| 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: Email address:

Address:

| 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:

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

| Current MCO: | Phone: |
|---|---|
| Current Care Coordinator: | |
| Care Coordinator Phone: | Email: |
| List Current Authorizations & Associated Services: (Innovations Waiver, State-Funded, etc.) | |
| | |
| | |
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| | |

**Previous Services / Provider Agencies:**

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

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

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

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

# MEDICAL INFORMATION

| Type | Name | Address | Phone |
|---|---|---|---|
| Primary | | | |
| Dentist | | | |
| Specialist | | | |

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

**Current Target Population:_____Current SNAP Index:_____Current SIS Score:_____**

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

| Medication Name | Dosage & Route | Schedule | Target Symptoms |
|---|---|---|---|
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**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 | | |

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

# 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: |
| | | | | | | | |
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**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:

**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 complete Person-Centered Plan / Individual Service Plan
- Copy of current Risk Assessment and Crisis Plan
- Copy of current NC SNAP and/or SIS Evaluation

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 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

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

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

# 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<br>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 |
|---|---|---|
| | | |
| | | |
| | | |

Physician's Signature Date