CROSS INC.

712 Pinola Road
Shippensburg, PA 17257-9341
717 -530-1788
www.crossinc.com

POPULATION SERVED: Adults with developmental disabilities

OWNERSHIP: Private, non-profit corporation.
Governed by a Board of Directors.

INCORPORATION DATE: April 1985

BUDGET: 2016-2017Budget - $556,000
50% of the operating budget is from contributions.

PERSONAL CARE HOMES:

Grace Home, 712 Pinola Road, Shippensburg.
Opened July 1987
Capacity – Eight (8) Residents

Griffith House, 1345 Apple Way, St. Thomas
Opened January 1996
Capacity - Six (6) residents

Cumberland Vista, 1073 York Road, Dillsburg, Pa.
January 1, 2006
Capacity: Eight (8) Residents

OTHER PROGRAMS:

Sponsors Coffee Houses for adults with disabilities.
Camp CROSSroads – camps for children and adults with disabilities.

ADMINISTRATIVE STAFF Executive Director, House parents

PROGRAM STAFF: Houseparent model. Part-time direct care staff

ADMISSION CRITERIA

1. AMBULATORY AND SELF-PRESERVING

   Each resident must be able and evacuate a building without physical help or have the knowledge training to go out an exit promptly when an alarm is sounded.

2. PRIMARY DIAGNOSIS OF DEVELOPMENTAL DISABILITY

3. ABLE AND WILLING TO PARTICIPATE IN FULL-TIME DAY ACTIVITY OUTSIDE THE HOME

4. NOT IN NEED OF HOSPITAL CARE OR INTERMEDIATE OR SKILLED NURSING CARE

   Health problems must be limited to those which can be managed through regular trips to a physician.

5. ELIGIBLE FOR SOCIAL SECURITY BENEFITS (OR ABLE TO PAY PRIVATELY)

6. POSSESS INDEPENDENT BATHING AND DRESSING SKILLS WITH SOME PROMPTING, ASSISTANCE AND SUPERVISION AS NEEDED

7. NOT VIOLENT OR PHYSICALLY AGGRESSIVE

8. ABLE AND WILLING TO ATTEND CHURCH REGULARLY AND REFRAIN FROM THE USE OF ALCOHOL, TOBACCO PRODUCTS, ILLEGAL DRUGS, AND PROFANITY

9. CAPABLE OF FEEDING SELF

10. PERSONALLY WILLING TO ENTER THE PROGRAM AND COOPERATE ON A VOLUNTARY BASIS

BECOMING A RESIDENT
GENERAL INFORMATION

DAILY LIVING

Each person has his/her own bedroom. Grace House, Griffith Home and Cumberland Vista provide a bed, dresser with mirror, nightstand, lamp and chair. Each room has a large closet for storage. Linens and towels are provided. A person may choose to partially or totally furnish his/her room. **CROSS has a no firearms or weapons policy for residents.**

Residents are encouraged to add personal belonging and decorations to their rooms. In addition, they may bring items such as a television, tape player, etc. While staff do oversee resident activities and make efforts to prevent deliberate destruction of property, CROSS cannot be responsible for these items.

Each resident has an assigned laundry day. Staff provides assistance as needed. Consequently, a resident should have at least seven changes of clothing for each season. Residents need at least two pair of shoes - dress and casual. A light jacket or sweater, a winter coat, hat and gloves and boots are also needed. It is not imperative that clothing be labeled, but it is helpful.

CROSS provides each resident's personal items such as soap, toothbrush, toothpaste, deodorant, shampoo and sanitary pads. Families are encouraged to provide the male residents with an electric razor.

Residents assist in the day to day routines of living. They help with cleaning their rooms as they are able, and other routines.

NON-PROVIDED SERVICES

CROSS does not provide Physical Therapy, Occupational Therapy, Speech Therapy, Laboratory Tests, Podiatry Services, Hearing or Vision Evaluations, Psychiatric Evaluations, Ambulance Transportation, nor an in-house doctor on staff.

If a resident would require any of the above services, CROSS will arrange for these services with an outside agency as per doctors orders. CROSS will also see that transportation is available for same.

RECREATION

A monthly Activity schedule is planned and posted in each home. These activities may include picnics, band concerts, swimming, bowling, eating *out,* shopping, etc. Residents are expected to attend church on Sunday morning. As other church activities are available, they may participate in those.

