

# **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.

# In order to process a request for admission the following documents are required:

- 1. CHVH Application (3 pages)
- 2. Signed consent for criminal background check
- 3. Flu Vaccine Consent Form
- 4. Proof of Maryland residency (Driver's license, ID card, etc.)
- 5. DD214 or equivalent of honorable discharge from the military

### If you are unable to obtain a copy please contact the Admissions Office immediately

- 6. A copy of insurance cards (front and back) including:
  - Medicare Card
  - Medicare Part D Card
  - Supplemental Insurance Cards
  - Prescription Plan Card
- 7. A copy of any legal documents available including:
  - Power of Attorney
  - Living Will
  - Advance Directives
- 8. If the applicant is the spouse of a veteran please include:
  - A copy of the marriage certificate or death certificate (if applicable)
- 9. Medical documentation as follows:
  - If the applicant is currently in a hospital or a skilled nursing facility please speak with the covering social worker to have medical records faxed to 301-263-7194
  - If applicant is currently living at home please have his/her primary care physician complete the Physician Documentation Checklist and Health Care Practitioner Physical Assessment Form enclosed within this packet.

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 admission package as quickly as possible and **fax to 301-263-7194**, or mail to CHVH Admissions Office at the address above.

Charlotte, Hal	e s	Cha Maryla	lotte Hal arlotte Ha and 20622 Ext. 1409	ll Road ( Telepho	Charlot one 301	te Hall, I-884-8	,	1	OF MAR	HIM	
Applying from:	Home	Hospital		N	ursing	Home/	Assisted	d Living	5		
Requesting placement for: Nursing Home				sisted 1	Living		_				
This application is f	or a:	Veteran		Sp	ouse						
How did you hear a	bout Charl	otte Hall Ve	terans Ho	ome?							
			Demo	ographic l	nforma	tion					_
Last Name				First	Name					MI	
Current Address					Cou			ounty			
City			State		Zip						
Telephone Number				Birth	Place						
Birth Date		Ag	ge	Soci	al Secu	urity #					_
Religion		Ra	ce		Moth	ner's Ma	iden Na	ame			
Marital Status	Single	Mar	ried	Divorc	ed	Wie	dowed		Separa	ated	
		Legal Date	of Separa	ation or l	Divorce	e					_
			Military F	Records In	nformat	ion					
Branch of Service				Serv	vice #						
Entry Date		Separation	on Date			Dis	scharge	Туре			
War Era	WWII (	WWII (Europe)			WWII (South Pacific)				Korea		
Vietnam				Gulf War				Peace Time			
Are you currently o	•	previously		-		-					
American L	egion			ary Order of the Purple Heart AMVET						ETS	
Masons			-	hts of Columbus Elks							
		Lions						DAR			
Veterans of	U U		Moose	e Lodge	Lodge					DAV	
	her Membe										
Are you currently re	-	-	-	A Pensio		_					
Aid and Attendance		les	No			ment Pe		_	Yes		No
Do you have a serv		-			Yes		No	Percei	ntage		
Former POW?	Yes	N		Retu	red Mil	litary?		Yes		No	
Are you in enrolled			ystem?		Yes		No				
Have you used a V.				Yes		No	Lo	cation			
Spouse Informatio		-			~		•				
		Social Security #									
				Date of I	Vlarrıaş	ge					
Street Addre											
City				_ State				Zip			
Current Pho	one #										

Insurance Information									
Medicare:	Part A	Part B	Member	r #					
Have you been receivi	ng your medic	ations from the	VAMC or	a base?	Yes	1	No		
Are you enrolled in a N	Medicare Part	D Program?	Yes	No					
Company				Policy #					
Medicaid:	Yes	No	Medica	id #					
Private Insurance:	1 2				ID #				
How is the premium paid? Deduction from pension Debit from bank account Check									
Long Term Care Insura	ance:	Company							
Please provide a copy of all insurance cards (front and back) and any Long Term Care Insurance Policy (If Applicable)									
			Contact In						
<b>Responsible Party:</b>	Name								
Street Address									
	Home		Work			Cell			
			Send	biannual r	newsletter		Yes		No
Second Contact:	Name			Rela	ationship				
Street Address									
City			State			Zip			
Phone #:	Home		Work			Cell			
Email				biannual n	ewsletter		Yes		No
	~		al Documen	its					
Is there a Power of Attorney or Guardian for your affairs? Yes No									
If so, Name: Healthcar					cial POA				
Is there an Advance Directive or Living Will? Yes Is No <i>If so, please provide a copy</i>									
Is there a living trust? Yes No If so, please provide a copy									
Do you have any pre-p		arrangements?	Yes	No	Funeral p	baid for	? }	les	No
Funeral Home of Choice    City/State:      Medical Service Utilization									
Have you utilized reha	-	-		Yes		No			
		tion(s) and date							
Location:					Dates:				
Location:									
Location:					Dates:				
Additional Information									
Have you traveled outside of the United States in the past 30 days? Yes No									
If so where?									
Has your family travel	ed outside of t	he United States	s in the pas	t 30 days?	)	Yes		No	
If so where?									

