Pathway to Everyday Life

SIL & TL
Referral Intake
Application Package

Please ensure that all sections of these forms are completed. Submitting an incomplete form may delay the placement process.

The referral WILL NOT be accepted without a 30-days supply of medication or prescriptions for all current medications taken.

Pathway to Everyday Life Human Services, Inc.
595 N. Laurel Street Unit 1N Hazleton, PA 18201
Tel. (484) 209-9981 Fax: (484) 214-0088
Email: admissions@pathwayeverydaylife.com
Website: www.patyhwaytoeverydaylife.com

SUPERVISED INDEPENDENT/ TRANSITIONAL LIVING APPLICATION

Purpose: Use this form to have a CPS youth or young adult along with their caseworker request placement in a CPS supervised independent or transitional living setting.

Directions: Explain the purpose to the interested youth or young adult, and have youth or young adult complete, sign, and date the form, and return the form to you. Sign and date on the appropriate line and have your supervisor do the same.

After the form is completed by you and the youth/young adult, sign and have your supervisor sign and approve; then forward the following to Pathway to Everyday Life Admissions mailbox at admissions@pathwayeverydaylife.com. Questions about the form or program can be sent to the same mailbox:

- Completed Supervised Independent / Transitional Living Application with required signatures.
- PEATC Life Skills Assessment

For Enhanced Case Management also attach the following:

- Most recent physical, dental, vision and hearing examination
- Most Recent Psychological or Psychiatric Evaluation
- Most Recent Service Level
- List of all current medications and/or prescriptions

SUPERVISED INDEPENDENT/TRANSITIONAL LIVING PROGRAM
To be completed by the Caseworker:
Select which program applying for: ☐ Supervised Independent Living (SIL) ☐ Supervised Transitional Living (TL)

YOUTH/YOUNG ADULT'S INFORMATION			
Date:	Applicant's Full Name:		
Applicant's Last 4 SSN:	Applicant's Legal Region:	Date of Birth:	Age:
Applicant's Full Address, City, State, Zip code, and County:			
Applicant's Email Address:			
Applicant's Phone Number:			

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PERSONAL IDENTIFICATION

Check what documents you have below:

- ☐ State Issued I.D
- ☐ Original Birth Certificate
- ☐ Original Social Security Card
- ☐ Health Insurance Card
- ☐ Permanent Resident Card
- ☐ None

CASEWORKER ONLY:

For all unchecked items, Caseworker will need to provide an explanation and a plan to obtain:

EMPLOYMENT/EDUCATION INFORMATION

Are you still in high school: ☐ Yes ☐ No

If yes what grade and when will you graduate:

Are you still in a GED program: ☐ Yes ☐ No

If yes what is the program and when will you be complete:

Are you currently attending a college, university, or vocational/training program: ☐ Yes ☐ No

If yes where are you attending and how many hours are you taking:

Are you currently working: ☐ Yes ☐ No

If yes briefly describe:

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CITY PREFERENCES

List your top three cities/areas of Northeast Pennsylvania where you would want to live:

1.
2.
3.

☐ No preference

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TYPES SUPERVISED INDEPENDENT/TRANSITIONAL LIVING SETTINGS

There are different housing options that are considered an appropriate SIL/TL setting. These settings have been contracted by Pathway to Everyday Life and may include:

Apartment Setting. An apartment setting is a room or suite of rooms with kitchen facilities designed as a residence and generally located in a building occupied by more than one resident. This setting includes on- site management.

Shared Housing Setting. A shared housing setting is described as several people living cooperatively as an unrelated family in a house with an individual with one person to a bedroom. This involves people renting a house in the community, like an apartment situation. This includes on-site management.

Non-College Dorm Setting. A non-college dorm setting is a building containing several private or semiprivate bedrooms for housing several persons in a community whose inhabitants are either employed and/or in school and commute to these and other personal and social activities. This is like a college dorm without the relationship to an institution of higher learning. This includes on-site management.

Check your top two SIL/TL settings where you would want to live:

- ◯ Apartment Setting
- ◯ Shared Housing Setting
- ◯ Non-College Dorm Setting

Respond to the following questions in the space provided. Attach additional pages if needed.

1. Would you be willing to accept an SIL/TL setting outside of your top two above? ◯ Yes ◯ No;
2. Do you have any specific needs, requests and or accommodation, such as a wheelchair, for an SIL/TL setting?
3. The SIL/TL program does not provide daily supervision. Explain your level of readiness to live in a non-supervised setting?

