Charlotte Hall Veterans Home
HMR of Maryland, LLC

29449 Charlotte Hall Rd
Charlotte Hall, MD 20622

Admissions Documentation Checklist
Coming from Home or another Assisted Living Facility

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)
  - 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 Application forms (enclosed)
- ❑ Completed Financial Questionnaire – (enclosed - With Applicable Attachments)
    - Copy of **last 3 years** bank statements (for all bank accounts and all pages of statements)
    - 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 applicant is spouse of a veteran, include copy of marriage certificate or death certificate (if applicable)
- ❑ Copy of Power of Attorney/Living Will/Advance Directives
- ❑ Signed consent for criminal background check (enclosed)
- ❑ Signed consent for criminal background disclosure (enclosed)
- ❑ Flu Vaccine Consent Form (enclosed)

Prior to Assisted Living 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 or 454.** Please complete the admission package as quickly as possible and either fax to **301-263-7194**, or mail to CHVH Admissions Office.

Charlotte Hall Veterans Home
29449 Charlotte Hall Road
Charlotte Hall, MD 20622
Telephone: 301-884-8171 Ext. 1409, 1454
Fax: 301-263-7194

Applying from: ☐ Home ☐ Hospital_____ ☐ Nursing Home/Assisted Living_____
Requesting replacement for: ☐ Nursing Home ☐ Assisted Living
This application is for a: ☐ Veteran ☐ Spouse
How did you hear about Charlotte Hall Veterans Home? _____

Demographic Information

Last Name _____ First Name_____ MI _____
Current Address _____ County _____
City _____ State _____ Zip _____
Telephone Number _____ Birth Place _____
Birth Date _____ Age _____ Social Security # _____
Religion _____ Race _____ Mother's Maiden Name _____
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Legal Date of Separation or Divorce _____

Military Records Information

Branch of Service _____ Service # _____
Entry Date _____ Separation Date _____ Discharge Type _____
War Era: ☐ WWII (Europe) ☐ WWII (South Pacific) ☐ Korea ☐ Vietnam ☐ Gulf War ☐ Peace Time

Are you currently or were you previously a member of any Service Organization?

☐ American Legion	☐ Military Order of the Purple Heart	☐ AMVETS	☐ DAR
☐ Moose Lodge	☐ Knights of Columbus	☐ Elks	☐ DAV
☐ 29th Division	☐ Veterans of Foreign Wars	☐ Lions Club	☐ Masons

Other Membership _____

Are you currently receiving any of the following VA Pensions?
Aid and Attendance ☐ Yes ☐ No Retirement Pension ☐ Yes ☐ No
Do you have a service connected disability? ☐ Yes ☐ No Percentage _____
Former POW? ☐ Yes ☐ No Retired Military ☐ Yes ☐ No
Are you enrolled with the VA Health System? ☐ Yes ☐ No
Have you used a VA Medical Center? ☐ Yes ☐ No Location _____

Spouse Information (For VA Records)

Name _____ Social Security # _____
DOB _____ Date of Marriage _____
Street Address _____
City _____ State _____ Zip _____
Current Phone # _____

Insurance Information

Medicare: ☐ Part A ☐ Part B Member # _____

Have you been receiving your medications from the VAMC or a base? ☐ Yes ☐ No

Are you enrolled in a Medicare Part D Program? ☐ Yes ☐ No

Company _____ Policy # _____

Medicaid: ☐ Yes ☐ No Medicaid # _____

Private Insurance: Company _____ ID # _____

How is this premium paid? ☐ Deduction from pension ☐ Debit from bank account ☐ Check

Long Term Care Insurance: Company _____

***Please provide a copy of all insurance cards (front and back) and any Long Term Care Insurance Policy (if applicable)*

Emergency Contact Information

Responsible Party: Name _____ Relationship _____

Street Address _____

City _____ State _____ Zip _____

Phone #: Home _____ Work _____ Cell _____

Email _____ Send Bi-Annual Newsletter ☐ Yes ☐ No

Second Contact: Name _____ Relationship _____

Street Address _____

City _____ State _____ Zip _____

Phone #: Home _____ Work _____ Cell _____

Email _____ Send Bi-Annual Newsletter ☐ Yes ☐ No

Legal Documents

Is there a Power of Attorney or Guardian for your affairs? ☐ Yes ☐ No

If so, Name: Healthcare POA _____ Financial POA _____

Is there an Advance Directive or Living Will? ☐ Yes ☐ No *If yes, please provide a copy*

