Charlotte Hall Veterans Home

HMR of Maryland, LLC

29449 Charlotte Hall Rd
Charlotte Hall, MD 20622

Admissions Documentation Checklist

Dear Applicant and/or Family:

Thank you for your interest in Charlotte Hall Veterans Home (CHVH), located in beautiful St. Mary's County, Maryland. We offer Skilled Nursing Care, including two secured Memory Care units and three levels of Assisted Living, in a tranquil setting within easy reach of the Nation's Capital.

The following is a checklist of the materials needed for a complete application:

- ❑ DD214 or equivalent of honorable discharge from the military
- ❑ Proof of Maryland residency (Driver's license, ID card, etc)

  For Assisted Living Applicants:
  - Must prove two years residency immediately prior to admission to CHVH

    OR
  - Maryland must be listed as the veteran's "Home of Record" on the DD214
- ❑ Completed Admission Information forms (enclosed)
- ❑ Completed Social History Information (enclosed)
- Completed Financial Questionnaire (enclosed -With Applicable Attachments)
  - Copy of **last 3 months** bank statements - for all bank accounts
  - CD/IRA/401K Statements (most recent)
  - Stock/investment statements (most recent)
  - Award letters for all monthly incomes, any other pertinent financial information - Social Security, Pension, Veterans Benefits, etc.
  - Copy of latest Tax return
  - Life Insurance (s) - Declaration page or Verification of cash value
  - Real Estate Information – Mortgage Statement (most recent)
- ❑ Copy of Medical Insurance cards front and back (Medicare, and any supplemental insurance)
  - Insurance Premium Notice – showing current monthly premium if any
- ❑ Garnishment Information (if applicable)
- ❑ If spouse, include copy of marriage certificate
  - If divorced – include copy of divorce decree
- ❑ Copy of Power of Attorney/Living Will/Advance Directives
- ❑ Medical Package to be completed by Physician (enclosed)
- ❑ Flu Vaccine Consent Form (enclosed)
- ❑ Signed consent for criminal background check (enclosed)

For Assisted Living Applicants:

- ❑ Prior to admission to CHVH, an interview is required to determine medical appropriateness and to determine the applicant's cost of care. This interview will be scheduled only after all required paperwork is submitted to the Admissions Office.

All paperwork including the physician's forms must be completed and turned in before a resident can be admitted to CHVH. If you have any questions about this admissions process, please feel free to contact the **Admissions Office at 301-884-8171 ext 409.** Please complete the admissions packet as quickly as possible and either fax to **301-263-7194**, or mail to the CHVH Admissions Office.

Charlotte Hall Veterans Home
Admission Application

Nursing Home **Assisted Living** **Veteran** **Spouse**

Mr. Mrs. Ms.

Last Name ____________________ First Name ________________ Middle Initial ______

Current Address ______________________________County ____________________

City ________________________ State _______________ Zip _________________

Current Telephone Number _______________________Birthplace ____________

Age _________ Date of Birth ________________ Social Security # __________________

Religious Preference __________ Race __________ Mother's Maiden Name __________

Marital Status Single Married Divorced Widowed Separated

(legal date of separation) ____

Spouse Name ______________________________ Spouse SS# ___________________

Spouse Date of Birth ______________ Current Phone Number ______________________

Spouse Address ____

City ______________________________ State __________ Zip __________________

Military Service **Army** **Navy** **Marine Corps** **Air Force** **Coast Guard**

Date Entered Service __________________Date Separated__________________________

Service Number ____________________Type of Discharge __________________________

War Era WWII (Europe) WWII (South Pacific) Korean Vietnam Gulf War Peacetime

Service Organization Memberships ____

Are you currently receiving any of the following VA pensions?

