HILLTOP BRAIN INJURY SERVICES

# Life Adjustment Program

Residential Referral Packet

1405 Wellington Ave., Grand Junction, CO 81501
Fax (970) 242-6609

Thank you for your interest in Hilltop's Brain Injury Services Life Adjustment Residential Program!

**Admission Criteria**

Applicants must meet the following criteria to be considered for admission:

- Appropriate via Assessment Criteria (attached)
- 21 years or older
- Free of contagious diseases
- Medically stable, not requiring 1:1 supervision
- Adequate funding source to meet service cost

**Assessment Process**

Step 1: Referral packet review and evaluation of assessment criteria
Step 2: Interview and tour reviewing services and program
Step 3: Assessment with Life Adjustment Program leadership
Step 4: Admission to Life Adjustment Program

**Required Documents**

To begin the assessment process, the following documents must be submitted:

_____ Complete Referral Packet

_____ Release of Confidential Information age 11)

_____ Background Authorization

_____ Current physical and history

_____ Current medication list

_____ Verification of income

HILLTOP BRAIN INJURY SERVICES

# Admission Criteria

| Appropriate | Requires Additional Evaluation | Not Appropriate |
|---|---|---|
| Needs minimal daily wellness checks, assistance or interventions | Needs > 2 daily wellness checks, assistance or interventions | Needs 1:1 staffing or 24-hr supervision; > 3 hours direct assistance per day; interventions more than every 4 hours |
| ADLs executed independently | ADLs require some/intermittent support | ADLs require full support |
| Able to self-feed and hydrate | Requires line of sight or food/meal adjustments | Requires feeding or hydration support; tube feeding |
| Continent of bowel and bladder | Cuing or support of bowel/bladder incontinence | Total incontinence of bowel and/or bladder requiring support;<br>Ostomy requiring support |
| No permanent PPE requirements | Intermittent PPE required | Full PPE required for all care |
| Self-transfer in/out of chairs and bed | DME to participate in transfers | Unable to participate in transfers; mechanical lifts |
| Able to navigate campus (with/without DME) | Occasional support in ambulation | Requires support location to location |
| Able to independently navigate local community | Requires some support for safe or effective community navigation | Requires locked campus or limited community access |
| Aware and oriented to person, place and time | Mild disorientations to person, place or time resulting in safety concern(s) | Profoundly disoriented to person, place or time resulting in safety risk(s) |
| Good physical health | Minimal health concerns | More than 1x/week nursing intervention; diagnosed MDRO; IV antibiotics; wounds; ill |
| Able to consent to medical treatment; legal remedy in place (i.e. guardian) | Limited ability to participate in care; pending legal remedy | Unable or unwilling to communicate or participate in care |
| Current medication orders; appropriate medication supply on-hand | Current medication orders; no medication supply on-hand | No current medication orders |
| Stable medication management | Unstable medication management, willing to participate | Unstable medication management, unwilling to participate |
| Minimal to no criminal history | Significant criminal history (timing and charges considered) | Active warrants; significant criminal history (timing and charges considered) |
| Able to thrive in LAP community with LAP residents and staff | Indication of behavior that negatively impacts LAP; concern of ability to thrive in LAP community | Exhibit behavior that impacts LAP; unable to thrive in LAP community |
| Able to self-mitigate behavior, agitation or anger appropriately | Requires support to mitigate behavior, agitation or anger appropriately | Behavior (including history of) that places staff or residents at risk |
| Balanced mental health | Potentially unbalanced mental health w/ active participation in mental health resources; history of self-harm | Unbalanced mental health potentially placing self, staff or residents at risk |
| Sustained sobriety | Active substance use (including alcohol); history of illicit drug use | Active substance abuse (including alcohol); active use of illicit drugs |
| Effectively able to communicate needs | | Unable to communicate needs |

