HILLTOP
Brain Injury Services

LIFE ADJUSTMENT PROGRAM

RESIDENTIAL PROGRAM

REFERRAL PACKET

Return Packet to lindsayp@htop.org or Fax (970) 242-6609
Questions? lindsayp@htop.org or (970) 245-3952

RESIDENTIAL REFERRAL APPLICATION

GENERAL

Full Legal Name:			
Nickname (s):		Phone Number:	
SSN:		DOB:	Age:
Birthplace:			
Height:	Weight:	Hair Color:	Eye Color:
Identifying Characteristics (birthmarks, tattoos, etc.)			

Do you have a legal guardian or power of attorney? Yes____ No_____

Name	Type	Phone Number

SOCIAL HISTORY

Level of Education:
Job Status:
Marital Status:

Do you have Children? Yes____ No ____

Name	Age	Gender
Please explain current child custody and/or visitation arrangements:		

CRIMINAL HISTORY

Have you ever been convicted of a crime? Yes____ No_____

Please describe:

Are you currently under court ordered supervision? Yes____ No_____

Please describe:

Contact information for supervising party

Name	Agency	Phone Number

DRUG/ALCOHOL HISTORY

Please describe any *past* use of alcohol or other drugs:
Please describe any *current* use of alcohol or other drugs:
Discuss any past or present treatment or sobriety services (examples: past inpatient treatment, current attendance at AA/NA etc.)

PRESENT LIVING SITUATION

Current Address:
If this is a placement/facility please describe:
How long at this address?
Reason for leaving:

Please provide a contact at this address

Name	Relationship/Title	Phone Number

Previous living arrangements/placements for last 10 years

	How long?	Contact Name	Contact Number
Address/Type of Placement:			
Reason for Leaving:			
Address/Type of Placement:			
Reason for Leaving:			
Address/Type of Placement:			
Reason for Leaving:			

FAMILY CONTACT INFORMATION

Primary Contact

Name	Relationship	Address	Phone Number

Other Family Member(s)

Name	Relationship	Address	Phone Number

MEDICAL INFORMATION

Current Medical Diagnosis(s)

Type/Cause	Approximate Date of Onset	Current Treatment

Current Treating Physician(s)

Name	Address	Phone Number

Allergies

Type/Cause	Known Reaction	Treatment

(Provide all previous medical records)

PSYCHIATRIC/PSYCHOLOGICAL INFORMATION

Current Diagnosis(s)

Type	Approximate Date of Onset	Current Treatment

Current Treating Psychiatrist/Psychologist/Counselor

Name	Address	Phone Number

(Provide all previous medical records)

MEDICATION INFORMATION

Please list all current medications, including non-prescriptive medications

Drug	Dose/Frequency	Prescribing Physician

(Use a separate sheet of paper if necessary)

FINANCIAL INFORMATION

How are you planning to pay for the service requested at LAP?

Do you have a person who manages your money (Representative Payee)? Yes_____ No_____

Name	Address	Phone Number

Do you have income? Yes____ No____

Income source	Amount and Frequency

Account Information

Do you have a	Yes	No	Amount
Checking Account?			
Savings Account?			
Trust Account?			
Additional Assets? (i.e. real estate, vehicles, etc.)			

(Assets could impact insurance eligibility)

INSURANCE INFORMATION

Medicaid #			
Caseworker Name:		Contact Number:	
Medicare #			

Other Insurance

Company Name:		
Address:		
Policy Number:	Group Number:	Contact Number:

Please note that the requested information is required and failure to provide complete and accurate information could result in delay or denial of services.

SELF-CARE QUESTIONNAIRE

MEDICAL

	YES	NO	If Yes, Please Explain
Do you or have you ever had seizures?			
Are you visually impaired?			
Are you hearing impaired?			
Do you have problems controlling your bladder?			
Do you have problems controlling your bowels?			
Do you have disabilities affecting use of any extremity?			
Do you have difficulty swallowing?			
Do you have problems affecting speech?			
Do you smoke?			

EMOTIONAL/BEHAVIORAL ADJUSTMENT

Do you struggle with	YES	NO	When angry/under stress, you	YES	NO
Depression?			Swear at or threaten others?		
Anxiety?			Physically attack others?		
Mood Swings?			Throw or break things?		
Feelings of Paranoia?			Do nothing?		
Thoughts of suicide?			Run Away?		
Other? (specify)			Other? (specify)		

COGNITION

Do you have problems with	YES	NO	Do you have problems with	YES	NO
Memory?			Organization?		
Judgment?			Initiating activities?		
Orientation? (person, place, time)			Other? (specify)		

MOBILITY

Do you need assistance with	YES	NO	Do you need assistance with	YES	NO
Getting into or out of bed?			Opening doors?		
Sitting down or getting up from a chair?			Getting into or out of tub/shower?		
Walking up and/or down stairs?			Picking up objects from the floor?		
Please list any adaptive equipment used:					

LIVING SKILLS

Do you need assistance with:	YES	NO	Do you need assistance with:	YES	NO
Bathing?			Cleaning your teeth or dentures?		
Dressing?			Brushing your hair, shaving or applying make-up?		
Eating?			Using the telephone?		
Writing with a pen or pencil?			Cleaning the house?		
Washing dishes?			Reading?		
Do you drive?					
Other? (specify)					

GOALS

Applicant: What are you hoping to accomplish while receiving service at LAP? (Medical, Recreational, Vocational, Social, etc.)

Goal #1:
What actions will be necessary to achieve this goal?
1.
2.
3.

Goal #2:
What actions will be necessary to achieve this goal?
1.
2.
3.

Family/Authorized Representative: What are you hoping your loved one will accomplish while receiving service at LAP? (Medical, Recreational, Vocational, social, etc…)

Goal #1:
What actions will be necessary to achieve this goal?
1.
2.
3.

Goal #2:
What actions will be necessary to achieve this goal?
1.
2.
3.

(Use a separate sheet of paper if necessary)

Hilltop's Brain Injury Services: Life Adjustment Program

1405 Wellington Avenue, Grand Junction, CO 81501 (970) 245-3952

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 Hilltop Community Resources 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 (Programs, Staff, Contracts, Students)
Mesa County Department of Human Services	St. Mary's Hospital, St. Mary's Family Practice, and Affiliates
Marillac Clinic Services	St. Mary's Billing Department
Community Hospital and Affiliates	Grand Junction Police Department
Grand Junction Fire Department	NuMotion (Durable Medical Equipment)
Grand Mesa Medical Supply (Durable Medical Equipment)	Apria Health Care (Respiratory Supplies)
Omnicare Pharmacy	Rocky Mountain Health Plans
Other:	Other:

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	Printed Name	Date

Signature of Guardian	Printed Name	Date