Aide and Attendance	Yes	No	
Service Connected	Yes	No	If yes what percent? ____________
Retirement Pension	Yes	No	
Are you a former POW?	Yes	No	
Are you Retired Military?	Yes	No	

Does anyone have power of attorney /guardianship for your affairs? Yes No
If Yes - Please provide a copy

Healthcare POA __________________ Financial POA __________________________

Is there an Advance Directive or Living Will in place?______________ **If so, please provide a copy**

Is there a Living Trust? __________________________________ **If so, please provide a copy**

Any prearranged funeral arrangements? Yes No Funeral home of Choice _______________

Revised October 3, 2014

Name of Spouse/Responsible Party________________________________Relationship_______________

Address ____

City _________________________State __________________________Zip ______________________

Home Phone__________________ Work Phone _________________ Cell Phone __________________

Email Address ______________________________________ Send quarterly newsletter? Yes No

Alternate person to contact ______________________________________ Relationship ______________

Address ____

City ______________________ State ___________________________ Zip ______________________

Home Phone _______________ Work Phone ______________________Cell Phone _________________

Email Address __________________________________ Send quarterly newsletter Yes No

Are you enrolled in the VA medical center? Yes No

Have you ever used the VA medical Center? Yes No If yes, where? _________________

Do you have medical/health insurance? Yes No

Medicare number __________________________ Medicaid number ____________________________

Private Insurance (Blue Cross/Blue Shield, AARP, etc)

Company Name ___________________________ Policy Number ______________________________

Have you enrolled in a Medicare part D program? Yes No

If yes, which one _________________________ ID# _________________________________

PLEASE PROVIDE COPY OF INSURANCE CARD AND PREMIUM NOTICE***

Do you have Long Term Care Insurance? Yes No **If Yes – Please provide a copy of policy**

Company Name ____

Please include copies of your Military discharge/DD214, health insurance cards (front and back) , Drivers License/State ID and any other requested information with this form.

How did you hear about Charlotte Hall Veterans Home?

Hospital Dept. of Aging Veteran Service Organization

Friend/family Senior Presentations Conference Television Ad

Live Near By Print Ad Web Site Face Book Radio Ad

Other ____

Your Signature or Responsible Party _____________________________ Date ______________________

CHARLOTTE HALL VETERANS HOME
29449 Charlotte Hall Rd
Charlotte Hall, MD 20622
(301) 884-8171

We have found that the more details we know about our residents when they are admitted, the better care we can give. Often, the details of a person's past life turn out to be important factors in his/her happiness here at our facility. The information you provide us here is confidential and used only for professional purposes. Sending these completed forms in advance will offer us the opportunity to better know your loved one when they are admitted. If you are uncertain about any of these questions, please feel free to skip them or call and ask for assistance.

Resident's Name ____

Name Resident prefers to be called ________________________________

CURRENT SITUATION

A. Living Arrangements

Living alone (apartment or own home) ___________________________

Living with family/friend, if so who ___________________________

Hospital, if so specify ___________________________

Nursing home/Assisted Living, if so specify ___________________________

Describe what has changed in the present situation that requires the resident to come to Charlotte Hall

____

____

Has the resident been told about coming to Charlotte Hall Veterans Home? Yes No

What was the reaction?

____

____

B. Physical/Medical Information

Name of Primary Care Physician ___________________________

Address___________________________

Phone Number___________________________

1. **Ambulation**

Walking Normal Slow but steady Unsteady Not walking

Cane Crutches Walker Leg braces

Artificial limb

Wheelchair Propels self Others push Motorized

Bedridden Yes No

Describe any recent history of falling and any injuries related to falls

____

____

____

2. **Care of Self**

	Alone	Needs Help	Unable
Dressing self			
Washing hands and face			
Showering/Bathing			
Getting in and out of bed			
Getting in and out of chair			
Washing/Combing hair			
Trimming finger/toe nails			
Shaving			
Brushing teeth/dentures			
Using toilet			

Bowel Control Normal Occasional Loss of control Unable to control Enemas/Suppositories

