St. Mary's Independent Living Extensions, Inc.
Enrollment Application

Use blue or black ink. Do not use white out.

Application Date: _____

Demographic Information

Full Name: _____
First, Middle, Last
Current Address: _____
Number, Street, City, State, Zip Code

Home Phone: _____ Cell Phone: _____
Date of Birth (mo./day/year): _____ Age: _____ Gender: ☐ Male ☐ Female
Current Living Status: ☐ Family home ☐ Provider home ☐ Other _____
Employment Status: ☐ Not Employed ☐ Employed – Employer: _____

Current Medicaid Waiver: ☐ COMP ☐ NOW ☐ No Medicaid Waiver
Current Services: ☐ Community Access-Group (CAG) ☐ Community Access-Individual (CAI) ☐ Community Residential Alternatives (CRA) ☐ Community Living Supports (CLS) ☐ Supported Employment ☐ Transportation ☐ Respite ☐ None
Services Desired: ☐ Residential ☐ Day Program ☐ Supported Employment ☐ Transportation

Guardianship

☐ Legally Competent ☐ Adjudicated Incompetent Letters of Guardianship? ☐ Yes ☐ No ☐ N/A

Legal Guardian's Name: _____ Relationship to Individual: _____

Upon enrollment, a copy of the guardianship document is required.

Financial Information

The SMILE Residential Services Programs are government-funded, and Medicaid specifically states that reimbursement or payments for the program do not include the cost of room and board. This means that while the services of care and support are covered by the Medicaid Waiver, the cost of housing, utilities, food, clothing, and personal items are not and need to be covered separately, often by the individual or from other sources such as Social Security.

Representative Payee Name _____ Relationship _____

SSI Award Monthly Amount: _____

Medicaid Insurance? ☐ Yes ☐ No Medicare Insurance? ☐ Yes ☐ No

Other Insurance: _____

Referral Source

Name:_____

Agency:_____

Address:_____

Phone:_____ Email:_____

Support Systems

Applicant's current living arrangement: Family Home? Yes No

Agency:_____

Agency Contact:_____

Address:_____

Phone:_____ Email:_____

Is the Applicant Employed? Yes No

Employer:_____

Supported Employment Agency:_____

Contact Person: _____

Address:_____

Phone:_____ Email:_____

Additional Support System(s)

_____

_____

Diagnoses

Primary:_____

Secondary:_____

Other:_____

Allergies:_____

Professional Contacts

Please list all of the Applicant's doctors. Attach an additional sheet if necessary.

Name:_____

Practice/Agency:_____

Specialty/Position:_____

Phone:_____ Fax:_____

Email:_____

Name:_____

Practice/Agency:_____

Specialty/Position:_____

Phone:_____ Fax:_____

Email:_____

Name:_____

Practice/Agency:_____

Specialty/Position:_____

Phone:_____ Fax:_____

Email:_____

Care Needs and Life Skills Abilities

Please check each box regarding the person's level of support or if support is needed.

Communication

Expressive Language (ability to express wants/needs through verbal/non-verbal communication)

- ☐ Has no/minimal barriers to putting thoughts into words and sentences that makes sense and is grammatically correct
- ☐ Limited speech
- ☐ Uses Sign Language
- ☐ Uses Gestures

- ☐ Uses assistive technology to communicate
- ☐ Other _____

Receptive Language (ability to understand and comprehend spoken language heard or read)

- ☐ Has no/minimal barriers to understanding spoken language
- ☐ Reads with comprehension
- ☐ Follows directions
- ☐ Requires simple one to two-step instructions at a time
- ☐ Understands what gestures mean
- ☐ Identifies objects and pictures
- ☐ Uses facial expressions to understand
- ☐ Other means of understanding _____

Eating and Drinking

- ☐ Eats independently
- ☐ Drinks independently
- ☐ Needs help eating and drinking
- ☐ Blended or Special Diet – Please specify: _____
- ☐ Uses feeding tube
- ☐ Feeds self with spoon
- ☐ Feeds self with fork
- ☐ Must have food cut

Continence

- ☐ Independent with toileting
- ☐ Independent with bladder control
- ☐ Independent with bowel control
- ☐ Needs assistance with toileting
- ☐ Wears disposable underwear
- ☐ Toilets on a schedule
- ☐ Needs assistance with managing menstrual cycle hygiene
- ☐ Explain: _____

Mobility

- ☐ Walks independently
- ☐ Uses a cane
- ☐ Uses a walker
- ☐ Uses a wheelchair
- ☐ Wears orthopedic footwear/orthotics
- ☐ Other:_____

Self-Care

- ☐ Bathes independently
- ☐ Shaves independently
- ☐ Needs help with bathing
- ☐ Needs help with shaving
- ☐ Chooses appropriate clothing for the weather
- ☐ Dresses independently
- ☐ Independently puts on shoes/ties shoelaces
- ☐ Grooming Needs _____
- ☐ Other:_____

Independent Living

- ☐ Cooking
- ☐ Shopping
- ☐ Laundering
- ☐ Driving
- ☐ Cleaning
- ☐ Understanding the value of money
- ☐ Other:_____

Miscellaneous

Explain other relevant information that SMILE should be aware of regarding care needs and abilities.

