Life Adjustment Program (LAP)

Application for Residency

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Admissions and Discharge Coordinator

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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.

_____

_____

_____

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)

Note: If the applicant does not have an ID, the program will assist in obtaining one.

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

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Applicant Information		
Last Name:	First Name:	Middle Name:
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?	
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?	**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

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 (Programs, Staff, Contracts, Students, Volunteers)
All Colorado Departments of Human Services and Case Management Agencies	St. Mary's Hospital, St. Mary's Family Practice, and Affiliates
Marillac Clinic Services	St. Mary's Billing Department
Community Hospital and Affiliates	All Law Enforcement Agencies / Courts / Public Defenders
Grand Junction Fire Department / All Emergency Services	Telligen
Mind Springs / West Springs / Colorado Crisis Line / Colorado Mental Health Line / 988 Crisis Line	NuMotion (Durable Medical Equipment)
Omnicare Pharmacy	Apria Health Care (Respiratory Supplies)

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