Life Adjustment Program (LAP)

Application for Residency

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Welcome to Hilltop's Life Adjustment Program!

Thank you for your interest in our program. Below is an overview of our admissions process, eligibility criteria, and required documentation.

Admissions Process

To be considered for admission, applicants must meet the following criteria:

- **Age:** 21 years or older
- **Health:** Free of contagious diseases, medically stable (not requiring 24-hour supervision)
- **Condition:** Diagnosed with a brain injury
- **Insurance:** Have or be eligible and willing to apply for Long-Term Care Medicaid (specifically on the Brain Injury Waiver) for all care and medical costs
- **Income:** Have or be eligible and willing to apply for Social Security Income to cover room and board
- **Mobility:** Able to navigate a large, open campus with minimal physical health concerns
- **Participation:** Capable of engaging in the program, personal care, and medical management
- **Behavior:** Able to conduct oneself appropriately on campus, with no current substance abuse, criminal activity, or behaviors that put yourself or others at risk
- **Community Navigation:** Able to navigate the local community with minimal support
- **Daily Living:** Capable of performing Activities of Daily Living (ADLs) without maximum support

Do you feel you meet the criteria as listed above? Yes or No, if not, please explain.

_____

Have you ever been convicted of a crime? Yes or No, if so, please explain.

_____

_____

_____

Please acknowledge with your signature that you (or your guardian) understand that your benefits (if any) such as Medicaid / SNAP / LEAP / etc, may change or end if you choose to move to Hilltop's Life Adjustment Program: Signature: _____ Date: _____

Please contact your State / Federal Benefit worker for more information as this is not Hilltop's decision.

Hilltop's Life Adjustment Program (LAP) works closely with Omnicare Pharmacy, a long-term care pharmacy which delivers medications directly to campus twice a day on weekdays and once a day on weekends. We have great rapport with them and coordinate to ensure medications are refilled, delivered, and that the costs are known to you. You can choose to use another pharmacy if you wish to but will be responsible for getting the medications refilled and delivered to the medication room at LAP. Please circle if you'd like to use: Omnicare Pharmacy or list your pharmacy of choice _____.

Please read, sign & acknowledge:

I consent to Hilltop's Life Adjustment Program staff managing my medication including managing, storing and administering my medications to me. I understand that I have to follow these guidelines to continue living at the Life Adjustment Program unless my physician gives consent for me to manage my own medications.

X _____ Date: _____

Assessment Process

The assessment process includes the following steps:

1. **Intake Screening:** Conducted over the phone or in-person.
2. **Application Submission:** Complete and submit the Application for Residency for evaluation.
3. **Interview and Tour:** Interview with the Admissions & Discharge Coordinator and complete a campus tour.
4. **Program Leadership Assessment:** Interview with program leadership, followed by participation in a campus activity and socializing.

Admission Documentation

Please submit the following documents with your application:

- **Medical Information: Complete** and current medical history and physical from a physician
  - Mental health evaluations (if applicable)
  - Complete list of medications
  - Vaccination records
- **Financial Information:**
  - Verification of income (e.g., Social Security, Social Security Disability explanation of benefits, and any other sources of income)
- **Additional Documents:**
  - Copy of insurance cards (Medicaid, Medicare, or other insurance)
  - Copy of Social Security card (original needed if no ID is available)
  - Copy of birth certificate (certified original needed if no ID is available)
  - **Copy of any current Guardianship / Power of Attorney paperwork**
  - **Copy of any Advanced Directives**

Note: If the applicant does not have a photo ID, the program will assist in obtaining one. ***Please provide your birth certificate and social security card to complete this process.***

We look forward to guiding you through this process and helping you explore the opportunities within our Life Adjustment Program.