Staff will assist the resident in using free time creatively and productively.

The resident is responsible for any recreational expenses.

FAMILY CONTACT

Families are an important part of the resident's life and routine contact with them is encouraged. Families may visit any evening prior to 9:00 p.m. It is advisable to call to ensure that the resident is at home. Generally, Sunday afternoon and evenings are times when families visit and no other activities are planned. Telephone contacts are also appropriate.

Overnight visits to the homes of family and friends are permitted and encouraged. These should be arranged at least one week in advance. Shorter day trips or going out for several hours is also permitted.

Residents usually spend about three days with their families at holidays (Easter, Memorial Day, July 4, Labor Day, Thanksgiving and Christmas). Each year a holiday schedule is sent to families.

It may be in the best interest of a new resident to have limited contact with the family while he/she makes the transition to living here. This is done on a case by case basis.

MEDICAL/DENTAL

Thirty (30) days prior to the admission date, a new resident must have physical completed by his/her physician. A specific form is used which is called an MA 51. This form will be provided to the family in time for this. An annual physical exam is required.

If the resident's physician has a local practice, the resident continues to use that office for any illnesses, medications, etc. If a new doctor is needed, staff will work with the resident to secure one. Staff schedule and accompany the resident to the doctor.

Blister packs are recommended for medications. This packaging is used to minimize any medication errors. Staff can assist with filling prescriptions. The dispensing of medications depends on the resident's individual abilities. All medications are kept in a locked cabinet. The doctor gives written permission each year for any over the counter medications that can be used.

A resident sees his/her dentist a minimum of annually.

Residents are financially responsible for any medical costs.

FINANCIAL

If the family is the representative payee for the resident, they should make payment by check at the beginning of the month. If there is a need, CROSS can become the representative payee for the resident.

CROSS will accept as payment the established amount from SSI and SS as determined by DPW. This fee represents approximately 75% of the actual cost per month. We encourage families to contribute to CROSS as they are financially able. Private pay is $1,370 per month. A person who is ineligible for SSI is considered private pay.

Each resident receives a personal allowance of $85.00 per month. Funds are usually kept in a bank account which is maintained by CROSS in the resident's name. Some cash is kept in the home in a locked cabinet and dispersed to the resident as he/she has need. All cash expenditures are documented.

A resident reimburses a transportation fee to CROSS each month for transportation to the day program.

Any earnings from the day program belong to the resident and is put into his/her account.

FEE SCHEDULE

The current fee for a resident to live at one of CROSS's homes is the equivalent of his/her Social Security benefits (including SSI) and the Personal Care Home supplement less the current personal needs allowance.

The 2017 private pay rate is $1,370 per month.

DAY PROGRAM

Residents are required to participate in a Day program. CROSS will provide or assist in arranging transportation.

Staff will attend the annual review of each resident. Families are welcome to continue their attendance of these reviews also.

Residents take a packed lunch to the day program. If he/she prefers to purchase food items at the program, personal cash is used.

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EVALUATION INFORMATION

In addition to the information required on the admission application, we ask that you include the following information:

1. Medical history and statement of current health. (Personal Care Home regulations require that a new resident be examined by a doctor within 30 days prior to admission. Should the applicant be accepted for admission, a form will be forwarded to you.)
2. Dental history.
3. Psychological assessment.
4. Psychiatric evaluation. Summary of any therapies. (If this is applicable to the applicant.)
5. Social history.
6. Educational/vocational records.

Enclosed are release forms which you may use to obtain this information.

DISCHARGE CRITERIA

A participant of the program may be discharged from CROSS when one or more of the following occurs:

1. Development of a primary diagnosis of mental illness or manifestation of strong characteristics of mental illness and/or emotional disorder.

2. Development of physical, psychological and/or medical restrictions which prevent a reasonable degree of participation in CROSS'S overall program.

3. Loss of ability to attend to own basic needs as outlined in CROSS's admissions criteria.

4. Physician can no longer certify that resident is not in need of hospital care or intermediate or skilled nursing care.

5. Demonstration of inappropriate physical, social or sexual behavior.

6. The resident endangers his/herself or others.

In the event of discharge, it shall be understood that the individual is entitled to the same rights, privileges, and treatment as any other program participant regardless of special needs and will be cared for appropriately until the discharge procedure has been completed. Except for those situations demanding immediate discharge, the staff will counsel with the participants family members, state agency, or private program, et. al. to develop an appropriate placement plan prior to discharge.