Is there a living trust? ☐ Yes ☐ No *If yes, please provide a copy*

Do you have any pre-planned funeral arrangements? ☐ Yes ☐ No Funeral paid for? ☐ Yes ☐ No

Funeral Home of Choice _____ City/State _____

Medical Service Utilizations

Have you utilized rehab, inpatient, or outpatient services? ☐ Yes ☐ No

If yes, please provide the location(s) and date(s):

Location: _____ Dates: _____

Location: _____ Dates: _____

Location: _____ Dates: _____

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 traveled outside of the United States in the past 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 monthly amount)

	Veteran	Spouse
Social Security	☐ $_____	☐ $_____
Employer Pensions	☐ $_____	☐ $_____
Union Pensions	☐ $_____	☐ $_____
Veteran Benefits	☐ $_____	☐ $_____
Trust	☐ $_____	☐ $_____
Annuity	☐ $_____	☐ $_____
IRA Distribution	☐ $_____	☐ $_____
Other _____	☐ $_____	☐ $_____

Resources: (Check where applicable and provide 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 payment? ☐ Yes ☐ No Amount: $_____

Do you have a reverse mortgage? ☐ Yes ☐ No Amount: $_____

Liabilities:

Do you currently have any deductions to income as a result of a debt owed (IRS, Alimony, etc.)? ☐ Yes ☐ No

If yes, please indicate: Type of Deduction _____ Amount: $_____

Type of Deduction _____ 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 indicate: Asset Type _____ Value: $_____

Asset Type _____ 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 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.

Signature Relationship to Applicant Date

Disclosure

We (**HMR of Maryland, LLC**) will obtain one or more consumer reports or investigative consumer re- ports (or both) about you for admission purposes. The reports will include information about your character, general reputation, personal characteristics, and mode of living.

We will obtain these reports through a consumer reporting agency. Our consumer reporting agency is General Information Services, Inc. GIS's address is P.O. Box 353, Chapin, SC 29036. GIS's telephone number is (866) 265-4917. GIS's website is at www.geninfo.com, where you can find information about whether GIS's international privacy practices.

To prepare the reports, GIS may investigate your education, work history, professional licenses and credentials, references, address history, social security number validity, right to work, criminal record, law- suits, driving record, credit history, and any other information with public or private information sources.

You may obtain a copy of any report that GIS provides and GIS's files about you (in person, by mail, or by phone) by providing identification to GIS. If you do, GIS will provide you help to understand the files, including trained personnel and an explanation of any codes. Another person may accompany you by providing identification.

If GIS obtains any information by interview, you have the right to obtain a complete and accurate disclosure of the scope and nature of the investigation performed.

Please sign below to acknowledge your receipt of this disclosure.

Signature of Veteran or legal representative	Date
Printed Name of Veteran or legal representative	**Veteran's name (if not acknowledged by resident)**

Do not attach this document to, or include it in, an application or any other document.

Updated: 04/21/2015

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 of Maryland, LLC**) one or more reports based on that in- formation; 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 a 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 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;

Printed name: _____
First Middle (☐ none) Last

Other names used: _____

Current and former addresses:

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

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 live in California, Minnesota, or Oklahoma, you may request a copy of the report by checking this box: ☐.

Print Name (Individual granting authorization) _____ Date _____

Signature (Individual granting authorization) _____ **Admissions 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 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 form the lists these offers are based on. You may opt out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).**

- **The following FCRA right applies with respect to nationwide consumer reporting agencies:**

  CONSUMERS HAVE THE RIGHT TO OBTAIN A SECURITY FREEZE

  You have a right to place a "security freeze" on your credit report, which will prohibit a consumer reporting agency from releasing information in your credit report without your express authorization. The security freeze is designed to prevent credit, loans, and services from being approved in your name without your consent.
  However, you should be aware that using a security freeze to take control over who gets access to the personal and financial information in your credit report may delay, interfere with, or prohibit the timely approval of any subsequent request or application you make regarding a new loan, credit, mortgage, or any other account involving the extension of credit.

  As an alternative to a security freeze, you have the right to place an initial or extended fraud alert on your credit file at no cost. An initial fraud alert is a 1-year alert that is

placed on a consumer's credit file. Upon seeing a fraud alert display on a consumer's credit file, a business is required to take steps to verify the consumer's identity before extending new credit. If you are a victim of identity theft, you are entitled to an extended fraud alert, which is a fraud alert lasting 7 years.