_____

_____

_____

Overall Wellness

General

- ☐ Ability to process information correctly (thought/perception)
- ☐ Ability to understand their surroundings
- ☐ Awareness of their physical location
- ☐ Awarenes of the current date
- ☐ Awareness of the current time

Appearance and Hygiene

- ☐ Independent with grooming
- ☐ Needs assistance with grooming
- ☐ Challenges with maintaining good oral hygiene
- ☐ Challenges with regular bathing and/or persistent body odor
- ☐ Other – Explain:_____

Speech and Language

(Describe if there are challenges with speech and language that affect the person's ability to produce and/or understand speech.)

- ☐ No significant challenges with speech and language.
- ☐ Explain challenges or support needed.

  _____

Judgement/Decision Making Ability

- ☐ No significant challenges with judgement and decision making.
- ☐ Explain challenges and/or support needed with judgement and decision making.

  _____

Attitude and Insight *(emotional tone displayed toward others)*

- ☐ Sociable
- ☐ Cheerful
- ☐ Quiet
- ☐ Passive
- ☐ Other Explain:_____

Suicidal Ideations / History of Suicidal Attempts

- ☐ Yes – Please Explain:_____
- ☐ No

Psychosis: *Hallucinations (sensing things that aren't real), delusions (false beliefs), disorganized speech or thinking, and changes in behavior, etc.*

- ☐ Yes – Please Explain:_____
- ☐ No

Self-Harm (Skin picking, cutting, headbanging, etc.)

- ☐ Yes – Please Explain:_____
- ☐ No

Appropriate Sexual Boundaries

- ☐ Yes
- ☐ No – Please Explain:_____

Aggression (Physical, Object, Property Destruction, etc.)

- ☐ Yes – Please Explain:_____
- ☐ No

Does the Applicant have a Mental Health and/or Social Work Assessment? Yes or No

☐ Social Work Assessment ☐ Mental Health Assessment

Indicate the name of the health professional who completed the assessment and provide the date of the assessment and the health professional's contact number/address:

_____

_____

Has the applicant ever been arrested, charged or convicted of a crime? Yes or No – If yes, describe.

_____

Has a crime ever been committed against the applicant? Yes or No – If yes, describe. *(physical/sexual assault, exploitation, identity theft, etc.)*

_____

_____

Has the applicant communicated threatening behavior to self or others? Yes or No *(Any statement or indication of an intention to inflict pain, injury, damage, or other hostile actions.)* If yes, explain.

_____

_____

Health Conditions

Include active and previous conditions.

- ☐ Asthma _____
- ☐ Allergies _____

- ☐ Seizures _____
- ☐ Cancer _____
- ☐ Migraines _____
- ☐ Falls _____
- ☐ Diabetes _____
- ☐ Infectious Diseases _____
- ☐ Eating Disorders _____
- ☐ Cardiac Disease _____
- ☐ Hypertension _____
- ☐ Brain Injury _____
- ☐ Sleep Apnea _____
- ☐ Insomnia _____
- ☐ Fractures _____
- ☐ Mobility Issues _____
- ☐ Smoking / Vaping _____
- ☐ Substance Abuse _____
- ☐ Medical Devices _____
- ☐ Obesity / Overweight _____
- ☐ Other _____

Medications

Attach an additional page or copy of MAR if necessary.

Medication Name	Dosage	Frequency	Doctor

Pharmacy Name _____ **Pharmacy Number** _____

Pharmacy Address _____

Important To / Important For

Describe the applicant's likes, dislikes, hobbies and preferred home and community activities.

_____

_____

_____

_____

Describe the applicant's preferred day program activities, volunteer opportunities or employment aspirations._____

_____

_____

_____

Describe elements of the applicant's preferred home environment. *(Examples: Active, quiet, adequate space, natural light, indoor lighting, noises/sound control, pets, temperature, etc.)*

_____

_____

_____

_____

Prior to starting services, the following documents are required.

1. Copy of Annual Physical Examination Record
2. Copy of Social Work Assessment
3. TB Test – negative results
4. Copy of Guardianship Documentation (if applicable)
5. Copy of GA State ID Card
6. Copy of Insurance Card(s)
7. Copy of Social Security Card
8. Copy of Medicaid ID Card
9. Benefit Verification Letter (Annual SSI Award Letter)
   https://www.ssa.gov/manage-benefits/get-benefit-letter

Date Application Completed: _____

Application Completed By:_____

Relationship to Applicant: _____