Client Name: (last, first, middle) (maiden)	AKA	Date

The Enola Group
APPLICATION FOR ADMISSION

Applying for: ☐ **Signature Day Program** ☐ **Signature Living (AFL)**

Referring Agency:

Contact Person: Phone:

Current Address:	**Contact Numbers:**
	Home:
	Work:
County:	Other:

Parent/Guardian Name: Phone:

Address:

Resides with:			Relationship:	
Age:	DOB:	Sex:	Race:	Marital Status:
SSN:		Medicaid ID:		
Height:	Weight:	Language:		Religious Preference:
Special accommodations (i.e., wheelchair, interpreter, etc.):				

Emergency Contact: Phone:

Address:

Primary Care Physician:

Primary Care Physician Phone:

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Current MCO:	Phone:
Current Care Coordinator:	
Care Coordinator Phone:	Email:
List Current Service Authorizations: (Innovations Waiver, State-Funded, etc.)	

Previous Services / Providers:

Previous Residences (include names, address, phone numbers):

Natural Supports (include names, address, phone numbers):

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SCREENING

Presenting Need:_____Date of Contact:_____

Current = within 1 year
History of = Documented occurrences prior to 1 year

Current	History of			Current	History of			Current	History of	
		Danger to Self				**Danger to Others**				**Change in Biological Functioning**
		None				None				None
		Thoughts of suicide				Thoughts to harm others				Sleep
		Threats of suicide				Threats to harm others				Nightmares
		Plan for suicide				Plan to harm others				Appetite
		Preoccupation with death				Felt like killing someone				Bed Wetting
		Suicide gesture				Attempts to harm others				Bowel Control
		Suicide attempts				Inability to care for dependents				Other:
		Family hx of suicide				Legal / law involvement				
		Inability to care for self				Other:				
		Other:								**Substance Abuse**
										None
						Anti-Social Behavior				Alcohol
		Affect				Psychotic-like behavior				Other drugs:
		Euphoric				Anxiety/Stress				
		Depressed				Manic-like behavior				Date of last use:
		Fearful				Depressive-like behavior				
		Anxious								
		Apathetic								
		Flattened				**Psychosis**				**Behavioral Control**
		Labile				None				Formal Behavior Support Plan
		Angry				Hallucinations				Date:
		Normal				Delusions				Benign Intervention:
						Formal Thought Disorder				Verbal Correction
										Positive Redirection
		Abuse History								Specific Guidelines
		None				**Behaviors of Concern**				Restrictive Intervention
		Physical				Verbal abuse				Physical Restraints
		Sexual				Non-compliance				Psychotropic Medications
		Emotional				Combative				Time-Out
		Neglect				Inappropriate behavior				
		Domestic Violence				Wandering				
						Running away				
						Injurious to:				
						Self				
						Others				
						Property Damage				
		Other				**Other**				**Other**

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MEDICAL INFORMATION

Type	Name	Address	Phone
Primary			
Dentist			
Specialist			

Axis	Code	Diagnosis	Indicate Primary with "P"	Date of Onset
I				
II				
III				
IV				
V				

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Current Target Population:_____ Current SNAP Index:_____

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Medication Name	Dosage & Route	Schedule	Target Symptoms

List all known allergies (food / medication / animals / environmental):

	Medical Concerns		Neurological		Adaptive Ability Level		Functional Limitations
	Ostomy Care		Convulsions		Mild		
	Esophageal Care		Seizures		Moderate		**Vision:**
	History of decubitus ulcers		Grand Mal		Severe		Normal
	Contractures		Petit Mal		Profound		Impaired
	Diabetic		Frequency:				Blind
	Type I				**NC SNAP #:**		
	Type II						**Hearing:**
	Hypertension		Other:				Normal
	Insomnia						Deaf
							Other:
	Contagious/Communicable Disease(s)?						
	If Yes, list:						

Supportive / Protective Devices			
	None		Supportive Belts
	Wheelchair		Gait Belt
	Walker / Crutches / Braces		Bed Rails
	Hearing Aid		Lap Trays
	Glasses		Modified Shoes
	Dentures		Mittens / Splints
	Adaptive Clothing		
	Adaptive Eating Utensils		Other:
	Helmet		
	Supportive Belts		

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ADAPTIVE BEHAVIOR / DAILY LIVING SKILLS