A security freeze does not apply to a person or entity, or its affiliates, or collection agencies acting on behalf of the person or entity, with which you have an existing account that requests information in your credit report for the purposes of reviewing or collecting the account. Reviewing the account includes activities related to account maintenance, monitoring, credit line increases, and account upgrades and enhancements.

- **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 CFPB:	a. Consumer Financial Protection Bureau 1700 G Street, N.W. Washington, DC 20552 b. Federal Trade Commission Consumer Response Center 600 Pennsylvania Avenue, N.W. Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above: a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks 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	a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050 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 Financial Protection (OCFP) Division of Consumer Compliance Policy and Outreach 1775 Duke Street Alexandria, VA 22314
3. Air carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, S.E. Washington, DC 20590
4. Creditors Subject to the Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street, S.W. Washington, DC 20423
5. Creditors Subject to the Packers and Stockyards Act, 1921	Nearest Packers and Stockyards Administration area supervisor
6. Small Business Investment Companies	Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, S.W., Suite 8200 Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission 100 F Street, N.E. 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	Federal Trade Commission Consumer Response Center 600 Pennsylvania Avenue, N.W. 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.

All users of consumer reports must comply with all applicable regulations. Information about applicable regulations currently in effect can be found at the Consumer Financial Protection Bureau's website, www.consumerfinance.gov/learnmore.

NOTICE TO USERS OF CONSUMER REPORTS: OBLIGATIONS OF USERS UNDER THE FCRA

The Fair Credit Reporting Act (FCRA), 15 U.S.C. §1681-1681y, requires that this notice be provided to inform users of consumer reports of their legal obligations. State law may impose additional requirements. The text of the FCRA is set forth in full at the Bureau of Consumer Financial **Protection's (CFPB) website at www.consumerfinance.gov/learnmore. At the end of this document is a list of United States Code citations for the FCRA. Other information about user duties is also available at the CFPB's website. Users must consult the relevant provisions of the FCRA for details about their obligations under the FCRA.**

The first section of this summary sets forth the responsibilities imposed by the FCRA on all users of consumer reports. The subsequent sections discuss the duties of users of reports that contain specific types of information, or that are used for certain purposes, and the legal consequences of violations. If you are a furnisher of information to a consumer reporting agency (CRA), you have additional obligations and will receive a separate notice from the CRA describing your duties as a furnisher.

I. OBLIGATIONS OF ALL USERS OF CONSUMER REPORTS

A. Users Must Have a Permissible Purpose

Congress has limited the use of consumer reports to protect consumers' privacy. All users must have a permissible purpose under the FCRA to obtain a consumer report. Section 604 contains a list of the permissible purposes under the law. These are:

- **As ordered by a court or a federal grand jury subpoena. Section 604(a)(1)**
- **As instructed by the consumer in writing. Section 604(a)(2)**
- **For the extension of credit as a result of an application from a consumer, or the review or collection of a consumer's account. Section 604(a)(3)(A)**
- **For employment purposes, including hiring and promotion decisions, where the consumer has given written permission. Sections 604(a)(3)(B) and 604(b)**
- **For the underwriting of insurance as a result of an application from a consumer. Section 604(a)(3)(C)**
- **When there is a legitimate business need, in connection with a business transaction that is initiated by the consumer. Section 604(a)(3)(F)(i)**
- **To review a consumer's account to determine whether the consumer continues to meet the terms of the account. Section 604(a)(3)(F)(ii)**
- **To determine a consumer's eligibility for a license or other benefit granted by a governmental instrumentality required by law to consider an applicant's financial responsibility or status. Section 604(a)(3)(D)**
- **For use by a potential investor or servicer, or current insurer, in a valuation or assessment of the credit or prepayment risks associated with an existing credit obligation. Section 604(a)(3)(E)**
- **For use by state and local officials in connection with the determination of child support payments, or modifications and enforcement thereof. Sections 604(a)(4) and 604(a)(5)**

In addition, creditors and insurers may obtain certain consumer report information for the purpose of making "prescreened" unsolicited offers of credit or insurance. **Section 604(c)**. The particular obligations of users of "prescreened" information are described in Section VII below.

B. Users Must Provide Certifications

Section 604(f) prohibits any person from obtaining a consumer report from a consumer reporting agency (CRA) unless the person has certified to the CRA the permissible purpose(s) for which the report is being obtained and certifies that the report will not be used for any other purpose.