Life Adjustment Program (LAP)
Application for Residency

Applicant Information		
Last Name:	First Name:	Middle Name:
Phone Number:	Email address:	
Do you have a preferred name?		
Date of Birth:	Social Security#:	
Marital Status:	Maiden Name if applicable:	
Are you a Veteran?	What is your Religious Preference if any?	
Current Residency and Mailing Addresses:		
Emergency Contact 1: Name: Address: Mailing Address: Phone Number: **What circumstances should we contact you?**		
Emergency Contact 2: Name: Address: Mailing Address: Phone Number: **What circumstances should we contact you?**		
Do you have any advanced directives? Yes **No** **If yes, please provide a copy.**		
Residency Information		
Most Recent Address / Name of Facility if applicable:		
Residency Dates:	Reason for Leaving:	
Address / Name:		
Residency Dates:	Reason for Leaving:	

Address / Name:	
Residency Dates:	Reason for Leaving:

Reason for Application

Describe reason for seeking residency:

Benefits and Income

Do you have a person who manages your money **(Representative Payee or Conservator)?** ☐ Yes ☐ No

Are you your own guardian? ☐ Yes ☐ No
(If no, please indicate who is and provide paperwork detailing guardianship / POA / etc)

First Name:	Last Name:
Relationship:	
Phone Number:	Email:
Preferred method of contact: ☐ Phone Call ☐ Email	
Current/Former Employer:	Military Service ☐ Yes ☐ No How many years?
Your Monthly Income:	SSDI/SSI Income:
Checking/Savings Amount: Bank Name(s):	Other Income Amount (i.e. from employment, disability funding, dividends):
Medicaid ☐ Pending ☐ Approved	Long-Term Care Medicaid ☐ Pending ☐ Approved
Medicaid Number:	Medicaid Case Manager:
Medicaid Case Manager Phone Number:	Case Manager Email Address:
Medicare ☐ Yes ☐ No Part C ☐ Part D ☐	Medicare Number:
Residing County:	Other Medical Coverage:

Do you have a trust if so, please indicate the type:	Do you own property? If so, please indicate?
Medical History	
Date of Brain Injury:	**Diagnosis:**
Describe the event in which your brain injury occurred:	
Have you had COVID? ☐ Yes ☐ No	Dates:
COVID Vaccination Date:	Last Flu Vaccination Date:
Do you have any allergies? (laundry soap / pets / seasonal etc)	**Do you have any food allergies?**
Current Medical Providers	
Primary Physician Name:	**Physician Phone Number:**
Physician Address:	Physician Fax Number:
Neurologist Name:	**Neurologist Phone Number:**
Neurologist Address:	Neurologist Fax Number:
Mental Health Provider Name:	**Provider Phone Number:**
Provider Address:	Provider Fax Number:
Dental and Vision Providers	
Dentist Name:	**Dentist Phone Number:**
Date of Last Visit:	Address:
Eye Doctor Name:	**Eye Doctor Phone Number:**
Date of Last Visit:	Address:
Getting to Know You	

What do you want us to know about you?
What supports do you need?
What are some of your goals?
What are your favorite activities or things to do?

Signature of Applicant | Printed Name | Date

Signature of Guardian If applicable) | Printed Name | Date

Please note: The applicant must sign themself unless they have a legal guardian or if they have a power of attorney that specifies, they can act in one's place immediately after signature.

Release of Confidential Information

I authorize and consent The Life Adjustment Program to receive and provide any confidential information, mental health and psych records, medical records, educational information, evaluation, and other pertinent information about the below named individual with the agencies or persons listed below. I understand that if I do not wish The Life Adjustment Program to contact or exchange information with any of the below persons or agencies, or their authorized representatives, I may cross them off. The information received and/or released shall be used solely for planning, coordinating and delivering the best and most appropriate services offered by The Life Adjustment Program. I understand that I may cancel all or part of this consent by writing to the Life Adjustment Program. Copies of this consent shall be deemed to have the same force and effect as the original. I understand that if the person listed below commits a crime while residing at The Life Adjustment Program or is accused of committing a crime or being a party to a crime, this release allows The Life Adjustment Program to communicate information to applicable legal agencies in order to cooperate with all legal proceedings.

