per 24 hour
Fever Under 101 (if over 101, see doctor)	Tylenol/ Acetaminophen (To start at temperature of 100°)	(2) - 325 mg tablets	Every 4 hours	Max: 8 tablets
Seasonal Allergies -Hay fever, watery eyes, runny nose, sneezing due to allergens	Benadryl Allergy	25mg	2 teaspoonfuls every 4 to 6 hours	Max: 6 doses in 24 hours.
Minor Cuts	Triple Antibiotic Ointment	Apply to affected area	follow directions stated on the tube	Not to exceed 4 applications in a 24 hour period
Menstrual Cramps	N/A	N/A	N/A	N/A
Other:				

*ANY DRUGS THAT SHOULD NEVER BE GIVEN: _____

*The listed Medications may be interchanged with generic medications that are equal to the indicated brand name, unless otherwise noted by the doctor.

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. This packet needs to be completed in full before a move in date will be identified.

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 Resources 100 Abington Exec. Park, Suite B, Clarks Summit, PA 18411