Frequency ______________________ Time of Day ______________________

Bladder Control Normal Occasional Loss of control Unable to control
Catheter

Frequency ______________________ Time of Day ______________________

3. **Impairments or Problems**

Speech Clear Unclear Nonverbal

If impaired - how does resident communicate____________________________

Vision Clear Glasses Poor Blind

Hearing Clear Hearing Aid Poor Deaf

Teeth Yes Dentures (upper/lower) None

Skin condition

____

Any Wounds - If so describe ____

Feet /legs condition ____

Any amputations ____

Any other physical impairments/problems _______________________________________

4. **Medication**

Current medications

____

____

Any allergies or sensitivities to medicines

____

Any major illnesses____

____

5. **Psychiatric**

Any history of mental illness

____

____

Has the resident ever seen a psychiatrist? If so, for what reason

____

(Provide psychiatric evaluations and list history of hospitalizations, locations, treatments, etc separately)

Psychiatrist__________________________Phone Number ______________________

Address:____

Any history of drug or alcohol abuse ____________________________________

If yes, how long ago ____

Did you complete a structured program ___________________________

If so, when and where: ____

Does the resident have any past arrests or pending criminal charges (including DUI/DWI)
If yes please list -

____

____

____

6. **Preferences**

A. **Eating**

Foods resident dislikes

____

Foods resident is allergic to

____

Food that causes indigestion

____

Appetite Normal Poor Overeats

Eating Feeds self Needs help Tube fed

B. **Sleeping**

Usual bedtime ___________PM usually awakens _____________AM

Sleeping habits Normal Restless Wanders at night

Daytime dozing Needs side rails

C. Smoking

Does the resident smoke Yes No Non-Smoker
If so, amount, brand preference, and who will supply: ______________________

C. **Personality**
Check any of the following, which describe resident's present condition. Star (*) any items that have developed recently

	Cooperative		Wants to get Well
	Sociable		Noisy
	Cheerful		Silent
	Independent		Reserved
	Too independent		Aggressive
	Mentally alert		Temper outburst
	Confused		Withdrawn
	Chronic complaining		Depressed
	Slightly forgetful		Often angry
	Very forgetful		Poor judgment
	Prefers groups		Worries
	Prefers to be alone		Has spoke of suicide
	Easily fatigued		Has attempted suicide
	Sensitive		Paranoid
	Cries easily		Sees things that are not there
	Excessive laughter		Hears things others do not

2. How does the resident accept reality ____

____

3. Anything specific that upsets resident - Suggestions for handling ____________________

____

4. Who does the resident trust the most ____

____

5. Who does the resident trust the least ____

____

6. Can the resident manage pocket money - If so, how much ______________________________

____

7. Are there financial problems the resident is worried about ______________________________

   If so please explain ____

8. Any interests/hobbies ____

____

9. In the event the resident improves and is able to be discharged, the tentative plan would be

Own home Home of family member, Name_______________________________

Assisted living No plan

Any additional information or comments ____

____

____

INFORMATION ON PAST LIFE

Born and raised where

____

Native language ______________________ Speaks native language frequently? ____________________

Names, ages, and location of siblings (if deceased please note when) _____________________________

____

Please describe resident's childhood/adulthood ____

____

____

Any travels?

____

How far did the resident go in school ____

Any trade school or on the job training ____

What was the resident's main occupation (s) ____

Did the resident plan for retirement ____

Date of retirement ___________________________ Voluntary Involuntary

Reaction to retirement ____

Any work after retirement ____

Marriage

Date of marriage: ____________________________Spouse's name ___________________________

Is spouse still living Yes No

If deceased, when and what was resident's reaction ____

Describe any important characteristics of the marriage ____

Number of children, location, and relationship with resident ____________________________________

____

Any grandchildren Yes No If yes how many? ____________________________________

Thank you for completing this application. We look forward to you and your loved ones joining our facility family.

______________________________________ ______________________________

Signature Date

PLEASE SUPPLY PROOF OF VETERANS STATUS, COPIES OF ALL INSURANCE CARDS, AND ALL STATEMENTS OF FINANCIAL VERIFICATION THAT APPLY, ALONG WITH THE FULLY COMPLETED APPLICATION. WE CANNOT COMPLETELY PROCESS YOUR ADMISSION REQUEST WITHOUT THIS INFORMATION.

