



## **HISTORY AND OVERVIEW OF AGENCY**

Western North Carolina Group Home for Autistic Persons, Inc. (known as WNC Group Homes) is a non-profit corporation established to serve developmentally disabled persons with autism and mental retardation. Four of the present group homes are Intermediate Care Facilities for the Mentally Retarded (ICF/MR), each serving five to six residents, with priority placement given to those from the Western twenty-five counties of North Carolina. The fifth home is an Adult Care group home for Developmentally Disabled Adults (DDA).

The first home, Ora Street Group Home, was built in 1984 with a HUD grant. The home was certified as an ICF/MR facility in May of 1985. In November of 1989, the Board submitted two Certificate of Needs (CON) applications to the Division of Facility Services, one to expand our first home from five to six residents and one to build a new group home for six adults. Both applications were approved and we admitted our sixth resident at our first home in September 1990. Construction on the second group home for adults began in the fall of 1990. The home, Pisgah View Group Home, was licensed in June and certified in September 1991.

Our third home is a children's home that opened in February 1993. The Kenmore Street Group Home currently serves young adolescents and adults. As the children age, however, this home will eventually become an adult home.

Our fourth home opened in January 1994. It is a Developmentally Disabled Adult home that serves high functioning adults with a variety of disabilities. The home will serve two to four persons with autism, the remainder with other disabilities. This deviation from serving only autistic persons is to provide increased socialization opportunities for the residents.

Our fifth home, Montford Group Home, was awarded a Certificate of Need in November 1993 and accepted residents in February 1995. Currently, this home serves five adolescents and young adults. As these residents age, eventually this home will become an adult home. Montford is an ICF/MR facility.

The Board of Directors of the agency is composed of parents of autistic or autistic-featured individuals, various professionals in the fields of autism and mental retardation, and concerned citizens.

It is the philosophy of WNC Group Homes that every human being has the inherent right to enhance their development and maximize their achievement of self-determination and autonomy in the least restrictive, most humanistic and normalizing environment available to them. It is also the philosophy of the group home that families and guardians are encouraged to become involved in the daily activities of the group home. Visits between residents and their families are encouraged, whether at the group home or at the family's home.

Residents of these group homes are involved in an active treatment plan. This active treatment plan is developed by an interdisciplinary team comprised of specialized consultants, group home staff, parents, guardians, and when possible, the resident him or herself. This plan provides for specialized services which encourage the individual resident to develop skills enabling him or her to become more self-sufficient, independent, and to maximize social acceptance. The following services are available for each resident as needs are identified: medical, nutritional and nursing services, physical and occupational therapy, psychological, speech, language, hearing, social, recreational, and education/vocational.



## **APPLICATION FOR ADMISSION - REQUIREMENTS AND PROCESS**

Attached is an application packet for admission to the Western North Carolina Group Home for Autistic Persons, Inc. (known as WNC Group Homes - or "WNCGH" throughout this application). These forms represent the initial phase of the admission process and must be completed in full.

All applicants must:

1. be a resident of North Carolina
2. be diagnosed with autism or have autism features (the Gwen Rash Memorial Group Home, however, will serve persons with a developmental disability who do not have autism)
3. have an appointed guardian if over age 18
4. must be eligible for placement in a school program (child) or in a day training program (adult)
5. demonstrate the potential for progress during treatment and training
6. be able to have his/her health needs met within the existing WNCGH program
7. agree to provide remuneration for services if he/she is ineligible for entitlement of funds
8. not demonstrate a need for continual one-to-one services

Due to the "aging up" of the Kenmore and Montford Group Homes, applicants must fall within a similar age range and functioning level as the other residents of these homes.