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INDEPENDENT LIVING SKILLS

On a scale of 1 to 5, check how confident you are with performing the following task. Note: (1) is not confident and (5) is extremely confident. Also, indicate your experience with each task.

How confident are you with skills in self-care (Example: Bathing, dressing self)? :

◯1 ◯2 ◯3 ◯4 ◯5

Applicant Comments:

Caseworker Comments:

How confident are you with cooking? :

◯1 ◯2 ◯3 ◯4 ◯5

List your experience with cooking (Example: I can cook the following: I've never had a chance to cook; etc.)

Applicant Comments:

Caseworker Comments:

How confident are you with budgeting? :

◯1 ◯2 ◯3 ◯4 ◯5

List your experience with budgeting (Example: I have a checking account; I know the difference between need and want; I save more than I spend; I've never had my own money; etc.)

Applicant Comments:

Caseworker Comments:

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How confident are you with grocery shopping? :

1 2 3 4 5

List your experience with grocery shopping (Example: I can shop for vegetables, snacks, meats; I've never bought groceries; etc.)

Applicant Comments:

Caseworker Comments:

How confident are you with cleaning? :

1 2 3 4 5

List your experience with cleaning (Example: I clean my room, clothes, kitchen, bathroom; I've never had to clean; etc.)

Applicant Comments:

Caseworker Comments:

How confident are you with transportation? :

1 2 3 4 5

List your experience with transportation (—Example: I have a driver's license; I can access public transportation; etc.)

Applicant Comments:

Caseworker Comments:

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How confident are you with scheduling your own doctor's appointments?:

1 2 3 4 5

List your experience with scheduling doctor appointments (Example: I can make an annual doctor appointment; I know who to call when I need to see a doctor; etc.)

Applicant Comments:

Caseworker Comments:

How confident are you with Sharing a House? :

1 2 3 4 5

List your experience with sharing a space.

Applicant Comments:

Caseworker Comments:

How confident are you in waking up in the morning, getting to work or school, following house rules, sharing a house? :

1 2 3 4 5

Applicant Comments:

Caseworker Comments:

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Life Management:
Describe a challenge or difficulty that you have experienced in the last 6 months and how you handled the situation? (Example: Work, school, friendships, the balancing of a challenging schedule, getting along with difficult people). Applicant Comments: Caseworker Comments:
Describe how you get along with others you live with and what makes a good house mate? Applicant Comments: Caseworker Comments:

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GOALS

In order to remain eligible for the Program, you must be employed or attending school, or enrolled in a program that removes barriers to employment. List one educational goal and one employment goal you would like to accomplish while in the SIL/TL setting.

Educational Goal:

How do you plan to accomplish this goal?

Employment Goal:

How do you plan to accomplish this goal?

What other goal(s) do you have for the next three years:

How do you plan to accomplish this goal?

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ENHANCED CASE MANAGEMENT SERVICES

This section is to be completed by the Caseworker only

Enhanced Case Management (ECM) services can be provided to eligible young adults that participate in the Supervised Independent Living (SIL) or the Transitional Living (TL) Program when the young adult requires additional support or services to be able to adjust and maintain independence while residing in the SIL/TL placement.

Young adults requiring enhanced case management services may have the following characteristics that include, but not limited to:

- Does not require 24-hour supervision while in the supervised independent living or transitional living program.
- Has basic skills in self-care and the ability to follow a daily routine.
- Has one or more of the following characteristics:
  - frequent, but non-violent, antisocial acts;
  - frequent or unpredictable physical aggression;
  - depressive behaviors including being markedly withdrawn and self-isolating;
  - major self-injurious actions, including attempting suicide in the last 12 months;
  - current abuse of alcohol, drugs, or other conscious-altering substances, that results in severe impairment due to the substance abuse and there is a primary diagnosis of substance abuse or dependency;
  - has an intellectual or developmental disability.