APPLICANT NAME

LAST	FIRST	MIDDLE INITIAL

APPLICANT'S CURRENT MAILING ADDRESS

APPLICANTS PRIMARY ADDRESS

SOCIAL SECURITY NUMBER	DATE OF BIRTH	MARITAL STATUS

MEDICARE NUMBER(attach card copy)	MARYLAND MEDICAID NUMBER (attach notice of eligibility)

INCOME	**APPLICANT**	**APPLICANT SPOUSE**
SOCIAL SECURITY (MONTHLY AMOUNT) attach current year benefit statement		
PENSION attach benefit statement Source:		
PENSION attach benefit statement Source:		
SSDI/SSI (MONTHLY AMOUNT) attach current year benefit statement		
VETERANS BENFITS (MONTHLY AMT) attach current year benefit statement		
OTHER (SPECIFY)		
TAX RETURN COPY most recent statement		

ASSETS Attach all pages of statements for last 3 months	**APPLICANT**	**APPLICANT SPOUSE**
CHECKING ACCOUNT Bank Name Names on account: Account #	Current Balance	Current Balance
CHECKING ACCOUNT Bank Name Names on account: Account #	Current Balance	Current Balance
SAVINGS ACCOUNT Bank Name Names on account: Account #	Current Balance	Current Balance
SAVINGS ACCOUNT Bank Name Names on account: Account #	Current Balance	Current Balance

ASSETS Attach all pages of most recent statement	**APPLICANT**	**APPLICANT SPOUSE**
IRA/CD	Current Value	Current Value
Bank Name		
Names on Account		
Account #		
STOCKS AND BONDS		
Current Value		
INTEREST IN ESTATE OR TRUST		
(Attach Trust copy)		
ANNUITY		
CASH ON HAND		
LIFE INSURANCE	Company	
Cash Value	Policy #	
	(attach current letter from company stating	
Face Value	face and cash values)	
LIFE INSURANCE	Company	
Cash Value $	Policy #	
	(attach current letter from company stating	
Face Value $	face and cash values)	
LIFE INSURANCE	Company	
Cash Value $	Policy	
	(attach current letter from company stating	
Face Value $	face and cash values)	

REAL ESTATE	
Primary Residence Address	
County and State	
Mortgage Co and Balance Owed	(Attach a copy of most recent Mortgage Statement)
REAL ESTATE	
Secondary Property including land	
County and State	(If property is out of state, attach copy of
Mortgage Co and Balance Owed	tax assessment and deed.)
OTHER	

TRANSFERS Have you sold, transferred, or created a joint tenancy or life estate in any property in the last 5 years? This includes cash and bank accounts.	APPLICANT		SPOUSE	
	Yes	NO	Yes	NO

If yes, to (or with) whom?	
Describe the Property	
Date of transaction	
What was done with the proceeds?	What amount did you receive for it?

Has the applicant been in a nursing or VA facility before?	YES		NO	
If yes, where	When			
Does the applicant need to DISENROLL from an HMO?	YES		NO	
Does the applicant need to ENROLL in Medicare Part D?	YES		NO	

Name of person completing this form:	Relationship to Applicant
Signature of person completing this form	Date

Authorization

Authorization: By signing below, you authorize: (a) General Information Services, Inc. ("GIS") to request information about you from any public or private information source; (b) anyone to provide information about you to GIS; (c) GIS to provide us (**HMR VETERANS SERVICES, INC.**) one or more reports based on that information; and (d) us to share those reports with others for legitimate business purposes related to your employment. GIS may investigate your education, work history, professional licenses and credentials, references, address history, social security number validity, right to work, criminal record, lawsuits, driving record, credit history, and any other information with public or private information sources. You acknowledge that a fax, image, or copy of this authorization is as valid as the original. You make this authorization to be valid for as long as you are an applicant or employee with us.

The Consumer Financial Protection Bureau's "Summary of Your Rights under the Fair Credit Reporting Act" is attached to this authorization. If you are a New York applicant, a copy of New York's law on the use of criminal records is attached. By signing below, you acknowledge receipt of these documents.

Personal Information: Please print the information requested below to identify yourself for GIS.