	Communication		Bathing		Dining		Dressing
	Verbal		Independent		Independent		Independent
	Non-verbal		Minimal Assistance		Minimal Assistance		Minimal Assistance
	Manual Sign Language		Maximum Assistance		Maximum Assistance		Maximum Assistance
	Symbol Board		Total Assistance		Must be fed		Total Assistance
	Gestural		Resistant		Special diet		Resistant
	None		Other:		Parenteral		Other:
	Other:				Tube Feed		
					Other:		
	Toileting		**Ambulation**		**Activities / Social**		**Sleeping Habits**
	Independent		Ambulatory		Passive		Sleeps through the night
	Minimal Assistance		Semi-ambulatory		Active		Gets up for bathroom
	Maximum Assistance		Propels self in w/chair		Swims		Sleeps some during day
	Total Assistance		Dependent wheelchair		**Yes**		Incontinent at night
	Wears diapers / Attends		Confined to bed		**No**		Difficulty sleeping
	Other:		Ambulates w/assistance		Group Participation		Receives meds for sleep
			Other:		Re-socialization		Type/Dosage:
					Family Supportive		
					Activities to Avoid:		
							Other:

Need(s) as perceived by client or others :

Client Name: (last, first, middle) (maiden)	AKA	Date

For Signature Living (AFL) only, please complete this page:

Personal Living Preferences: for purposes of determining appropriate match of person with provider family.

1. Are there any special considerations about your residential needs that we should know?

2. Have you ever lived in a group home, Alternative Family Living Home, or apartment?

3. Are you comfortable living with a family with: ☐ young children ☐ men ☐ women ☐ cat ☐ dog

4. What type of environmental adaptations are needed to make a living space accessible to you? (i.e., ramp, wheelchair-accessible entrance / bathroom / shower, etc.).

5. Do you prefer a private bathroom?

6. What hours of direct supervision will you need?

7. What kind of day services do you prefer:
☐ ADVP ☐ School ☐ Supplemental Employment ☐ Outside Work ☐ Signature Day Program

8. Do you have any unusual fears or preferences that might affect your interaction with others?

9. Do you have any transportation issues?

10. List preferred contact persons and phone numbers:

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11. Approved visitors and relationships:

Client Name: (last, first, middle) (maiden)	AKA	Date

With this application and attached Authorization to Use and Disclose Protected Health Information, I grant The Enola Group permission to perform any needed professional evaluations or assessments that may be necessary to meet the admission requirements for my son/daughter/dependent.

Guardian Signature Date

The following items ***MUST*** be returned with this completed application in order to be considered for admission to The Enola Group services.

- Copy of proof of guardianship
- Current Psychological Evaluation
- Social History / Educational History
- Medical History (past and present)
- Current Physical Exam (within 1 year prior to date of application) (AFL only)
- Dental Exam (within 6 months prior to date of application) (AFL only)
- Immunization Records
- Signed Authorization to Use and Disclose Protected Health Information
- Copy of current Person Centered Plan
- Copy of current NC SNAP

Another requirement for admission to The Enola Group is an initial screening within 24 hours prior to admission to identify the need for any immediate medical care and to assess for any communicable diseases.

Attached is a copy of the medical clearance form to be completed by a Licensed Physician 24 hours prior to admission.

If you have any questions regarding this application, please call:

Adult Services Program Director
Karin McDaniel, Director
828-604-4906, ext. 455

Signature Services Director
Liz Curtis
828-433-0056

This form was completed by (print name) _____, and is an accurate representation of the applicant.

Signature/Title of Person Completing Form Date

Client Name: (last, first, middle) (maiden)	AKA	Date

Please return completed application to The Enola Group, PO Box 250, Morganton, NC 28680.
Incomplete applications will not be processed.

The Enola Group

MEDICAL CLEARANCE FORM

(MUST be completed 24 hours prior to admission by a Licensed Physician)

MEDICAL HISTORY

□ Surgery:	□ Cancer:
□ Blood Pressure (high, low):	□ Head Injury:
□ Heart Disease / Stroke:	□ Pregnancy
□ Liver Disease or damage	□ Sensory Impairments
□ Kidney Disease	□ Glaucoma
□ Thyroid or Goiter problems	□ Epilepsy / Seizure How often:
□ Infectious disease (HIV, TB)	□ Difficulty Urinating
□ Hepatitis (type):	□ Abuse (Physical/Sexual):
□ Diabetes (type):	□ Special diet (type):
□ Allergies:	□ Other:

Medical concerns that require immediate care:

Any Communicable Diseases? □ **YES** □ **NO**

If yes, please list:

Current Medications

Name of Medication	Dose	Purpose of Medication

Client Name: (last, first, middle) (maiden)	AKA	Date

Physician's Signature Date