



## CERTIFIED RESIDENTIAL OPPORTUNITIES ADMISSION PLAN SPECIALIZED NEEDS, PROPOSED SERVICES, AND SUPPORTS

**Instructions:** As indicated in the Protocol for Certified Residential Opportunities (CRO), the Admission Plan is completed collaboratively between the CRO Team and the residential provider prior to admission. This form must be completed by the CRO Team member and the residential provider staff member with decision making authority related to staffing, programmatic, and environmental modification expenses.

The intention of the Admission Plan is to exchange information about the individual's specialized needs including how the agency plans to meet those needs. CRO staff will obtain information for this plan through the review of all available materials, including risk management, behavior support, and/or medical plans. The provider may offer additional information they may have obtained through the screening process.

Prior to admission, the Residential Provider will be responsible for securing the enhanced supports and services described below.

***To be completed by CRO staff***

Date: \_\_\_\_\_ Individual: \_\_\_\_\_ DOB: \_\_\_\_\_

CRO Staff completing this form: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Residential provider: \_\_\_\_\_

Residential provider staff completing this form: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

***To be completed by CRO and provider staff***

Diagnoses (list all): \_\_\_\_\_

Current living arrangement: \_\_\_\_\_

Is there a Risk Management Plan in place:  Yes (attach plan)  No

Is there a Behavior Support Program in place:  Yes (attach plan)  No

Forensic History:  Yes  No If so, briefly explain: \_\_\_\_\_

***On the following table, CRO staff first completes column A, B, and C. Column D is then completed by the residential provider.***

(A) Specialized Needs	(B) Y/N	(C) Description of Need Based on Current Behavior Support Program and History:	(D) Proposed Plan to Meet Need (including service and associated time-frames, e.g. 1 hr, 3x/wk, etc.)
Time Out Room &/or Quiet Area	<input type="checkbox"/> Yes <input type="checkbox"/> No		
SCIP-R/Promote	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Alarmed or Locked Exterior Doors	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Media Restrictions, Including Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Community Restrictions	<input type="checkbox"/> Yes	Staffing Ratio Required: Description:	

	<input type="checkbox"/> No		
Alarmed or Locked Windows & Interior Doors	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Secured Sharp Items	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Removal of Objects in Environment	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Restitution	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Locked kitchen	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Special Residential Staffing Considerations	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other			
<b>(A) Clinical/Medical Treatment Needs:</b>	<b>(B) Y/N</b>	<b>(C) Description and Frequency:</b>	<b>(D) Proposed Plan to Meet Need:</b>
Relapse Prevention Treatment Needs	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Drug and Alcohol Treatment Needs	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Anger Management	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sex Offender Treatment Required	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Psychotropic Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No		
PRN Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Non-Traditional Feeding (e.g. G or J-Tube Feedings)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Highly Specialized Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other	<input type="checkbox"/>		

***To be completed by provider***

Day Services Plan

Provider agency's proposed plan for day services (e.g. employment/vocational training, day programming, school/education): \_\_\_\_\_

Supports and Resources Required

Identify **existing** clinical and/or medical staff that will support this individual including average number of hours of service (per week or month): \_\_\_\_\_

Identify **new** clinical and/or medical staff resources to be acquired to support this individual include including average number of hours of service (per week or month): \_\_\_\_\_

In addition to the required OPWDD and Agency trainings, the residential provider will provide the following additional trainings to staff in support of this individual's needs (*list*): \_\_\_\_\_  No additional trainings required

**----- THIS SECTION TO BE COMPLETED BY THE CRO TEAM -----**

Plan Approved                       Plan Not Approved *reason:* \_\_\_\_\_

CRO Team Leader: \_\_\_\_\_                      Date: \_\_\_\_\_