C. Users Must Notify Consumers When Adverse Actions Are Taken

The term "adverse action" is defined very broadly by Section 603. "Adverse actions" include all business, credit, and employment actions affecting consumers that can be considered to have a negative impact as defined by Section 603(k) of the FCRA – such as denying or canceling credit or insurance, or denying employment or promotion. No adverse action occurs in a credit transaction where the creditor makes a counteroffer that is accepted by the consumer.

1. Adverse Actions Based on Information Obtained From a CRA

If a user takes any type of adverse action as defined by the FCRA that is based at least in part on information contained in a consumer report, Section 615(a) requires the user to notify the consumer. The notification may be done in writing, orally, or by electronic means. It must include the following:

- **The name, address, and telephone number of the CRA (including a toll-free telephone number, if it is a nationwide CRA) that provided the report.**
- **A statement that the CRA did not make the adverse decision and is not able to explain why the decision was made.**
- **A statement setting forth the consumer's right to obtain a free disclosure of the consumer's file from the CRA if the consumer makes a request within 60 days.**
- **A statement setting forth the consumer's right to dispute directly with the CRA the accuracy or completeness of any information provided by the CRA.**

2. Adverse Actions Based on Information Obtained From Third Parties Who Are Not Consumer Reporting Agencies

If a person denies (or increases the charge for) credit for personal, family, or household purposes based either wholly or partly upon information from a person other than a CRA, and the information is the type of consumer information covered by the FCRA, Section 615(b)(1) requires that the user clearly and accurately disclose to the consumer his or her right to be told the nature of the information that was relied upon if the consumer makes a written request within 60 days of notification. The user must provide the disclosure within a reasonable period of time following the consumer's written request.

3. Adverse Actions Based on Information Obtained From Affiliates

If a person takes an adverse action involving insurance, employment, or a credit transaction initiated by the consumer, based on information of the type covered by the FCRA, and this information was obtained from an entity affiliated with the user of the information by common ownership or control, Section 615(b)(2) requires the user to notify the consumer of the adverse action. The notice must inform the consumer that he or she may obtain a disclosure of the nature of the information relied upon by making a written request within 60 days of receiving the adverse action notice. If the consumer makes such a request, the user must disclose the nature of the information not later than 30 days after receiving the request. If consumer report information is shared among affiliates and then used for an adverse action, the user must make an adverse action disclosure as set forth in I.C.1 above.

D. Users Have Obligations When Fraud and Active Duty Military Alerts are in Files

When a consumer has placed a fraud alert, including one relating to identity theft, or an active duty military alert with a nationwide consumer reporting agency as defined in Section 603(p) and resellers, Section 605A(h) imposes limitations on users of reports obtained from the consumer reporting agency in certain circumstances, including the establishment of a new credit plan and the issuance of additional credit cards. For initial fraud alerts and active duty alerts, the user must have reasonable policies and procedures in place to form a belief that the user knows the identity of the applicant or contact the consumer at a telephone number specified by the consumer; in the case of extended fraud alerts, the user must contact the consumer in accordance with the contact
information provided in the consumer's alert.

E. Users Have Obligations When Notified of an Address Discrepancy

Section 605(h) requires nationwide CRAs, as defined in Section 603(p), to notify users that request reports when the address for a consumer provided by the user in requesting the report is substantially different from the addresses in the consumer's file. When this occurs, users must comply with regulations specifying the procedures to be followed. Federal regulations are available at www.consumerfinance.gov/learnmore/.

F. Users Have Obligations When Disposing of Records

Section 628 requires that all users of consumer report information have in place procedures to properly dispose of records containing this information. Federal regulations have been issued that cover disposal.

II. CREDITORS MUST MAKE ADDITIONAL DISCLOSURES

If a person uses a consumer report in connection with an application for, or a grant, extension, or provision of, credit to a consumer on material terms that are materially less favorable than the most favorable terms available to a substantial proportion of consumers from or through that person, based in whole or in part on a consumer report, the person must provide a risk-based pricing notice to the consumer in accordance with regulations prescribed by the CFPB.

Section 609(g) requires a disclosure by all persons that make or arrange loans secured by residential real property (one to four units) and that use credit scores. These persons must provide credit scores and other information about credit scores to applicants, including the disclosure set forth in Section 609(g)(1)(D) ("Notice to the Home Loan Applicant").

