

## ADMISSION CRITERIA

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An applicant for a Skill Creations, Inc. facility must have a diagnosis of mental retardation/intellectual disability. In addition, the applicant must have it determined by an interdisciplinary team that he/she needs ICF/MR level of care. The applicant must be qualified to receive Medicaid benefits, or be financially able to pay for private placement at the current daily rate utilized by the facility. The adult applicant must have a legal guardian prior to placement, and the child applicant must have a custodian.

The following restrictions on admission apply:

1. Applicants with severe disruptive, aggressive, and/or destructive behaviors will not be admitted.
2. Applicants with severe and chronic medical problems requiring significant medical intervention will not be admitted.
3. In some facilities, clients utilizing wheelchairs must be able to easily transfer from the wheelchair to other chairs, commodes, and automobile seats to require admission. The facilities with this limitation are:  
Wilson, Roanoke House, Nash House, Sanford, Greenville

The following must be submitted before the Admission Committee will begin considering an applicant:

1. A personal history, in writing, to include a family background, family contact persons, educational history, and an institutional behavior, and ability/inability to interact with staff and peers. Include Legal Guardianship information.
2. A complete medical history prepared by a physician must be submitted with the application. This history must include an immunization record.

Application Form and all attached should be submitted to:

Donald C. Neal, Jr.  
Director of Social Work  
P.O. Box 1636  
Goldsboro, NC 27533-1636  
919-920-8061



Marital Status: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Working Hours: \_\_\_\_\_ Telephone: \_\_\_\_\_  
(Area Code)

Are both parents in the home? \_\_\_\_\_ If no, please explain: \_\_\_\_\_

Names of all children in family:	Date of Birth
_____	_____
_____	_____
_____	_____

Names of other residing in home:	Date of Birth	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

**PHYSICAL/MEDICAL INFORMATION**

Please list and explain any physical handicaps and/or severe & chronic medical problems:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(use other side for continuation if needed)

Allergies (food and/or medication) \_\_\_\_\_

\_\_\_\_\_

List name(s) of all hospitalizations (including birth) or residential placements and reasons. Also include any Centers or programs that have evaluated the applicant: (Use additional sheet, if necessary.)

\_\_\_\_\_

\_\_\_\_\_

Immunizations: Are they up to date? \_\_\_\_\_ Yes \_\_\_\_\_ No  
(Please send copy of immunization record)

Does the applicant have seizures? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, are they under control? \_\_\_\_\_ Yes \_\_\_\_\_ No  
How many average per week/month? \_\_\_\_\_

Is the applicant presently on any medication? \_\_\_\_\_ If yes, what medication and why?  
(list on next page)

**Name of Medication**

**Dosage**

**Reason**

<b><u>Name of Medication</u></b>	<b><u>Dosage</u></b>	<b><u>Reason</u></b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Physician Name and Address: \_\_\_\_\_

**DENTAL INFORMATION:**

Name and address of applicant's dentist: \_\_\_\_\_

When was the last time the applicant was seen by the dentist? \_\_\_\_\_

Was all work done which the dentist recommended? \_\_\_\_\_ If no, what work needs to be done?

**INFORMATION ON BEHAVIOR:**

Does applicant have temper tantrums? \_\_\_\_\_ If yes, how often and what does he/she do to hurt himself? \_\_\_\_\_

Is the applicant aggressive toward other children or adults? \_\_\_\_\_ If yes, how frequently and what type of aggressive behavior does he/she have? \_\_\_\_\_

Does the applicant run away? \_\_\_ If yes, how frequently? \_\_\_\_\_  
Describe any other inappropriate behaviors the applicant may have: \_\_\_\_\_

**COMMUNITY INVOLVEMENT:**

Does the applicant attend any programs in your community? \_\_\_\_\_ If yes, complete the following (next page):

<u>Name of Program</u>	<u>Address Program</u>	<u>Hours Type of per Day</u>	<u>Number Mo.'s per Year</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does the program(s) meet all the applicant's need? If no, what needs does it not meet?

