

**Screening Procedure:**

Cornerstone Support Services will receive applications for individual services from any source.

This is a prescreening form/application for services. The applicant, his or her family member, or others with knowledge of the applicant will be encouraged to provide information for the application to help in this process. Additional information will also be requested.

After the required information is submitted, an interview process will be completed to determine whether or not the facility can provide services to address the individual's needs and desired outcomes.

If the screening and interview process determines that Cornerstone can provide services, DBHDS, the applicant, and all relevant parties will be notified. The applicant will then be subject to the admission process. If the screening review determines that Cornerstone is not the most appropriate service provider to meet the applicant's needs, all relevant parties will be notified of this determination with recommendations.

---

Date: \_\_\_\_\_

Name of Person(s) Completing Form: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

**Requested Service: Group Home Supported Living Community Engagement Other**

**Demographic Information:**

Full Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Current IQ Score: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male Female

County Of Legal Residence: \_\_\_\_\_

Home Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Current Residency (Group Home, Institution, etc.) and/or Day Program and/or Place of Employment:  
Name and Address: (Include Contact Person)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Contact Person: \_\_\_\_\_

Substitute Decision Maker, if applicable (include type; i.e. Guardian, Conservator, AR, etc.): \_\_\_\_\_

---

Address: \_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (work) \_\_\_\_\_

County: \_\_\_\_\_

Referred By: \_\_\_\_\_

Natural Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (work) \_\_\_\_\_

Education: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Working Hours: \_\_\_\_\_

Natural Mother's Name:

Address: \_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (work) \_\_\_\_\_

Education: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Working Hours: \_\_\_\_\_

Family Involvement: \_\_\_\_\_

\_\_\_\_\_

Religious Preference: \_\_\_\_\_

Current Marital Status of Parents:

(If divorced, please give information regarding current spouse(s), if applicable. If additional space is needed, please use back of this sheet).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medical Information:**

Present: Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Personal Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

List Psychiatric Diagnoses (if any):

---

---

---

List Medical Diagnoses:

---

---

---

Does Applicant Carry Any Contagious Disease(s)? \_\_\_\_\_

(If So, What Type?) \_\_\_\_\_

Last Physical Examination: \_\_\_\_\_

Describe history of medical care:

---

---

Current Diet: \_\_\_\_\_

Seizures: Yes    No

Type: \_\_\_\_\_

Frequency: \_\_\_\_\_

List Seizure Medications (Name / Dosage / Frequency): *Add additional page if necessary*

_____	_____
_____	_____
_____	_____
_____	_____

**Behavior Information:**

Please describe what is important to you: (Interests, Hobbies, Activities and/or Likes & Dislikes)

---

---

---

Disposition of the Individual:

---

---

---

Psychotherapeutic Medication (Name / Dosage / Frequency): *Add additional page if necessary*

---

---

---

Behavioral Support Needs: (Identify Any Maladaptive/Self-Injurious and/or Inappropriate Behaviors)

---

---

---

Frequency (Daily, Weekly, Monthly, Etc.): \_\_\_\_\_

Intensity (Mild, Moderate, Severe): \_\_\_\_\_

Planned Program/Guidelines/Behavior Support Plan (Description):

---

---

---

---

---

**Self Care Information:**

A. Dining:

1. Independent
2. Minimal Assistance  
(Basic Reminders)
3. Maximum Assistance  
(Physical/Verbal Assistance/ Prompting)

B. Bathing: *(Residential Services Only)*

1. Independent
2. With Assistance (Specific-Verbal,  
Physical, Gestural)
3. Full Physical
4. Resists Bathing

- 4. Requires Adaptive Equipment or Specialized Diet
- 5. G-Tube

Description of Needs: \_\_\_\_\_

\_\_\_\_\_

- C. Ambulation:
- 1. Ambulatory
  - 2. Semi-Ambulatory (Explain)
  - 3. Self-Propels Wheelchair (Independent)
  - 4. Wheelchair (Requires Assistance)

- D. Dressing:
- 1. Independent
  - 2. Verbal Prompts
  - 3. Physical Assistance

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- E. Toileting:
- 1. Independent
  - 2. Verbal Reminders
  - 3. Physical Assistance
  - 4. Incontinent

Description of Needs: \_\_\_\_\_

\_\_\_\_\_

- F. Communication:
- 1. Verbal
  - 2. Non-Verbal
  - 3. Symbol Board
  - 4. Manual Signs
  - 5. Gestures
  - 5. Problems Sleeping At Night
  - 6. Other

- G. Sleeping Habits: *(Residential Services Only)*
- 1. Sleeps Through the Night
  - 2. Gets Up To Use the Bathroom
  - 3. Sleeping During the Day
  - 4. Bed Wetting
- (Explain)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- 6. Receives Medication for Sleep  
(if so, what type/dosage)

\_\_\_\_\_

**Reason for Service:**

Why are you interested in utilizing Cornerstone's services? (Use additional space if needed on back of this sheet)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

---

---

---

---

---

Have you utilized other DBHDS Community Programs (*Residential or Day Services*) in the last three (3) years?  
Yes No

If yes, please explain:

---

---

---

Have you ever been denied or asked to leave a community program? Yes No

If yes, please explain:

---

---

---

Consent for Release of Information:

With this application I grant representatives of Cornerstone Support Services permission to perform any needed professional evaluations that may be necessary to meet the admission requirements.

\_\_\_\_\_  
Signature of Applicant or Authorized Representative

\_\_\_\_\_  
Date

**The following documents may be requested (If not immediately available to you, these items can be submitted at a later date pending contact from Cornerstone):**

- Current Person Centered Plan or ISP (Individual Support Plan)
- Psychological Evaluation
- VIDES Assessment
- SIS Assessment
- Medical History (Past and Current)
- Current Physical
- Immunization Records
- Behavior Support Plan
- Therapy Plans
- Etc.

**Thank you for taking the time to complete this Screening Application for Cornerstone Support Services. We want all of the people interested in our services to have a positive and successful experience. The information you provided will be helpful in accomplishing this goal.**

---

**For Office Use Only:**

Date: \_\_\_\_\_

Date of Initial Contact: \_\_\_\_\_

Name of Screening Employee: \_\_\_\_\_

Method of Screening:

Screening Form Completed and Reviewed? Date and Initials: \_\_\_\_\_

Evaluations Submitted and Reviewed? Date and Initials: \_\_\_\_\_

Interview Process Completed with Interdisciplinary Team? Date and Initials: \_\_\_\_\_

Admitted to Service? Date and Initials: \_\_\_\_\_

Put on Wait List? Date and Initials: \_\_\_\_\_

Referred to other Service for further Assessment? Date, Initials & Name of Service: \_\_\_\_\_

Screening Recommendations:

---

---

---