CROSS, Inc.
712 Pinola Road
Shippensburg, PA 17257

Application for Admission

General Information

Applicants Name:_____

Social Security #_____

Address:_____

Phone# _____ Date of Birth: _____

Sex: _____ Race: _____

Citizenship: _____ Language: _____

Marital Status: _____ Religious Affiliation: _____

Height: _____ Weight: _____

Hair Color: _____ Eye Color: _____

Information Cont.

Father's Name:
_____

Address: _____

Phone: _____

Mother's Name:_____

Address:_____

Phone: _____

Applicant resides with: □ Parent(s) □ Sibling

□ Other _____

Emergency Contact:

Name:_____

Address:_____

Phone:_____ Relationship:_____

Next of Kin:_____

Address:_____

Phone:_____ Relationship:_____

INCOME

Social Security:_____ Supplemental Security Income(SSI):_____

Public Assistance:_____ Waiver Funding: _____

Other (List source & amount)_____

MEDICAL INSURANCE

□ None

□ Medicaid # _____

□ Medicare# _____

□ PA DPW Health Card# _____

□ Other _____

DAY PROGRAM INFORMATION
(If Applicable)

Program:_____

Address:_____

Phone:_____

Contact Person: _____

Transportation Arrangements: _____

PERSONAL FINANCES

□ Applicant handles personal finances

□ Applicant can handle finances on a limited basis:

- □ Daily Amount_____
- □ Weekly Amount _____

□ Caregiver must handle all of the applicant's finances.

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Lifetime Medical History

Name_____ Birthdate_____

Place of Birth_____ Race _____

List any identifying marks (scars, birthmarks, etc.)

_____

Does this individual have a court-appointed legal guardian ____Yes ____No

Guardian name_____ Relationship_____

Address_____

Phone_____ Cell phone_____

Does this individual have a Power of Attorney? ____Yes ____No

POA Name_____ Relationship_____

Address_____

Phone_____ Cell phone_____

Current Health Care Providers

Family Physician_____ Phone_____

Dentist_____ Phone_____

Specialists / Therapists

Name _____ Specialty _____ Phone_____

Name _____ Specialty _____ Phone_____

Name _____ Specialty _____ Phone_____

Name _____ Specialty _____ Phone_____

Immunization History and Testing

TYPE	Date Received	TYPE	Date Received
Tetanus/Diptheria		Hepatitis Vaccine	
TB Test (date/result)		Hepatitis Profile	
Flu Shot		Pneumovax	
Other (name/date)		Other (name/date)	

Level of Intellectual Disability ____Profound ___Severe ___Moderate ___Mild

Mental Health Diagnosis/Diagnoses	Year Diagnosed

Medical Diagnosis/Diagnoses	Year Diagnosed

Does this Individual have a seizure disorder? ____Yes ____No
Is it controlled? ____Yes ____No

Current Medications and Treatments

Medication	Diagnosis	Dosage & Frequency	Prescribing Physician

Allergies / Sensitivities

Item	**Type** (food, drug, environmental)	**Reaction**

Hospitalizations

Year of Admission	**Hospital**	**Diagnosis / Reason / Surgery**

Check any of the following conditions that apply. Check if it affects daily routine.

	Yes	No
□ Heart Disease	□	□
□ Cancer	□	□
□ High Blood Pressure	□	□
□ Diabetes	□	□
□ Arthritis or Rheumatism	□	□
□ Chronic Kidney Disease	□	□
□ Stroke	□	□
□ Stomach Ulcers	□	□
□ Emphysema	□	□
□ Asthma	□	□
□ Chronic Bronchitis	□	□
□ Epilepsy (Seizures)	□	□
□ Tuberculosis	□	□
□ Hepatitis	□	□
□ Liver Disease	□	□
□ Anemia	□	□
□ Multiple Sclerosis	□	□
□ Muscular Dystrophy	□	□
□ Cerebral Palsy	□	□
□ Polio	□	□
□ Parkinson's disease	□	□
□ Hearing Impairment	□	□
□ Vision Impairment	□	□
□ Speech Impairment	□	□
□Missing fingers, hand or arm	□	□
□ Missing toes, foot or leg	□	□
□ Paralysis	□	□
□ Chronic back problems	□	□

(Cont.)