#### **Financial Information**

The Charlotte Hall Veterans Home, in its financial planning, must have information about the financial ability of each applicant requesting admission. Please complete the following financial worksheet and provide as much detail as possible for each question. In a case where an applicant has a living spouse, information must be provided for both individuals. Should the Department of Admissions have any questions, you will be contacted by telephone at the number provided on this application.

**Income:** (Check where applicable and provide the monthly amount)

		Veteran		Spouse			
Social Security	\$			\$			
Employer Pensions	\$			\$			
Union Pensions	\$			\$			
Veteran Benefits	\$			\$			
Trust	\$			\$			
Annuity	\$			\$			
IRA Distribution	\$			\$			
Other	\$			\$			
Resources: (Check where	e applicabl	e and provid	le current	balance)			
Total Amount in Checking Accounts	\$			\$			
Total Amount in Savings Accounts	+			\$			
Total Amount in Other Accounts	¢			\$			
Total Amount in Stocks/Bonds/CDs	\$			\$			
Total Amount in IRA/KEOGH/401K	\$			\$			
Total Life Insurance/ (Face/Cash Value)	\$	/		\$ /			
Total Amount in Trust	\$			\$			
Other	\$			\$			
Real Estate: Address							
					_		
Do you have a mortgage paymen		Yes Yes	No No	Amount: \$ Amount: \$			
Do you have a reverse mortgage					_		
Liabilities Do you currently have any deduct Yes No If yes please indica				ebt owed (IRS, Alimony, etc) Amount \$			
i es i to in yes piease indica				Amount \$			
Has the applicant sold, gifted or transferred any cash, real estate or personal property within the past							
60 months? Yes No If yes, please indica	ate: Asset	Туре		Value \$			
	Asset	Туре		Value \$			

I agree to furnish, upon request, verification of assets and all sources of income. My spouse and/or designated representative also agree to provide financial information as required to apply for Medicaid benefits. I agree to pay for my cost of care from my income and assets according to current rates set by the State of Maryland as long as I am a resident. In the case that available funding cannot cover my cost of care, I agree to comply with the necessary steps in applying for Maryland Medicaid assistance and benefits.

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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 (<u>HMR VETERANS SERVICES, INC.</u>) one or more reports based on that information; and (d) us to share those reports with others for legitimate business purposes related to your admission. 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 applying or are a resident 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 the 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 (if none,	please check ()	Last	ast		
Other names used:							
Current and former a	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		
	any other purposes.	rmation sources requir	e the following information v		for records.		
	Date of Birth		Social Security Nur	Social Security Number			
	Driver's license	number & state	Name as it appears	Name as it appears on license			
Report Copy: If you a report by checking the		or live in California, Min	nesota, or Oklahoma, you r	nay request a	copy of the		
Signature			Date				
Facility			HR Representative				





Please take a moment to complete this brief survey. The information collected will be used to help determine the best methods for sharing information about Charlotte Hall Veterans Home.

- 1. Please select the age range of the person completing this survey.
  - o 20 to 40 o 60 to 80
  - o 40 to 60 o 80 and above
- 2. Please indicate the age of the applicant or potential applicant: \_\_\_\_\_ years old
- 3. For whom will Charlotte Hall Veterans Home staff have the privilege of serving? o A veteran • A spouse of a veteran
- 4. Where will the veteran/spouse be admitted from?
  - o Home
  - o Hospital
  - Assisted Living Facility
- 5. What service(s) will the spouse/veteran require?
  - Assisted Living 0
  - o Short-term rehabilitation with the intent of returning home
  - o Short-term rehabilitation then transitioning to long-term care
  - o Long-term (skilled nursing) care
  - o Hospice care
- 6. How long have you known about Charlotte Hall Veterans Home?
  - Less than 6 months
    5 to 10 years
  - Less than 1 year
  - o 1 to 5 years
- 7. How did you first learn about Charlotte Hall Veterans Home?
  - Newspaper advertisement Patient information guide
  - Magazine advertisement
  - Senior resource guide
  - 0
  - Senior resource guideresource guideTelevision advertisementoInternet advertisement includingoFacebookoCharlotte Hall Veterans HomeoWebsiteoOther:o 0
  - 0 website

- More than 10 years
- Newcomers and Chamber of Commerce

  - o Other:
- How were you referred to Charlotte Hall Veterans Home for this tour/admission? 8.
  - Hospital, Nursing Home, or Assisted Living staff (please circle to identify)
    - Home Health Agency
    - Friend or family
  - o Veterans Service Organization
  - Self-researched 0
  - Other: \_\_\_\_\_ 0
- Please rank the following characteristics in order of importance during your search for a Skilled 9. Nursing or Assisted Living Facility. Rank as 1-7 with 1 being most important and 7 being least important.
  - Distance from relatives
  - Age of building
  - Cost of care
  - Quality of care

- \_\_\_\_ Size of facility Veteran centered atmosphere
- \_\_\_\_ Cleanliness of facility

# Please provide the date you completed this survey (MM/DD/YY) \_\_\_\_

- Nursing Home Facility
- Rehabilitation Center o Other: \_\_\_\_\_