Printed name: ______________________________

First   Middle (☐ none)   Last

Other names used: ______________________________

Current and former addresses:

	current		
from Mo/Yr	to Mo/Yr	Street	City, State & Zip
from Mo/Yr	to Mo/Yr	Street	City, State & Zip
from Mo/Yr	to Mo/Yr	Street	City, State & Zip

Some government agencies and other information sources require the following information when checking for records. GIS will not use it for any other purposes.

Date of birth	Social security number
Driver's license number & state	Name as it appears on license

Report Copy: If you are applying for a job or live in California, Minnesota, or Oklahoma, you may request a copy of the report by checking this box: ☐.

Signature	Date
Facility	**HR Representative**

Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to** www.consumerfinance.gov/learnmore **or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identity theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.
- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8688.
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINESS:	CONTACT:
1.a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates. b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the Bureau:	a. Bureau of Consumer Financial Protection 1700 G Street NW Washington, DC 20552 b. Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357
a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks	a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050

b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and insured state branches of foreign banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations d. Federal Credit Unions	b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480 c. FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106 d. National Credit Union Administration Office of Consumer Protection (OCP) Division of Consumer Compliance and Outreach (DCCO) 1775 Duke Street Alexandria, VA 22314
3. Air carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Department of Transportation 400 Seventh Street SW Washington, DC 20590
4. Creditors Subject to Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 1925 K Street NW Washington, DC 20423
5. Creditors Subject to Packers and Stockyards Act	Nearest Packers and Stockyards Administration area supervisor
6. Small Business Investment Companies	Associate Deputy Administrator for Capital Access United States Small Business Administration 406 Third Street, SW, 8th Floor Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission 100 F St NE Washington, DC 20549
8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations	Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090
9. Retailers, Finance Companies, and All Other Creditors Not Listed Above	FTC Regional Office for region in which the creditor operates or Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357

ADDITIONAL INFORMATION ABOUT THE FAIR CREDIT REPORTING ACT

The Summary of Your Rights provided above does not reflect certain amendments contained in the Consumer Reporting Employment Clarification Act of 1998. The following additional information may be important for you:

- • Records of convictions of crimes can be reported regardless of when they occurred.
- • If you apply for a job that is covered by the Department of Transportation's authority to establish qualifications and the maximum hours for that job and you apply by mail, telephone, computer, or other similar means, your consent to a consumer report may validly be obtained orally, in writing, or electronically. If an adverse action is taken against you because of a consumer report for which you gave your consent over the telephone, computer, or similar means, you may be informed of the adverse action and the name, address and phone number of the consumer reporting agency, orally, in writing, or electronically.

ONLY FOR RESIDENTS OF NEW YORK

ARTICLE 23-A
LICENSURE AND EMPLOYMENT OF PERSONS PREVIOUSLY
CONVICTED OF ONE OR MORE CRIMINAL OFFENSES

Section 750. Definitions.
Section 751. Applicability.
Section 752. Unfair discrimination against persons previously convicted of one or more criminal offenses prohibited.
Section 753. Factors to be considered concerning a previous criminal conviction; presumption.
Section 754. Written statement upon denial of license or employment.
Section 755. Enforcement.

§ 750. Definitions. For the purposes of this article, the following terms shall have the following meanings:

(1) "Public agency" means the state or any local subdivision thereof, or any state or local department, agency, board or commission.

(2) "Private employer" means any person, company, corporation, labor organization or association which employs ten or more persons.

(3) "Direct relationship" means that the nature of criminal conduct for which the person was convicted has a direct bearing on his fitness or ability to perform one or more of the duties or responsibilities necessarily related to the license, opportunity, or job in question.

(4) "License" means any certificate, license, permit or grant of permission required by the laws of this state, its political subdivisions or instrumentalities as a condition for the lawful practice of any occupation, employment, trade, vocation, business, or profession. Provided, however, that "license" shall not, for the purposes of this article, include any license or permit to own, possess, carry, or fire any explosive, pistol, handgun, rifle, shotgun, or other firearm.

(5) "Employment" means any occupation, vocation or employment, or any form of vocational or educational training. Provided, however, that "employment" shall not, for the purposes of this article, include membership in any law enforcement agency.