III. OBLIGATIONS OF USERS WHEN CONSUMER REPORTS ARE OBTAINED FOR EMPLOYMENT PURPOSES

A. Employment Other Than in the Trucking Industry

If information from a CRA is used for employment purposes, the user has specific duties, which are set forth in Section 604(b) of the FCRA. The user must:

- **Make a clear and conspicuous written disclosure to the consumer before the report is obtained, in a document that consists solely of the disclosure, that a consumer report may be obtained.**
- **Obtain from the consumer prior written authorization. Authorization to access reports during the term of employment may be obtained at the time of employment.**
- **Certify to the CRA that the above steps have been followed, that the information being obtained will not be used in violation of any federal or state equal opportunity law or regulation, and that, if any adverse action is to be taken based on the consumer report, a copy of the report and a summary of the consumer's rights will be provided to the consumer.**

- **Before taking an adverse action, the user must provide a copy of the report to the consumer as well as the summary of consumer's rights. (The user should receive this summary from the CRA.) A Section 615(a) adverse action notice should be sent after the adverse action is taken.**

An adverse action notice also is required in employment situations if credit information (other than transactions and experience data) obtained from an affiliate is used to deny employment. **Section 615(b)(2)**.

The procedures for investigative consumer reports and employee misconduct investigations are set forth below.

B. Employment in the Trucking Industry

Special rules apply for truck drivers where the only interaction between the consumer and the potential employer is by mail, telephone, or computer. In this case, the consumer may provide consent orally or electronically, and an adverse action may be made orally, in writing, or electronically. The consumer may obtain a copy of any report relied upon by the trucking company by contacting the company.

IV. OBLIGATIONS WHEN INVESTIGATIVE CONSUMER REPORTS ARE USED

Investigative consumer reports are a special type of consumer report in which information about a consumer's character, general reputation, personal characteristics, and mode of living is obtained through personal interviews by an entity or person that is a consumer reporting agency. Consumers who are the subjects of such reports are given special rights under the FCRA. If a user intends to obtain an investigative consumer report, Section 606 requires the following:

- **The user must disclose to the consumer that an investigative consumer report may be obtained. This must be done in a written disclosure that is mailed, or otherwise delivered, to the consumer at some time before or not later than three days after the date on which the report was first requested. The disclosure must include a statement informing the consumer of his or her right to request additional disclosures of the nature and scope of the investigation as described below, and the summary of consumer rights required by Section 609 of the FCRA. (The summary of consumer rights will be provided by the CRA that conducts the investigation.)**
- **The user must certify to the CRA that the disclosures set forth above have been made and that the user will make the disclosure described below.**
- **Upon the written request of a consumer made within a reasonable period of time after the disclosures required above, the user must make a complete disclosure of the nature and scope of the investigation. This must be made in a written statement that is mailed or otherwise delivered, to the consumer no later than five days after the date on which the request was received from the consumer or the report was first requested, whichever is later in time.**

V. SPECIAL PROCEDURES FOR EMPLOYMEE INVESTIGATIONS

Section 603(x) provides special procedures for investigations of suspected misconduct by an employee or for compliance with Federal, state or local laws and regulations or the rules of a self- regulatory organization, and compliance with written policies of the employer. These investigations are not treated as consumer reports so long as the employer or its agent complies with the procedures set forth in Section 603(x), and a summary describing the nature and scope of the inquiry is made to the employee if an adverse action is taken based on the investigation.

VI. OBLIGATIONS OF USERS OF MEDICAL INFORMATION

Section 604(g) limits the use of medical information obtained from consumer reporting agencies (other than payment information that appears in a coded form that does not identify the medical provider). If the information is to be used for an insurance transaction, the consumer must give

consent to the user of the report or the information must be coded. If the report is to be used for employment purposes – or in connection with a credit transaction (except as provided in regulations issued by the banking and credit union regulators) – the consumer must provide specific written consent and the medical information must be relevant. Any user who receives medical information shall not disclose the information to any other person (except where necessary to carry out the purpose for which the information was disclosed, or as permitted by statute, regulation, or order).