HILLTOP BRAIN INJURY SERVICES

# Residential Referral Packet

## Personal

| | | | | | |
|---|---|---|---|---|---|
| First Name | | Last Name | | Preferred Name | |
| Social Security # | | Birthplace | | Gender | |
| Phone # | | DOB | | Age | |
| Race/Ethnicity | | Height | | Weight | |

## Social History

| | | | | | |
|---|---|---|---|---|---|
| Level of Education | | Job Status | | Former Occupation | |
| Religious Preference | | Marital Status | | Military Service | |

| | |
|---|---|
| Children (name & age) | |
| Visitation/Custody | |

| | |
|---|---|
| Why are you moving? | |

## Important Contact Information

Emergency Contacts

| | | | |
|---|---|---|---|
| Name | | Relationship | |
| Phone # | | Email | |
| Mailing Address | | | |

| | | | |
|---|---|---|---|
| Name | | Relationship | |
| Phone # | | Email | |
| Mailing Address | | | |

Other Family

| | | | |
|---|---|---|---|
| Name | | Relationship | |
| Phone # | | Email | |
| Mailing Address | | | |

| | | | |
|---|---|---|---|
| Name | | Relationship | |
| Phone # | | Email | |
| Mailing Address | | | |

Legal power of attorney / guardianship / financial conservator

| | | | |
|---|---|---|---|
| Name | | Relationship | |
| Phone # | | Email | |
| Mailing Address | | | |

## Benefits and Income

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

| | | | |
|---|---|---|---|
| Name | | Relationship | |
| Phone # | | Email | |
| Mailing Address | | | |

| | | | | | |
|---|---|---|---|---|---|
| SSDI/SSI Income | $ /month | Other Income | $ /month | Savings | $ |

| | | | |
|---|---|---|---|
| Medicaid Status | | Long Term Medicaid Status | |
| Medicaid Case Manager | | Phone # | |
| Medicaid # | | Residing County | |
| Medicare Status | | Other Medical Coverage | |

## Residency Information (10 years)

| | | | |
|---|---|---|---|
| Address/Name | | | |
| Residency Dates | | Reason for Leaving | |
| Address/Name | | | |
| Residency Dates | | Reason for Leaving | |

## Medical Information

| | | | |
|---|---|---|---|
| Describe your Brain Injury | | | |
| Diagnosis | | Date | |

## Mental Health Information

| | | | |
|---|---|---|---|
| Primary Provider | | | |
| Practice Name | | Phone # | |

Current Mental Health Diagnoses

| | | | |
|---|---|---|---|
| Diagnosis | | Date of Onset | |
| Current Treatment | | Symptoms | |
| Diagnosis | | Date of Onset | |
| Current Treatment | | Symptoms | |

| | Always | Sometimes | Rarely | Never | Details |
|---|---|---|---|---|---|
| Depression | | | | | |
| Anxiety | | | | | |
| Mood Swings | | | | | |
| Feelings of Paranoia | | | | | |
| Thoughts of Suicide | | | | | |

## Physical Health Information

| | | | |
|---|---|---|---|
| Primary Care Provider | | | |
| Practice Name | | Phone # | |
| Specialist Provider | | | |
| Practice Name | | Phone # | |

Current Medical Diagnoses

| | | | |
|---|---|---|---|
| Diagnosis | | Date of Onset | |
| Current Treatment | | Symptoms | |
| Diagnosis | | Date of Onset | |
| Current Treatment | | Symptoms | |
| Diagnosis | | Date of Onset | |
| Current Treatment | | Symptoms | |
| Do you have seizures? | | Date of Onset | |
| Describe | | Date of Last Seizure | |
| COVID Vaccination Date | | Have you had COVID? | Date |
| COVID Booster Date | | Flu Vaccination Date | |

## Dental

| | | | |
|---|---|---|---|
| Practice Name | | Phone # | |
| Last Visit | | | |

All of the items checked below apply to me:

- ☐ I have natural teeth
- ☐ I have no natural teeth
- ☐ I wear a complete upper/lower denture
- ☐ I wear a partial denture
- ☐ I have dental implants
- ☐ I wear a dental bridge