§ 751. Applicability. The provisions of this article shall apply to any application by any person for a license or employment at any public or private employer, who has previously been convicted of one or more criminal offenses in this state or in any other jurisdiction, and to any license or employment held by any person whose conviction of one or more criminal offenses in this state or in any other jurisdiction preceded such employment or granting of a license, except where a mandatory forfeiture, disability or bar to employment is imposed by law, and has not been removed by an executive pardon, certificate of relief from disabilities or certificate of good conduct. Nothing in this article shall be construed to affect any right an employer may have with respect to an intentional misrepresentation in connection with an application for employment made by a prospective employee or previously made by a current employee.

§ 752. Unfair discrimination against persons previously convicted of one or more criminal offenses prohibited. No application for any license or employment, and no employment or license held by an individual, to which the provisions of this article are applicable, shall be denied or acted upon adversely by reason of the individual's having been previously convicted of one or more criminal offenses, or by reason of a finding of lack of "good moral character" when such finding is based upon the fact that the individual has previously been convicted of one or more criminal offenses, unless:

(1) there is a direct relationship between one or more of the previous criminal offenses and the specific license or employment sought or held by the individual; or

(2) the issuance or continuation of the license or the granting or continuation of the employment would involve an unreasonable risk to property or to the safety or welfare of specific individuals or the general public.

§ 753. Factors to be considered concerning a previous criminal conviction; presumption.

1. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall consider the following factors:

(a) The public policy of this state, as expressed in this act, to encourage the licensure and employment of persons previously convicted of one or more criminal offenses.

(b) The specific duties and responsibilities necessarily related to the license or employment sought or held by the person.

(c) The bearing, if any, the criminal offense or offenses for which the person was previously convicted will have on his fitness or ability to perform one or more such duties or responsibilities.

(d) The time which has elapsed since the occurrence of the criminal offense or offenses.

(e) The age of the person at the time of occurrence of the criminal offense or offenses.

(f) The seriousness of the offense or offenses.

(g) Any information produced by the person, or produced on his behalf, in regard to his rehabilitation and good conduct.

(h) The legitimate interest of the public agency or private employer in protecting property, and the safety and welfare of specific individuals or the general public.

2. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall also give consideration to a certificate of relief from disabilities or a certificate of good conduct issued to the applicant, which certificate shall create a presumption of rehabilitation in regard to the offense or offenses specified therein.

§ 754. Written statement upon denial of license or employment. At the request of any person previously convicted of one or more criminal offenses who has been denied a license or employment, a public agency or private employer shall provide, within thirty days of a request, a written statement setting forth the reasons for such denial.

§ 755. Enforcement.

1. In relation to actions by public agencies, the provisions of this article shall be enforceable by a proceeding brought pursuant to article seventy-eight of the civil practice law and rules.

2. In relation to actions by private employers, the provisions of this article shall be enforceable by the division of human rights pursuant to the powers and procedures set forth in article fifteen of the executive law, and, concurrently, by the New York city commission on human rights.

CHARLOTTE HALL VETERANS HOME

INFLUENZA/ PNEUMOCOCCAL IMMUNIZATION

INFLUENZA VACCINE

ALLERGY TO EGGS: YES NO (Circle one) IF egg allergy present, do not administer flu vaccine

☐ I accept the Influenza Vaccine annually.

Date of last Influenza vaccine: ______________

☐ I decline Influenza vaccine.

Reason for refusal:____

☐ I have been given and understand the Center for disease Control Influenza Vaccine Fact Sheet

PNEUMOCOCCAL VACCINE

☐ I accept the Pneumococcal Vaccine as ordered by my physician.

Date of last Pneumococcal Vaccine: ________________

☐ I decline Pneumococcal Vaccine.

Reason for refusal:____

☐ I have been given and understand the Center for disease Control Pneumococcal Vaccine Fact Sheet

____ ______________

Signature- Resident and/or Responsible Party Date

____ ______________

Witness Signature/Title Date

Name: Last	First	Middle	Attending Physician	Medical Record #	Room #