VII. OBLIGATIONS OF USERS OF "PRESCREENED" LISTS

The FCRA permits creditors and insurers to obtain limited consumer report information for use in connection with unsolicited offers of credit or insurance under certain circumstances. **Sections 603(1), 604(c), 604(e), and 615(d)**. This practice is known as "prescreening" and typically involves obtaining from a CRA a list of consumers who meet certain pre-established criteria. If any person intends to use prescreened lists, that person must (1) before the offer is made, establish the criteria that will be relied upon to make the offer and to grant credit or insurance, and (2) maintain such criteria on file for a three-year period beginning on the date on which the offer is made to each consumer. In addition, any user must provide with each written solicitation a clear and conspicuous statement that:

- **Information contained in a consumer's CRA file was used in connection with the transaction.**
- **The consumer received the offer because he or she satisfied the criteria for credit worthiness or insurability used to screen for the offer.**
- **Credit or insurance may not be extended if, after the consumer responds, it is determined that the consumer does not meet the criteria used for screening or any applicable criteria bearing on credit worthiness or insurability, or the consumer does not furnish required collateral.**
- **The consumer may prohibit the use of information in his or her file in connection with future prescreened offers of credit or insurance by contacting the notification system established by the CRA that provided the report. The statement must include the address and toll-free telephone number of the appropriate notification system.**

In addition, the CFPB has established the format, type size, and manner of the disclosure required by Section 615(d), with which users must comply. The relevant regulation is 12 CFR 1022.54.

VIII. OBLIGATIONS OF RESELLERS

A. Disclosure and Certification Requirements

Section 607(e) requires any person who obtains a consumer report for resale to take the following steps:

- **Disclose the identity of the end-user to the source CRA.**
- **Identify to the source CRA each permissible purpose for which the report will be furnished to the end-user.**
- **Establish and follow reasonable procedures to ensure that reports are resold only for permissible purposes, including procedures to obtain:**
  - **(1) the identity of all end-users;**
  - **(2) certifications from all users of each purpose for which reports will be used; and**
  - **(3) certifications that reports will not be used for any purpose other than the purpose(s) specified to the reseller. Resellers must make reasonable efforts to verify this information before selling the report.**

B. Reinvestigations by Resellers

Under Section 611(f), if a consumer disputes the accuracy or completeness of information in a report prepared by a reseller, the reseller must determine whether this is a result of an action or omission on its part and, if so, correct or delete the information. If not, the reseller must send the dispute to the

source CRA for reinvestigation. When any CRA notifies the reseller of the results of an investigation, the reseller must immediately convey the information to the consumer.

C. Fraud Alerts and Resellers

Section 605A(f) requires resellers who receive fraud alerts or active duty alerts from another consumer reporting agency to include these in their reports.

IX. LIABILITY FOR VIOLATIONS OF THE FCRA

Failure to comply with the FCRA can result in state government or federal government enforcement actions, as well as private lawsuits. **Sections 616, 617, and 621**. In addition, any person who knowingly and willfully obtains a consumer report under false pretenses may face criminal prosecution. **Section 619**.

The CFPB's website, www.consumerfinance.gov/learnmore, has more information about the FCRA, including publications for businesses and the full text of the FCRA.

Citations for FCRA sections in the U.S. Code, 15 U.S.C. § 1681 et seq.:

Section 602	15 U.S.C. 1681	Section 615	15 U.S.C. 1681m
Section 603	15 U.S.C. 1681a	Section 616	15 U.S.C. 1681n
Section 604	15 U.S.C. 1681b	Section 617	15 U.S.C. 1681o
Section 605	15 U.S.C. 1681c	Section 618	15 U.S.C. 1681p
Section 605A	15 U.S.C. 1681cA	Section 619	15 U.S.C. 1681q
Section 605B	15 U.S.C. 1681cB	Section 620	15 U.S.C. 1681r
Section 606	15 U.S.C. 1681d	Section 621	15 U.S.C. 1681s
Section 607	15 U.S.C. 1681e	Section 622	15 U.S.C. 1681s-1
Section 608	15 U.S.C. 1681f	Section 623	15 U.S.C. 1681s-2
Section 609	15 U.S.C. 1681g	Section 624	15 U.S.C. 1681t
Section 610	15 U.S.C. 1681h	Section 625	15 U.S.C. 1681u
Section 611	15 U.S.C. 1681i	Section 626	15 U.S.C. 1681v
Section 612	15 U.S.C. 1681j	Section 627	15 U.S.C. 1681w
Section 613	15 U.S.C. 1681k	Section 628	15 U.S.C. 1681x
Section 614	15 U.S.C. 1681l	Section 629	15 U.S.C. 1681y

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 #13: _____
Date of last Pneumococcal Vaccine #23: _____