Provide the following information to determine need of service:

Date of last service level and level assigned:

Date of last hospitalization, if applicable:

Date of last physical aggression:

Explain:

Date of last self-harming incident:

Explain

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Date of last psychological or psychiatric evaluation:

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SIGNATURES	
I, _____do hereby acknowledge that the information in this document is true to the best of my knowledge. Furthermore, I authorize _____ to release this document and other relevant information to others only for the purposes of determining my eligibility for the SIL/TL Program.	
Youth or Young Adult: **X**	Date Signed:
Caseworker/Supervisor: By acknowledging below you affirm that that he/she has been prescreened and consulted for admission into the SIL/TL program and have found that he/she can or continues to meet the State requirements and is appropriate for placement in the SIL/TL Program.	
Primary Caseworker: **X**	Date Signed:
Supervisor: **X**	Date Signed:

PATHWAY TO EVERYDAY LIFE OFFICE USE ONLY

Accepted to Pathway IL Program: _____Yes _____ No

Why?: _____

_____

Move In Date:_____Time: _____ AM/PM

Address:_____

Admission completed by: _____ Date: _____

Copies of signed paperwork emailed to Caseworker: _____ Yes _____ No

Name:_____Date sent: _____

PDC PHARMACY PHILADELPHIA
INFORMATION NEEDED FOR NEW INDIVIDUAL

Individual Specific Information

- **Agency:** PATHWAY TO EVERYDAY LIFE HUMAN SERVICES, INC.
- **Full Name of Resident:** _____
- **Address at which the Individual Resides:** 565 N. LAUREL STREET UNIT 1N
  HAZLETON, PA 18201
- **Phone Number:** (484) 209-9981
- **Sex:** Male ☐ Female ☐
- **Date of Birth:** _____
- **Social Security Number:** _____
- **Expected Date Consumer Arriving:** _____
- **Is Consumer Coming With Medications or Are Medications Needed ASAP?:** _____
- **Previous Pharmacy Name & Phone #:** _____
- **Primary Care Physician Information If Applicable:**
  - **First/Last Name & Phone Number:** _____
- **Diagnosis:** _____
  _____
- **Allergy Information:** _____
  _____
- **Diet Information:** _____
- **Agency is Representative Payee (Guarantor):** Yes ☐ No ☐
  If no, please provide the Name, Address, and Phone Number of the responsible person:
  - **First and Last Name:** _____
  - **Address:** _____
    _____
  - **Phone:** _____
- **Does the resident attend a day program?** Yes ☐ No ☐
  If yes, please select the days of the week attended and enter the times of attendance:
  ☐ **Monday** (__-__) ☐ **Tuesday** (__-__) ☐ **Wednesday** (__-__) ☐ **Thursday** (__-__) ☐ **Friday** (__-__)
- **Please note any religious beliefs or cultural background that impact the patient's lifestyle and/or view of healthcare that will need to be considered by PDC Pharmacy when providing care**
  _____
- **Please attach Copies of all Insurance Cards (Include Medicare Card if applicable)**
- **Please include a copy of the current MAR for the individual.**

PDC Pharmacy

PATIENT AUTHORIZATION AND PLAN OF SERVICE

Patient Name: _____ ID_____

Insurance payment authorization: I request that Medicare and/or any other insurance plan that I have to make payments of authorized benefits on my behalf directly to PDC Pharmacy for pharmaceuticals that were furnished to me for which they bill Medicare and/or any other insurance plan on my behalf.

Release of insurance information: I request my medical insurance plan(s) to release to the above named pharmacy, any and all information which will assist in processing my claims for pharmaceuticals that I am receiving from the above named pharmacy even after service to me is discontinued. I also authorized any holder of hospital or medical information about me to release to the health care financing administration, its agents, my insurance company or the above named pharmacy any information needed to determine the benefits that are payable for related services.

I understand if my insurance plan(s) makes payment(s) to me for pharmaceuticals that I have received, rather than directly to the above named pharmacy, I agree to endorse those checks and send them immediately to the above named pharmacy.

I also understand that I am responsible for the payment of any deductible, co-insurance or other portion of my charges not paid by my insurance plan(s). I also understand that I may be eligible for a partial or complete waiver of any unpaid co-insurance charges only, under PDC Pharmacy financial hardship program.

_____ **(Initials) I acknowledge that I have been advised of my financial obligations to PDC Pharmacy including copays, deductibles and any anticipated denials for products furnished by PDC Pharmacy**

I hereby agree that PDC Pharmacy or any of its affiliates may contact me, or my authorized caregiver, by telephone at my place of residence.

I have reviewed and understand the information above. I have been instructed on and understand the use of the products provided. I have received the products ordered. I have received a copy of a patient handout that contains, patient rights and responsibilities, privacy standards, emergency planning, making decisions about your health care, grievance/complaint information and drug information. I have received monograph/instructions for medications received. I have received pharmacy marketing material and information on the pharmacy's scope of services. I have received instructions on how to follow up with PDC Pharmacy

I understand that prescribed pharmaceuticals cannot be re-dispensed. Therefore, these items cannot be returned for credit.