I would describe the general condition of my natural teeth as:

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Not Applicable

## Vision

| | | | |
|---|---|---|---|
| Practice Name | | Phone # | |
| Last Visit | | | |

I can see:

- ☐ standard print, standard screen size
- ☐ only large print, large screen size
- ☐ I am legally or totally blind even with correction
- ☐ I have an eye disease. Details: _____
- ☐ to dial a telephone or cellphone
- ☐ to use a computer or laptop

I wear glasses for ☐ distance ☐ reading ☐ close-up

## Hearing

- ☐ My hearing is okay without a hearing aid
- ☐ My hearing is okay with a hearing aid
- ☐ My hearing is poor even with a hearing aid
- ☐ My hearing is poor, I do not use a hearing aid

## Mobility

| I can do the following without help: | Always | Sometimes | Rarely | Never | Details |
|---|---|---|---|---|---|
| I can walk in my home | | | | | |
| I can walk in and out of doors | | | | | |
| I can climb stairs | | | | | |
| I can sit down/stand up from a chair | | | | | |
| I can get into and out of bed | | | | | |

| I use the following when I move around: | Always | Sometimes | Rarely | Never | Details |
|---|---|---|---|---|---|
| Nothing | | | | | |
| Assistive devices such as a walker or cane | | | | | |
| Wheelchair I propel myself | | | | | |
| Wheelchair another person pushes | | | | | |
| I support myself with walls or furniture | | | | | |
| I use a motorized scooter or wheelchair | | | | | |

## Falls

| How often do you fall? | /month | Cause of falls | |
|---|---|---|---|
| Date of last fall w/ injury | | Injuries from falls | |
| Interventions in place | | | |

## Sleep

| I usually wake up around | | I usually go to sleep around | |
|---|---|---|---|

| | Always | Sometimes | Rarely | Never | Details |
|---|---|---|---|---|---|
| I go to sleep without any trouble | | | | | |
| I stay asleep without any trouble | | | | | |
| I take sleeping pills to help me sleep | | | | | |
| I need music, TV or white noise to sleep | | | | | |

| My sleep is disturbed by | |
|---|---|
| If I can't get to sleep, I | |
| I use the following equipment to sleep | |

## Cognition

| | Always | Often | Sometimes | Never | Details |
|---|---|---|---|---|---|
| I forget things | | | | | |
| I forget people | | | | | |
| I lose track of where I am | | | | | |
| I lose track of time | | | | | |
| I need help organizing my thoughts | | | | | |
| I need reminders to start activities | | | | | |

## Nutrition

| Do you have difficulty swallowing? | |
|---|---|
| Do you require a special diet or special food preparation? | |
| Do you have food or medication allergies? | |

## Activities and Interests

| | |
|---|---|
| Activities I like to participate in are | |

# Activities of Daily Living

## Assistance

| I need assistance with the following: | Always | Sometimes | Rarely | Never | Details |
|---|---|---|---|---|---|
| Getting out of bed | | | | | |
| Sitting down or getting up from a chair | | | | | |
| Opening doors | | | | | |
| Picking up objects from the floor | | | | | |
| I use equipment for assistance, describe | | | | | |

## Dressing

| | Always | Sometimes | Rarely | Never | Details |
|---|---|---|---|---|---|
| I dress myself without assistance | | | | | |
| I put on socks and shoes without assistance | | | | | |
| I wear a brace and put it on without assistance | | | | | |

## Toileting

| | Always | Sometimes | Rarely | Never | Details |
|---|---|---|---|---|---|
| I can control my bladder | | | | | |
| I can control my bowels | | | | | |
| I get on and off the toilet without assistance | | | | | |
| I get to the bathroom at night without assistance | | | | | |
| I get to the bathroom without reminders | | | | | |
| I use incontinence pads or briefs | | | | | |
| I change protective garments without reminder | | | | | |
| I can take care of accidents if they occur | | | | | |
| I have a catheter, describe type | | | | | |