☐ **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 #

Charlotte Hall Veterans Home

29449 Charlotte Hall Rd
Charlotte Hall, MD 20622
(301) 884-8171

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.
   - ○ 20 to 40
   - ○ 40 to 60
   - ○ 60 to 80
   - ○ 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?
   - ○ A veteran
   - ○ A spouse of a veteran
4. Where will the veteran/spouse be admitted from?
   - ○ Home
   - ○ Hospital
   - ○ Assisted Living Facility
   - ○ Nursing Home Facility
   - ○ Rehabilitation Center
   - ○ Other: _____
5. What service(s) will the veteran/spouse require?
   - ○ Assisted Living
   - ○ Short-term rehabilitation with the intent of returning home
   - ○ Short-term rehabilitation then transitioning to long-term care
   - ○ Long-term (skilled nursing) care
   - ○ Hospice care
6. How long have you known about Charlotte Hall Veterans Home?
   - ○ Less than 6 months
   - ○ Less than 1 year
   - ○ 1 to 5 years
   - ○ 5 to 10 years
   - ○ More than 10 years
7. How did you first learn about Charlotte Hall Veterans Home?
   - ○ Newspaper advertisement
   - ○ Magazine advertisement
   - ○ Senior resource guide
   - ○ Television advertisement
   - ○ Internet advertisement including Facebook
   - ○ Charlotte Hall Veterans Home website
   - ○ Other: _____
   - ○ Patient Information Guide
   - ○ Newcomers and Chamber of Commerce resource guide
   - ○ Relative or friend
   - ○ Veterans Service Organization
   - ○ Case Manager or Social Worker
   - ○ Conference or Convention
8. How were you referred to Charlotte Hall Veterans Home for this tour/admission?
   - ○ Hospital, Nursing Home, or Assisted Living staff (*please circle to identify*)
   - ○ Home Health Agency
   - ○ Friend or family
   - ○ Veterans Service Organization
   - ○ Self-researched
   - ○ Other: _____
9. Please rank the following characteristics in order of importance during your search for a Skilled Nursing or Assisted Living Facility. Rank as 1-7 with 1 being most important and 7 being lease important.
   - ____ Distance from relative's
   - ____ 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) _____

MEDICAL PAPERWORK IS TO BE COMPLETED BY A PHYSICIAN

Fax to 301-263-7194

Attn: Admissions Department

OR

Paperwork may be mailed back to:

Charlotte Hall Veterans Home
Attn: Admissions Department
29449 Charlotte Hall Road
Charlotte Hall, MD 20622

If there are any questions, please call:

Lisa Murphy at 240-577-7009

Nicole Watson at 240-577-7026

Physician Documentation Checklist

When coming from Home:

- Health Care Practitioner Form 4506 (Included in packet)
- Physician Certification of Competency (included in packet, only 1 doctor needed)
- Maryland Medical Assistance Form DHMH 3871B (included in packet)
- Dept. of Health and Mental Hygiene PASRR Form DHMH 4345 (included in packet)
- Chest X-Ray within 90 days prior to admission
- LABS within 90 days prior to admission
    - CBC, CMP, TSH, US
    - DIG (if applicable) Dialntin (if appropriate)
- Immunization record (including influenza and pneumonia)
- Advance Directives / Living Will
- Any consult reports from last 6 months
- Any C & S relating to MRSA, VRE, C-Diff
- Any CT scans, Doppler studies, ECHO within last year
- B12, Folate, Fe studies within last year
- Last EKG
- Any pending appointments

PHYSICIAN CERTIFICATIONS RELATED TO MEDICAL CONDITION SUBSTITUTE DECISION MAKING, AND TREATMENT LIMITATIONS

PART 1: IDENTIFYING INFORMATION

-*Partner:* I am certifying information about _____.
-*Certifying practitioner (check all that apply):* I am ☐ the attending physician ☐ the medical director ☐ other_____
-*Time frame:* The following certifications ☐ are ☐ are not made within 2 hours of examining the individual.

PART 2: CERTIFICATIONS

a) Certification of General Status ☐ *THIS SECTION NOT APPLICABLE*

Based on my evaluation, I hereby certify that this individual (check all that apply):

☐ is in an END-STAGE CONDITION which is advanced, progressive, irreversible condition caused by injury, disease, or illness that has resulted in severe and permanent deterioration indicated by incompetence and complete physical dependency, and that to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective.

☐ is a PRESISTENT VEGETATIVE STATE caused by injury, disease, or illness resulting in a loss of consciousness; that this individual exhibits no behavioral evidence of self-awareness or awareness of surroundings in a learned manner other than reflex activity of muscles and nerves for low level conditioned response; and that, after the passage of a medically appropriate period of time, it has been or can be determined, to a reasonable degree of medical certainty, there can be no recovery.