	Yes	No
□ Fainting Spells	□	□

□ Other_____

Is the client in a special diet? □Yes □No

If yes, specify:

_____

_____

Does the client wear or need glasses or contact lenses? □Yes □No

Check those client uses or needs:

□Hearing Aid □Wheel Chair

□Crutches □Cane or Walker

□Artificial limb or brace □Dentures

□Other (specify):

_____

Does the client require assistance in utilizing any of the above devices or in walking? □Yes □No

PERSONAL CARE SERVICES

Check is the client requires assistance with any of the following. Describe the assistance needed and any special equipment or apparatus.

PERSONAL HYGIENE	**COMMENTS**
□ Bathing	_____
□Oral Hygiene	_____
□Hair – Grooming/Shampooing	_____
□Dressing/Undressing	_____
□Toileting	_____
□Care of Clothing	_____
□Personal Laundry	_____
□Shaving	_____
□Other (Specify)	_____

TASKS OF DAILY LIVING

□Securing Transportation	_____
□Shopping	_____
□Making and Keeping Appointments	_____
□Care of Personal Possessions	_____
□Use of Telephone	_____
□Getting in and out of Bed	_____
□Walking up and down Stairs	_____
□Aid with Bathing/Showering	_____
□Eating – Utensils	_____
□Other (Specify)	_____

SOCIAL PARTICIPATION

Indicate activities, pastimes or work the client especially enjoys; also list personal strengths and skills:

□Interacts readily with others
□Watches TV
□Enjoys being read to
□Jigsaw puzzles
□Games – Bingo, Uno, etc.
□Manipulates and/or stacks blocks
□Cuts using scissors
□Participates in sports activities
□Watches & follows sporting events/teams
□Can tell time
□Listens to music
□Looking at books/magazines
□Reads independently
□Word find puzzles
□Plays with balls
□Colors
□Outdoor activities
□Crafts
□Other
□Able to write

_____

_____

_____

CLIENT CHARACTERISTICS

Listed below are specific behavior, communication, and emotional problem areas. Check those which are problems for the client.

□Wets bed, incontinent
□Uses offensive language
□Unusual habits or rituals
□Abusive to self
□Is often afraid
□Alcoholism or drug abuse
□Wanders, gets lost
□Runs away
□Suicidal threats or behaviors
□Destructive
□Other (specify)

□Easily upset
□Depressed, unhappy
□Worries a lot
□Abusive to others
□Resists direction, supervision
□Upset over recent death of loved one
□Hallucinates
□Feels plotted against
□Has difficulty communicating

_____
_____

For problems checked, provide relevant details (i.e., frequency and intensity of problem, source of information, etc.):

_____
_____

REFERENCES

List persons familiar with the applicant and would give an assessment of how the applicant may function in a new living arrangement.

1. Name: _____

Address: _____

Phone: _____ Relationship:_____

2. Name: _____

Address: _____

Phone: _____ Relationship:_____

3. Name: _____

Address: _____

Phone: _____ Relationship: _____

_____ _____
Signature of Person Completing Application Date

Relationship: _____

INFORMAL SUPPORTS

Provide the names, addresses and phone numbers of family members and friends who are important to the applicant and might be of assistance to him/her. Indicate relationship.

1. Name: _____

Address: _____

Phone: _____ Relationship:_____

2. Name: _____

Address: _____

Phone: _____ Relationship:_____

3. Name: _____

Address: _____

Phone: _____ Relationship:_____

SERVICE SUPPORTS

List agencies providing services to the applicant at this time and a contact person who is familiar with the applicant.

Agency: _____
_____

Contact Person: _____

Agency: _____
_____

Contact Person: _____

Agency: _____
_____

Contact Person: _____

RELEASE OF INFORMATION

In order for the staff of CROSS, Inc. to provide comprehensive residential services to me, it is necessary for them to exchange information with other agencies that I am involved with.

My signature indicates that I,_____, am giving the staff of CROSS, Inc. permission for ongoing information exchange with the following agencies:

□Day program/Workshop_____
□Base Services Unit
□Medical/Dental Services (please list)

_____

_____

_____

□Other _____

_____

This release is no longer valid upon my discharge from CROSS, Inc.

_____ _____
Signature Date

_____ _____
Parent/Guardian Signature Date