I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service.

Identified needs/problems: The patient may be unfamiliar with use of the pharmaceuticals provided. Expected outcomes: The patient will be provided the pharmaceuticals to comply with the physician's prescription. The patient will use the pharmaceuticals as prescribed by the physician. The patient will know how to obtain follow-up services as needed.

PATIENT OR RESPONSIBLE PARTY SIGNATURE: X_____ DATE:___/___/____

PATIENT OR RESPONSIBLE PARTY

PRINT NAME: _____

IF BENEFICIARY IS UNABLE TO SIGN:_____

WITNESS SIGNATURE / RELATIONSHIP:_____

REASON PATIENT UNABLE TO SIGN:_____

Please return the Patient Authorization and Plan of Service Form to PDC Pharmacy Thank you for choosing PDC Pharmacy

Form Revised: 06/01/2017

Pathway to Everyday Life

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form is being submitted for the release and/or exchange of confidential information including but not limited to: medical, dental, educational, and psychological documents pertaining to _____, who was placed at Pathway to Everyday life group home on _____until _____. This information is being used for the coordination of services and well-being of the aforementioned child.

I, _____, legal guardian and/or custodian of _____

authorize Pathway to Everyday Life Human Services, Inc. to:

☐ release to:
☐ obtain from:
☐ exchange with: _____
_____

_____

_____

The following information pertaining to _____:

☐ Education Records / IEP
☐ Treatment Summary
☐ Dates of Treatment Attendance
☐ History / Intake
☐ Diagnostic
☐ Psychological Test Results
☐ Psychiatric Evaluation / Medication History
☐ Medical / Medication History

For the purpose of:

☐ Intake / Placement into the facility
☐ Evaluation / Assessment and/or Coordinating Treatment Efforts

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier dates, conditions, or event _____.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except that the information has already been released).

_____ Social Security #: _____Date of Birth _____
Signature & Date of Caseworker/Parent/Legal Guardian

_____ _____
Pathway Signature/Title Date

565 N Laurel St. Suite 1N * Hazleton PA 18201 * Tel.: (484) 209-9981 * Fax: (484) 214-0088
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Pathway to Everyday Life

We are committed to enhancing the quality of 'Everyday Life' for every individual.

565 N. Laurel St. Hazleton Pa 18201
Phone: (484) 209-9981; Fax: (484) 214-0088

MEDICAL / DENTAL AUTHORIZATION

Authorization is hereby given to:

Pathway to Everyday Life
Name

565 N. Laurel St. Unit 1N Hazleton PA 18201
Address

484-209-9981
Area Code / Telephone Number

To obtain routine and emergency medical and dental treatment for _____
Date of birth _____.

This authorization does not include non-routine, non-emergency treatment such as non-emergency surgery, cosmetic surgery, or experimental procedures or treatment.

The above names child/youth is in the legal custody of _____
and is in placement with the above-named provider, pursuant to Pennsylvania code Title 55 3130.91.

_____ _____
Caseworker/Legal Guardian/Parent Date

_____ _____
Pathway Signature/Title Date

Pathway to Everyday Life

CONSENT TO TREAT MINOR CHILDREN

In compliance with 3800.241

I, _____, parent or legal guardian of

_____(child's name), Age: _____, born ____/____/_____, **do hereby consent** to any medical and/or dental care and the administration of anesthesia determined by a physician to be necessary for the welfare of the child while said child is under the care of **Pathway to Everyday Life Human Services, Inc.** and I am not reasonably available to give consent.

This authorization is effective from:

Date of Admission: _____/____/_____ to **Date of Discharge:** ____/_____/_____. (3800.241 (b) 3)

_____ _____

Resident/Child Name Signature Date

_____ _____

Caseworker/Legal Guardian/Parent Date

_____ _____

Pathway Signature/Title Date

Pathway to Everyday Life

Additional information to assist in treatment (3800.241 (b) 3)

Family Address: _____

Telephone: _____

Father: _____Home: _____Work: _____

Mother: _____Home: _____Work: _____

Last Tetanus: _____

Allergies to drugs or food:

Special Medications, Blood Type or Pertinent Information:

(3800.241 (b) 2)

Child's Physician: _____**Phone:** _____

Insurance: _____**Policy #:** _____

Preferred Hospital: _____

Copy of the child's most recent health examination is attached. (3800.241 (b) 4)

****Take this consent form with the child to the hospital in an emergency or physician's office when the child is taken for treatment****