Priority for admission to WNCGH shall be awarded to:

1. Ora Street Group Home - residents of the 25 western counties of North Carolina
1. Pisgah View Group Home - residents of the 25 western counties of North Carolina
2. applicants whose current living situation and/or placement is most inadequate
3. applicants whose needs cannot be met by other available programs
4. applicants who demonstrate the ability to participate in the WNCGH program without limiting the delivery of services to other residents
5. applicants whose families or advocates are willing and able to support and be involved with the WNCGH program

Upon receipt of this application and all required attached documents (such as a current psychological evaluation, IEP, or current Habilitation plan), the application for admission

packet will be reviewed by the Social Services Coordinator. When an opening occurs, the Social Services Coordinator may request additional current information such as a social history and medical evaluations. The Social Services Coordinator and appropriate staff and/or consultants will make a preliminary prioritization of the applicant. The Social Services Coordinator will present the preliminary prioritization list, application information, and reasons for ranking to the Admissions and Discharge Committee of the Board of Directors. Non-eligible applicants will also be noted along with the reasons for ineligibility. The Admissions and Discharge Committee will submit applicants to the Interdisciplinary Team for further evaluation and recommendation of placement.

All applications remain active until such time as an applicant requests termination of their application or the applicant is determined to be ineligible with no probability of future eligibility. Applicants whose applications are being terminated will be notified of the termination.

All services provided by Western North Carolina Group Home for Autistic Persons, Inc. will be administered in such a manner that no person shall be excluded from participation in, or denied the benefits of, or be otherwise subject to discrimination on the grounds of sex, race, religion, age, or national origin.

Submit the completed application package to:

Social Services Coordinator  
WNC Group Homes  
28 Pisgah View Avenue  
Asheville, NC 28803



## APPLICATION FOR ADMISSION

### 1. Personal Information

Applicant's Name

\_\_\_\_\_  
First Middle Last

Also Known as

\_\_\_\_\_

Applicant's Present Address

\_\_\_\_\_  
PO Box/Street

\_\_\_\_\_  
City State Zip Code

Telephone Numbers

\_\_\_\_\_  
Home Work Cell

Applicant's Permanent Address

\_\_\_\_\_  
PO Box/Street

\_\_\_\_\_  
City State Zip Code

### 2. Legal Guardian Information

Guardian's Name

\_\_\_\_\_  
First Middle Last

Address

\_\_\_\_\_  
PO Box/Street

\_\_\_\_\_  
City State Zip Code



Mother's Name

\_\_\_\_\_  
First Middle Last

Address

\_\_\_\_\_  
PO Box/Street

\_\_\_\_\_  
City State Zip Code

Telephone Numbers

\_\_\_\_\_  
Home Work Cell

Preferred Time to Contact

\_\_\_\_\_  
Email Address \_\_\_\_\_

Brothers/Sisters

\_\_\_\_\_  
Name Age Current Residence

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

**4. Background Admission Request Information**

Applicant's County of Residence \_\_\_\_\_ Sex \_\_\_\_ Race \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

\_\_\_\_\_  
City/State  
County of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Eye Color \_\_\_\_\_ Hair Color \_\_\_\_\_

Primary Disability

\_\_\_\_\_

Age of Onset of Disability

\_\_\_\_\_

Other Disabilities (and age of onset of the disability)

---

**5. Financial Status**

Financial Support:

SS (monthly amount) \_\_\_\_\_

SSI (monthly amount) \_\_\_\_\_

Special Assistance (monthly amount) \_\_\_\_\_

Savings Account Balance \_\_\_\_\_ Family Trust (yes/no) \_\_\_\_\_

Other (Source and Amount)

---

**6. Insurance**

Medicaid

---

Number State/County

Medicare

---

Number State//County

Hospitalization Insurance

---

Name of Insurance Company

Policy Number

---

Policy Holder's Name

---



**B. Local Management Entity ( LME ) Involvement**

Responsible LME:

\_\_\_\_\_

Address:

\_\_\_\_\_

Phone and Contact Person:

