APPLICATION FOR ADMISSION

(Please Fill In All Answers)

Screening Procedure:

Cornerstone Support Services will receive applications for individual services from any source.

This is a prescreening form/application for services. The applicant, his or her family member, or others with knowledge of the applicant will be encouraged to provide information for the application to help in this process. Additional information will also be requested.

After the required information is submitted, an interview process will be completed to determine whether or not the facility can provide services to address the individual's needs and desired outcomes.

If the screening and interview process determines that Cornerstone can provide services, DBHDS, the applicant, and all relevant parties will be notified. The applicant will then be subject to the admission process. If the screening review determines that Cornerstone is not the most appropriate service provider to meet the applicant's needs, all relevant parties will be notified of this determination with recommendations.

Date: ____________________

Name of Person(s) Completing Form: ____

Relationship to Applicant: ____

Requested Service: Group Home Supported Living Community Engagement Other

Demographic Information:

Full Name: ____

Social Security #: _________________________ Current IQ Score: ________________________________

Birth Date: _________________________ Age: __________ Sex: Male Female

County Of Legal Residence: ___________________________________

Home Address: ____

Telephone: ____

Current Residency (Group Home, Institution, etc.) and/or Day Program and/or Place of Employment:
Name and Address: (Include Contact Person)

____

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____

Contact Person: ____

Substitute Decision Maker, if applicable (include type; i.e. Guardian, Conservator, AR, etc.): _____________

Address: ____

Telephone: (home) ______________________ (work) ____________________

County: ______________________________

Referred By: ____

Natural Father's Name: ______________________________________

Address: ____

Telephone: (home) ______________________ (work) ____________________

Education: ____

Place of Employment: ______________________________________

Working Hours: __________________________

Natural Mother's Name:

Address: ____

Telephone: (home) ______________________ (work) ____________________

Education: ____

Place of Employment: ______________________________________

Working Hours: __________________________

Family Involvement: ____

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Religious Preference: ______________________

Current Marital Status of Parents:
(If divorced, please give information regarding current spouse(s), if applicable. If additional space is needed, please use back of this sheet).

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Medical Information:

Present: Height: ________________ Weight: ______________

Personal Physician's Name: ____

Address: ____

Telephone: ______________________________

List Psychiatric Diagnoses (if any):

____

____

____

List Medical Diagnoses:

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Does Applicant Carry Any Contagious Disease(s)? ______________________________

(If So, What Type?) ____

Last Physical Examination: ______________________________

Describe history of medical care:

____

____

Current Diet: ____

Seizures: Yes No

Type: ____

Frequency: ______________________________

List Seizure Medications (Name / Dosage / Frequency): *Add additional page if necessary*

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Behavior Information:

Please describe what is important to you: (Interests, Hobbies, Activities and/or Likes & Dislikes)

____

Disposition of the Individual:

Psychotherapeutic Medication (Name / Dosage / Frequency): *Add additional page if necessary*

Behavioral Support Needs: (Identify Any Maladaptive/Self-Injurious and/or Inappropriate Behaviors)

Frequency (Daily, Weekly, Monthly, Etc.): ______

Intensity (Mild, Moderate, Severe): ______

Planned Program/Guidelines/Behavior Support Plan (Description):

Self-Care Information:

A. Dining:

1. Independent
2. Minimal Assistance (Basic Reminders)
3. Maximum Assistance (Physical/Verbal Assistance/ Prompting)
4. Requires Adaptive Equipment or Specialized Diet

B. Bathing: *(Residential Services Only)*

1. Independent
2. With Assistance (Specific-Verbal, Physical, Gestural)
3. Full Physical
4. Resists Bathing

5. G-Tube

Description of Needs: ____

____

C. Ambulation:

1. Ambulatory
2. Semi-Ambulatory (Explain)
3. Self-Propels Wheelchair (Independent)
4. Wheelchair (Requires Assistance)

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D. Dressing:

1. Independent
2. Verbal Prompts
3. Physical Assistance

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E. Toileting:

1. Independent
2. Verbal Reminders
3. Physical Assistance
4. Incontinent

Description of Needs: ____

____

F. Communication:

1. Verbal
2. Non-Verbal
3. Symbol Board
4. Manual Signs
5. Gestures 5. Problems Sleeping At Night
6. Other

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____

G. Sleeping Habits: *(Residential Services Only)*

1. Sleeps Through the Night
2. Gets Up To Use the Bathroom
3. Sleeping During the Day
4. Bed Wetting

(Explain)

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6. Receives Medication for Sleep
   (if so, what type/dosage)

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Reason for Service:

Why are you interested in utilizing Cornerstone's services? (Use additional space if needed on back of this sheet)

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Have you utilized other DBHDS Community Programs *(Residential or Day Services)* in the last three (3) years?
Yes No

If yes, please explain:

Have you ever been denied or asked to leave a community program? Yes No

If yes, please explain:

Consent for Release of Information:

With this application I grant representatives of Cornerstone Support Services permission to perform any needed professional evaluations that may be necessary to meet the admission requirements.

Signature of Applicant or Authorized Representative Date

The following documents may be requested (If not immediately available to you, these items can be submitted at a later date pending contact from Cornerstone):

Current Person Centered Plan or ISP (Individual Support Plan)
Psychological Evaluation
VIDES Assessment
SIS Assessment
Medical History (Past and Current)
Current Physical
Immunization Records
Behavior Support Plan
Therapy Plans
Etc.

Thank you for taking the time to complete this Screening Application for Cornerstone Support Services. We want all of the people interested in our services to have a positive and successful experience. The information you provided will be helpful in accomplishing this goal.

For Office Use Only:

Date: ______________________________________

Date of Initial Contact: _____________________________________

Name of Screening Employee: ____

Method of Screening:

Screening Form Completed and Reviewed? Date and Initials: ________________________

Evaluations Submitted and Reviewed? Date and Initials: _________________________

Interview Process Completed with Interdisciplinary Team? Date and Initials: _________________________

Admitted to Service? Date and Initials: ________________________

Put on Wait List? Date and Initials: ________________________

Referred to other Service for further Assessment? Date, Initials & Name of Service: ______________________
____

Screening Recommendations:
____
____
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