\_\_\_\_\_

\_\_\_\_\_

Is the client receiving any professional treatment (i.e. Physical Therapy, Occupational Therapy, Speech Therapy, etc.) now? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, list names of therapists, their address, and specialty: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SELF-HELP INVENTORY**

- |   |   |
|---|---|
| <p>1. <b><u>VISION:</u></b><br/> <input type="checkbox"/> Unknown<br/> <input type="checkbox"/> Unknown, but impairment suspected<br/> <input type="checkbox"/> Has no useable vision<br/> <input type="checkbox"/> Has limited vision<br/> <input type="checkbox"/> Sees without difficulty</p>  | <p>5. <b><u>ARM/HAND USE:</u></b><br/> <input type="checkbox"/> No use of hands/arms<br/> <input type="checkbox"/> Gross use of one arm/hand only<br/> <input type="checkbox"/> Gross use of both arms/hands<br/> <input type="checkbox"/> Gross and fine use of one arm/hand<br/> <input type="checkbox"/> Gross and fine use of both arms/hands</p> |
| <p>2. <b><u>HEARING:</u></b><br/> <input type="checkbox"/> Unknown<br/> <input type="checkbox"/> Unknown, but impairment suspected<br/> <input type="checkbox"/> Has no useable hearing<br/> <input type="checkbox"/> Has limited hearing<br/> <input type="checkbox"/> Hears without difficulty</p>  | <p>6. <b><u>COMMUNICATION TO OTHERS:</u></b><br/> <input type="checkbox"/> No meaningful communication recognized<br/> <input type="checkbox"/> Communicates by signs and sounds<br/> <input type="checkbox"/> Speech somewhat difficult to understand<br/> <input type="checkbox"/> Communicates well enough to make needs known</p>                 |
| <p>3. <b><u>AMBULATION:</u></b><br/> <input type="checkbox"/> Unable to crawl or walk<br/> <input type="checkbox"/> Crawls or rolls<br/> <input type="checkbox"/> Stands but cannot walk<br/> <input type="checkbox"/> Walks with assistance<br/> <input type="checkbox"/> Walks without assistance</p>   | <p>7. <b><u>PLACE ORIENTATION:</u></b><br/> <input type="checkbox"/> Would be lost if left on own in living area<br/> <input type="checkbox"/> Knows way around home<br/> <input type="checkbox"/> Can go about home alone<br/> <input type="checkbox"/> Can leave home alone</p>   |
| <p>4. <b><u>LOCOMOTION:</u></b><br/> <input type="checkbox"/> Cannot walk<br/> <input type="checkbox"/> Requires extensive support if moved<br/> <input type="checkbox"/> Can walk but must be lead<br/> <input type="checkbox"/> Can walk-need not be lead<br/> <input type="checkbox"/> Uses adaptive equipment (i.e. Wheelchair, walker, braces, etc.)<br/> Specify type used: _____</p> |   |

8. **COMMUNICATION FROM OTHER:**  
 Does not respond to prompts, gestures, or verbal commands  
 Responds to verbal commands with prompts and gestures  
 Responds to simple verbal commands  
 Understands verbal communications

9. **ADAPTABILITY:**  
 Adjusts slowly to new environments  
 Adjusts slowly to new people caring for him/her  
 Adapts quickly to new environments and new care takers

10. **BATHING & PERSONAL HYGIENE:**  
 Must be bathed  
 Must have teeth brushed  
 Requires help (bathing)  
 Requires help (teeth)  
 Bathes self  
 Brushes own teeth/dentures  
 Cares for self during menstruation

11. **DRESSING:**  
 Must be dressed  
 Requires much help  
 Requires little help  
 Dresses self except for buttons, zippers, or laces  
 Dresses self completely

12. **GROOMING:**  
 Makes no effort to stay neat and clean  
 Makes little effort to stay neat and clean  
 Will stay neat and clean if prompted  
 Stays neat and clean without prompting  
 Shaves when needed  
 Can take care of own laundry