\_\_\_\_\_

**C. Previous Involvement with WNC Group Home for Autistic Persons**

Has the applicant ever been admitted to WNC Group Homes? \_\_\_\_\_

If yes, when? \_\_\_\_\_

**8. Current Supports/Services ( Attach Person Centered Plan/Habilitation Plan )**

**A. Current Residential**

\_\_\_\_\_ Living at home with family

\_\_\_\_\_ ICF/MR Group Home

\_\_\_\_\_ DDA Group Home

\_\_\_\_\_ Psychiatric Facility

\_\_\_\_\_ State Developmental Center

\_\_\_\_\_ Other (specify type) \_\_\_\_\_

Agency/Contact Person/Position/Address/Phone for current residential placement

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If this is not a long term placement, identify timeframe and plan.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**B. Current Day Program/School/Work**

Agency/Contact Person/Position/Address/Phone

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

Number of hours per week \_\_\_\_\_

Type of activities involved in currently:

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

Attach latest IEP or explanation of termination of educational services if applicant is less than 22 years old.

School \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

School Contact Person/Position \_\_\_\_\_

**C. Other Current Services/Supports Being Received**

Support/Service	Provider	Funding Source
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**9. Diagnostic Information**

A. **Check all diagnoses which apply** (Attach copy of Psychological Evaluation.)

- Mild Mental Retardation
- Moderate Mental Retardation
- Severe Mental Retardation
- Profound Mental Retardation
- Seizure Disorder (note type/frequency) \_\_\_\_\_
- \_\_\_\_\_
- Mental Illness (specify) \_\_\_\_\_
- \_\_\_\_\_
- Autism Spectrum Disorder
- Cerebral Palsy (specify type) \_\_\_\_\_
- Visual Impairment (specify) \_\_\_\_\_
- Hearing Impairment (specify) \_\_\_\_\_

**B. Other Diagnoses**

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

**10. Medication/Medical Information** (Attach additional pages as needed.)

**A. Medications**

Medication	Dosage	Reason for Taking	Physician Ordering	Date Started

**B. List any medication to which there were severe or allergic reactions  
(describe reactions)**

---

---

---

**C. Additional medical issues/concerns**

---

---

---

---

**D. Current Physicians/Dentist**

Name	Specialty	Address	Telephone
<hr/>			
<hr/>			
<hr/>			
<hr/>			

**E. Most Recent Physical Exam**

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

Examiner/Contact Info:

---

---

---

Notable Findings:

---

---

---

---

**F. Immunizations/Medical Screenings**

Attach immunization records and results of hepatitis and tuberculosis screenings.

**G. Evaluations/Medical/Medication History**

Attach Psychological Evaluation completed within the past year for an applicant under 18 years of age, and within the past three years if for an adult. Also attach any diagnostic testing results which are significant.

Attach discharge summaries from all hospitalizations within the past three years and others which are significant.

Attach summary of medication history.

**Abilities/Skills/Support Needs**

H. NC SNAP Score: \_\_\_\_\_ Raw Scores: \_\_\_\_\_  
Date Completed: \_\_\_\_\_

**I. Ambulation**

- \_\_\_ Walks without assistance
- \_\_\_ Walks with assistance
- \_\_\_ Non-ambulatory/ can maneuver wheelchair
- \_\_\_ Non-ambulatory/ cannot maneuver wheelchair

**J. Communication**

EXPRESSIVE:

- \_\_\_ Uses verbal language clearly  
( \_\_\_ sentences \_\_\_ phrases \_\_\_ single words)
- \_\_\_ Uses augmentative communication device
- \_\_\_ Uses verbal language with difficulty
- \_\_\_ Uses manual or symbol communication
- \_\_\_ Uses informal communicative gestures
- \_\_\_ Vocalizes to communicate
- \_\_\_ Does not respond to intentionally express self

RECEPTIVE:

- \_\_\_ Understands most communication by others
- \_\_\_ Understands some communication by others

- Attends to gestures and auditory cues
- Does not respond to most communication by others

**K. Dressing**

- Dresses independently
- Requires verbal prompts
- Requires physical assistance
- Requires total assistance

**L. Toileting**

- Toilets independently
- Requires verbal prompts
- Requires physical assistance
- Incontinent (other info) \_\_\_\_\_

How does this person indicate the need to toilet?