## Personal Care

| | Always | Sometimes | Rarely | Never | Details |
|---|---|---|---|---|---|
| I get into the tub/shower without assistance | | | | | |
| I wash all of my body without assistance | | | | | |
| I comb my hair without help | | | | | |
| I clip my finger and toenails without help | | | | | |
| I brush my teeth or clean dentures without help | | | | | |
| I lotion my body after bathing without help | | | | | |

## Durable Medical Equipment

| | |
|---|---|
| I currently use | |
| Current provider | |
| I need equipment | |

## Community Access

| | Always | Sometimes | Rarely | Never | Details |
|---|---|---|---|---|---|
| I can safely access the community | | | | | |
| I need transportation to medical appts | | | | | |
| I need someone to attend medical appts with me | | | | | |

## Tobacco, Alcohol and Drugs

| | | | |
|---|---|---|---|
| Do you use nicotine/smoke cigarettes? | | Quantity | |
| What is your current alcohol use? | | What is your history of alcohol use? | |
| What is your current THC use? | | What is your current or history of illicit drug use? | |
| Describe current or previous support to maintain sobriety | | | |

## Social Engagement

| **I am or I like the following:** | **Always** | **Sometimes** | **Rarely** | **Never** | **Details** |
|---|---|---|---|---|---|
| High activity: talkative, likes to socialize with roommates/friends | | | | | |
| Medium activity: watch tv, dine together, visit with roommates and friends | | | | | |
| Low activity, like to be by myself | | | | | |
| Other people in my space is fun | | | | | |
| Other people in my space is not acceptable | | | | | |
| Morning person | | | | | |
| Night owl | | | | | |
| Shy | | | | | |
| Outgoing | | | | | |

| **The following apply to my personal space:** | **Always** | **Sometimes** | **Rarely** | **Never** | **Details** |
|---|---|---|---|---|---|
| Used for studying | | | | | |
| Used for relaxing | | | | | |
| Used for sleeping | | | | | |
| Hanging out with roommates and friends | | | | | |
| Quiet, mellow environment | | | | | |
| Noisy and active | | | | | |
| Is clean | | | | | |
| Is cluttered | | | | | |
| Is a disaster zone | | | | | |

| | **Always** | **Sometimes** | **Rarely** | **Never** | **Details** |
|---|---|---|---|---|---|
| I am able to express myself calmly | | | | | |
| I am not comfortable talking about things | | | | | |
| I swear at others when frustrated or mad | | | | | |
| I am physical with others when frustrated or mad | | | | | |
| I throw or break things when frustrated or mad | | | | | |
| I do nothing when frustrated or mad | | | | | |
| I run away when frustrated or mad | | | | | |
| I address frustration or anger directly | | | | | |
| When I am frustrated or mad, I can be calmed by: | | | | | |

HILLTOP BRAIN INJURY SERVICES

# Release of Confidential Information

I, _____ authorize Hilltop's Brain Injury Services to receive and provide protected health information including but not limited to mental health records, medical records, educational information, and other pertinent information about the applicant with the agencies or persons listed in the application and below. I understand that if I do not wish Hilltop to contact or exchange information with any of the below persons or agencies, or their authorized representatives, it will be noted. The information received and/or released shall be used solely for planning, coordinating and delivering the best and most appropriate services offered by Hilltop. I understand that I may change consent in writing to Hilltop's Brain Injury Services.

I understand that if the applicant 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.

**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 |
|---|---|---|
| | | |
| | | |
| | | |

## Providers

| Name | Relationship | Phone |
|---|---|---|
| | | |
| | | |
| | | |

## Support

| 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.

| | | |
|---|---|---|
| | | |
| Signature of Guardian | Printed Name | Date |

| | | |
|---|---|---|
| | | |
| Signature of Applicant | Printed Name | Date |

HILLTOP BRAIN INJURY SERVICES

# 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 | Printed Name | Date |