Applicant/Resident Name:	DOB:

Agencies/Vendors/People:

Colorado Department of Health Care, Policy and Finance	Hilltop (All Programs, Staff, Contractors, Students, Volunteers)
All Colorado Departments of Human Services and Case Management Agencies / Rocky Mountain Human Services	All Intermountain Health Branches & St. Mary's Hospital, St. Mary's Family Practice, and Affiliates St. Mary's Billing Department
Marillac Clinic Services / PrimeHealth+	Colorado Probation & Parole
Community Hospital and Affiliates	All Law Enforcement Agencies / Courts / Public Defenders / Correctional Facilities
Grand Junction Fire Department / All Emergency Services	Telligen
Mind Springs / West Springs / Colorado Crisis Line / Colorado Mental Health Line / 988 Crisis Line / Health Solutions West / Lifespan Psychiatry	NuMotion (Durable Medical Equipment) / National Seating
Omnicare Pharmacy	Apria Health Care (Respiratory Supplies)
Catholic Outreach / United Way / Homeward Bound / Brain Injury Association of Colorado	Millenium Medical Services / Sunshine Rides / GVT / Med Lift

Family: Name **Relationship** **Phone**

Current/Past Physicians/Dentists/Psychologist/Counselors:

Name **Relationship** **Phone**

Other: Name **Relationship** **Phone**

I understand that these records are protected under Federal and State Confidentiality Regulations. This information cannot be disclosed without my written consent, unless otherwise specifically provided for in the Regulations. I understand that I may revoke this consent at any time, otherwise it shall continue in effect for one year.

Signature of Applicant/ Guardian **Printed Name** **Date**

Fair Credit Reporting Act
DISCLOSURE REGARDING BACKGROUND INVESTIGATION

As an applicant of Hilltop Community Resources, Inc., you are a consumer with rights under the Fair Credit Reporting Act. When considering residency applications, Hilltop Community Resources, Inc. may choose to obtain and use information contained in either a consumer report or an investigative consumer report from a consumer reporting agency.

A "consumer reporting agency" is a person or business which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly assembles or evaluates consumer credit information or other information on consumers for the purpose of furnishing consumer reports to others, such as Hilltop Community Resources, Inc. A "consumer report" is a written, oral, or other communication of any information by a consumer reporting agency bearing on character, reputation, personal characteristics, or mode of living which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in establishing your eligibility for residency.

An "investigative consumer report" is a consumer report or portion thereof in which information on your character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with your neighbors, friends, associates reported on or with others with whom you are acquainted or who may have knowledge concerning any such items of information.

In the event an investigative consumer report is prepared, you may request additional disclosures regarding the nature and scope of the investigation requested as well as a written summary of your rights under the Fair Credit Reporting Act.

Background Authorization

I, _____, hereby authorize Hilltop Community Resources, Inc. to obtain either a consumer report or an investigative consumer report about me from a consumer reporting agency and to consider this information when making decisions regarding residency with Hilltop Community Resources, Inc.

I authorize all persons, including current and former employers and supervisors, educational institutions, law enforcement agencies, motor vehicle departments, and municipal, state, and federal courts to release information they may have about me to Hilltop Community Resources.

I acknowledge receipt of the "Disclosure Regarding Background Investigation" and "Summary of Your Rights Under the Fair Credit Reporting Act" and certify that I have read and understand both of these documents.

I understand that if I reside in a Hilltop program, this authorization shall remain in effect throughout my residency. This report may be delivered in either written or electronic form.

Social Security #		Date of Birth		Gender	
Current Address					

Residency

City	State	Length of Time at Address

List all previous names used including aliases, maiden or previous married names

Signature of Applicant / Guardian | Printed Name (First / Middle / Last) | Date

Please note: The applicant must sign themself unless they have a legal guardian or if they have a power of attorney that specifies, they can act in one's place immediately after signature.