\_\_\_\_\_

**M. Eating**

- Eats independently
- Requires verbal prompts
- Requires physical assistance
- Requires total assistance
- Requires tube feeding

Diet:  Regular  Chopped  Pureed  Liquid

Diet or Eating Concerns:

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

Food Favorites:

\_\_\_\_\_

Food Dislikes:

\_\_\_\_\_

Food Allergies:

\_\_\_\_\_

**N. Bathing**

- Bathes independently
- Requires verbal prompts
- Requires physical assistance
- Requires total assistance

Bathing preferences:

---

**O. Sleeping**

- Sleeps through the night
- Does not sleep through the night (describe)

---

- Has special sleep items (list)

---

Sleep preferences:

---

**P. Leisure**

- Independently plans/ spends leisure time
- Makes good use of leisure time
- Requires encouragement to spend leisure time well or with others
- Requires assistance with hobbies/ crafts
- Requires socialization skills building
- Requires activities to be planned by others

Leisure Activities Preferences:

---

How does the applicant respond when taken on community outings?

---

**Q. Socialization**

- Indicates interactions
- Responds to interactions
- Avoids interactions
- Little response to interactions

**R. Supportive/ Protective Devices**

- None
- Wheelchair
- Walker/ crutches/ braces
- Hearing aid
- Corrective lenses
- Adaptive clothing
- Helmet
- Supportive belts/ vests
- Bedrails

**S. Behavior Management**

- No special support needed

REQUIRES ONGOING MANAGEMENT OF: (Attach current behavior support plan/ guidelines/ crisis plan as well as data to indicate frequency/ intensity.)

- Self injury
- Verbal aggression
- Physical aggression (describe)

---

---

- Property destruction (describe)

---

---

- Inappropriate sexual behavior
- Taking others' belongings
- Tantrums
- Inappropriate attention seeking
- Other (specify)

---

How does the applicant respond to noise?

---

List situations which trigger problems:

---

---

---

---

---

---

---

**2. Legal Guardian Input** (Attach pages, if needed)

As guardian, include any additional comments you feel would be helpful in evaluating this request for admission to Western North Carolina Group Home for Autistic Persons, Inc.

---

---

---

---

---

---

I hereby request residential services from Western North Carolina Group Home for Autistic Persons, Inc. for the applicant described. I understand that consideration will be given to this request without regard to race, ethnic origin, sex, or ability to pay. I understand that return to community services will be an on-going goal for any individual admitted to an ICF/MR or DDA Group Home.

**Signature of Guardian/ Co-Guardians:**

---

**Printed Name of Guardian/ Co-Guardians:**

---

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

CHECKLIST: Items included in the application packet.

- \_\_\_ Application
- \_\_\_ Birth Certificate (copy)
- \_\_\_ Medicaid Card (copy)
- \_\_\_ Guardianship Papers (copy)
- \_\_\_ Social History
- \_\_\_ Person Centered Plan (if applicable)
- \_\_\_ IEP (if applicable)
- \_\_\_ Current Psychological Evaluation
- \_\_\_ Immunization Record
- \_\_\_ Results of Hepatitis/ Tuberculosis Screenings
- \_\_\_ Evaluations/ Diagnostic testing results completed in the last year and others which are significant
- \_\_\_ Discharge summaries for all hospitalizations in the past three years and others which are significant
- \_\_\_ Summary of medication history if medication regime evaluation is being requested
- \_\_\_ Current Behavior Support Plan and Crisis Plan; Frequency/ Intensity Data

**Mail the completed application packet to:**

**Social Services Coordinator  
WNC Group Homes  
28 Pisgah View Avenue  
Asheville, NC 28803**

**If you have questions, please call (828) 274-8368.**