CORNERSTONE
SUPPORT SERVICES

APPLICATION FOR ADMISSION

(Please Complete All Answers)

Screening Procedure:

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

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

After the required information is submitted, an admission process will be completed to determine whether Cornerstone can provide services to address the individual's needs and desired outcomes.

If the screening and admission process determines that Cornerstone can provide services, the applicant and all relevant parties will be notified. 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.

Date: _____ **Applicant's Full Name:** _____

Requested Service: Group Home Supported Living Other: _____

Applicant's Support Coordinator: _____ Community Services Board: _____

Social Services Agent or County for Medicaid Redetermination: _____

Name of Person(s) Completing Form for Applicant: _____

Relationship to Applicant: _____ Phone: _____

Applicant's Demographic Information:

Social Security #: _____

Birth Date: _____ Age: _____ Sex: Male Female

Religious Preference: _____

Medicaid #: _____ Medicare #: _____

Other Insurance: _____ #: _____

Other Insurance: _____ #: _____

Other Insurance: _____ #: _____

County of Legal Residence: _____

Home Address: _____

Telephone: _____

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

_____

_____

_____

Primary 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) _____

Email: _____

Natural Mother's Name:

Address: _____

Telephone: (home) _____ (work) _____

Email: _____

Other Parental Information:
(Please provide information regarding current spouse(s), if applicable. If additional space is needed, please use back of this sheet).

_____

_____

_____

_____

Applicant's Medical Information:

Present: Height: _____ Weight: _____

Personal Physician's Name: _____

Practice Group or Association: _____

Address: _____

Telephone: _____

List Psychiatric Diagnoses (if any):

_____

_____

_____

List Medical Diagnosis with Corresponding Medications: (***Seizure & Psychiatric Medications Listed Later***)

_____

_____

_____

Does Applicant Carry Any Contagious Disease(s)? _____

(If So, What Type?) _____

Last Physical Examination: _____

Describe Current or Historical Issues with Substance Abuse, if applicable: Not Applicable

_____

_____

Current Diet: _____

Seizures: Yes, Active No Has History of Seizure(s)

Type: _____

Frequency: _____

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

_____ _____

_____ _____

_____ _____

Applicant's Behavior Information:

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

Disposition of Applicant:

List Psychiatric Diagnosis with Corresponding Medications: (Name / Dosage / Frequency): *Add additional page if necessary*

Behavioral Support Needs: (Identify Any "At Risk" Maladaptive/Self-Injurious and/or Socially Inappropriate Behaviors toward others)

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

Intensity (Mild, Moderate or Severe): _____

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

Self-Care Information:

A. Dining:
1. Independent
2. Minimal Assistance (Supervision/Basic Reminders)
3. Maximum Assistance

B. Bathing: *(Residential Services Only)*
1. Independent
2. With Assistance (Specific-Verbal, Limited Physical, Gestural)
3. Full Physical

(Physical/Verbal Assistance/ Prompting)
4. Requires Adaptive Equipment or Specialized Diet
5. G-Tube

Description of Needs: _____

_____

C. Ambulation:
1. Ambulatory
2. Semi-Ambulatory (Explain)
3. Self-Propels Wheelchair (Independent)
4. Non-Ambulatory (Requires Total Assistance)

D. Dressing:
1. Independent
2. Verbal Prompts
3. Physical Assistance
4. Resists Bathing

E. Toileting:
1. Independent
2. Verbal Reminders
3. Physical Assistance
4. Incontinent

Description of Needs: _____

_____

F. Communication: *(Mark All that Apply)*
1. Verbal
2. Non-Verbal
3. Symbol Board
4. Sign Language (ALS or Custom)
5. Gestures 5. Problems Sleeping At Night (Disruptive)
6. Other (Explain)

G. Sleeping Habits: (*Residential Services Only)*
1. Independent (Sleeps Through the Night)
2. Periodic Bathroom Use (Requiring Assistance)
3. Sporadic Sleep Schedule (Non-Disruptive)
4. Incontinent
6. Receives Medication for Sleep
(if so, what type/dosage)

H. Describe Likes and Dislikes:

Reason for Service:

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

_____

_____

_____

_____

_____

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

List Weekly or Daily Schedule (Work, Day Support, Community Engagement, Volunteering, Etc.):

_____

_____

_____

_____

Please submit the following documents with this application if available. If some of these items are not immediately available to you, Cornerstone may be able to assist by communicating with the applicant's support coordinator.

Current Person-Centered Plan or ISP (Individual Support Plan)

Psychological Evaluation
VIDES Assessment
SIS Assessment
Medical History (Past and Current)
Current Physical
Immunization Records (Include COVID-19 Vaccination)
Behavior Support Plan
Therapy Plans
Proof of Income - Social Security / Wages

Thank you for taking the time to complete this Screening Application for Cornerstone Support Services. We want everyone 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:
_____
_____
_____
_____