13. **TOILET TRAINING:**  
 Physical disability prevents training  
 Not in training for reasons other than physical disability  
 In training-does not make needs known  
 In training-makes needs known  
 Trained for bowel movements  
 Trained for urination  
 Wears diapers  
 Wears training pants  
 Wets self at night  
 Wets self during day  
 Toilets independently

14. **EATING SKILLS:**  
 Feeds self with spoon  
 Feeds self with spoon & fork  
 Drinks from cup alone  
 Drinks from cup using straw  
 Uses all eating utensil appropriately  
**SPECIFY:**  
Food allergies: \_\_\_\_\_  
Special diet: \_\_\_\_\_  
Food Dislikes: \_\_\_\_\_  
Food preferences: \_\_\_\_\_  
\_\_\_\_\_  
Describe applicants appetite: \_\_\_\_\_  
Specify feeding techniques or problems (i.e. special preparation of food, special positioning of Individual, etc.) \_\_\_\_\_

15. **SLEEPING:**  
 Sleeps in room alone  
 Sleeps in room with others  
 Usually sleeps soundly  
 Usually wakes up at night (specify # of times per Night and length of time Awake each time) \_\_\_\_\_  
\_\_\_\_\_

16. **LEISURE ACTIVITIES**

- Stays to himself
- Prefers being alone, but will interact with others
- Interacts only when others initiate it
- Enjoys being with others

**SPECIFY:**

Favorite indoor activities: \_\_\_\_\_

Favorite outdoor activities: \_\_\_\_\_

17. **FINANCIAL CAPABILITIES:**

- Can identify coins and bills
- Knows value of coins and bills
- Can make change
- Handles own personal spending money
- Needs assistance in caring for personal finances, to include spending money

18. **HOUSEHOLD SKILLS:**

- Can do simple chores when supervised
- Keeps own room neat and clean
- Can prepare a snack for himself
- Has no household skills

**CHECKLIST COMPLETED BY: \_\_\_\_\_**  
**PLEASE PRINT NAME/RELATIONSHIP**

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**FINANCIAL INFORMATION**

Is the applicant currently receiving Medicaid benefits? Yes \_\_\_\_ No \_\_\_\_

If yes, please provide Medicaid number: \_\_\_\_\_

If receiving Medicare, provide number: \_\_\_\_\_

If eligible for Champus, provide number: \_\_\_\_\_

If Champus, name of person on Champus policy: \_\_\_\_\_

If applicant is not receiving Medicaid, date of application for Medicaid: \_\_\_\_\_

County applied in (Social Services): \_\_\_\_\_

Does the applicant receive any benefits from the Social Security Administration (example: Survivor benefits, Supplementary Security Income)? \_\_\_\_\_

If yes, please tell us the type and amount of the benefit: \_\_\_\_\_

Does the applicant receive any other income? \_\_\_\_\_

If yes, how much per month? \$ \_\_\_\_\_

What kind of income is it? \_\_\_\_\_

Does the applicant have a savings account, trust account, or other type of asset? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

**MISCELLANEOUS INFORMATION:**

Date applicant received psychological testing: \_\_\_\_\_

Level of mental retardation/ID indicated by evaluation: \_\_\_\_\_

Name of person completing this application: \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_ Phone#: \_\_\_\_\_

**LEGAL GUARDIAN'S SIGNATURE:** \_\_\_\_\_

WITNESS: \_\_\_\_\_ / \_\_\_\_\_  
NAME PRINTED SIGNATURE

TO BE COMPLETED BY CHAIRMAN OF SCI ADMISSION COMMITTEE **ONLY**

DATE REVIEWED BY ADMISSION COMMITTEE: \_\_\_\_\_

DISCIPLINES REPRESENTED AT REVIEW: \_\_\_\_\_

ADMISSION APPROVED: \_\_\_\_\_ ADMISSION DENIED: \_\_\_\_\_

REASON FOR APPROVAL/DENIAL: \_\_\_\_\_

CHAIRMAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

ADMISSION DATE: \_\_\_\_\_ (IF APPLICABLE)