☐ is in a TERMINAL CONDITION caused by injury, disease, or illness and which, to a reasonable degree of medical certainty, makes death imminent, and from which, despite the application of life-sustaining treatments, there can be no recovery.

Date:_____Signed:_____,MD,Attending

b) Certification of Ability to Comprehend Information and Make Decisions

1) Level of decision making capacity. Based on my evaluation, I hereby certify that this individual *(check all that apply)*

i) is ☐ able to understand and sign admission documents and other information
ii) is ☐ able to understand but unable to physically sign documents due to _____
iii) is ☐ unable to understand the nature, extent, or probable consequences of the proposed treatment of course of treatment
iv) is ☐ able ☐ unable to make a rational evaluation of the burdens, risks, and benefits of the treatment
v) is ☐ able ☐ unable to effectively communicate a decision

2) Diagnosis or reason for any incapacity: _____

Date:_____Signed:_____.MD,Attending

c) Certification regarding medical ineffectiveness of treatment

☐ I hereby certify that, to a reasonable degree of medical certainty, the following treatment(s), which under generally accepted medical practices are life-sustaining in nature, are being withheld because it (they) would not prevent or reduce the deterioration of the individual's health or prevent his or her impending death (list treatments): _____
_____

Date:_____Signed:_____,MD,Attending

☐ I concur ☐ DO NOT CONCUR with the above assessment _____ MD #2 Date:_____
Reason for non-concurrence:_____

If physician #2 does not agree with assessment completed by Attending Physician, the Medical Director will assess and note final decision below.

☐ I concur with Attending Physician ☐ I concur with Physician #2 Comments: _____
_____
_____

_____ _____
Signature Medical Director Date

Patient Name	Physician	Medical Record Number

Maryland Medical Assistance
Medical Eligibility Review Form #3871B

Part A – Service Requested (*indicates required field)

*1. Requested Eligibility Date_____ 2. Admission Date_____

*3. Check Service Type Below:

☐ Nursing Facility-please attach PASRR documentation if necessary (see Part F)

☐ Program of All-Inclusive Care for the Elderly (PACE) ☐ Brain Injury Waiver

☐ Chronic Hospital/Special Hospital vent dependent only (all other CH/SH use 3871) – please attach the Supplemental Ventilator Questionnaire

☐ Model Waiver vent dependent only (all other MW use 3871) – please attach the Supplemental Ventilator Questionnaire

☐ Medical Adult Day Care (new applicants currently placed in a hospital or nursing facility only)

*4. Check Type of Request

☐ Initial ☐ Conversion to MA ☐ Medicare ended ☐ MCO disenrollment

☐ Readmission– bed reservation expired (NF) ☐ Transfer new provider ☐ Update expired LOC ☐ Corrected Da

☐ Significant change from previously denied request ☐ Recertification (MW/PACE only)

☐ Advisory (please include payment)

*5. Contact Name_____ *Phone_____ *Fax_____

*E-Mail_____ *Organization/Facility_____

Part B – Demographics (* indicates required field)

*1. Client Name: Last _____First _____ MI ___ Sex: M F (circle)

*SS# _____- ____- _____ * MA # _____ *DOB _____

*2. Current Address (check one) ☐ Facility ☐ Home

*Address _____*City _____*State_____ *ZIP_____ *Phone_____

Nursing Facility name (if applicable) _____Provider #_____

If in acute hospital, name of hospital_____

*3. Next of Kin/ Representative

*Last name _____ *First Name _____ *MI _____

*Address _____ *City_____ *State____ *ZIP_____ *Phone_____

*4. Attending Physician

*Last name _____ *First Name _____ MI _____

Address _____ *City_____ *State_____ *ZIP_____ *Phone_____

Part C – Diagnoses

*Primary diagnosis related to the need for requested level of care	*ICD-10 Code	*Description
Other active diagnoses related to the need for requested level of care	Descriptions	

Applicant Name _____

Part D – Skilled Services:

Requires a physician's order. Requires the skills of technical or professional personnel such as a registered nurse, licensed practical nurse, respiratory therapist, physical therapist, and/or occupational therapist. The service must be inherently complex such that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel. Items listed under Rehabilitation and Extensive Services may overlap.

Table I. Extensive Services (serious/unstable medical condition and need for service)

Review Item	# Days Required
1. Tracheotomy Care: All or part of the day	
2. Suctioning: Not including routine oral-pharyngeal suctioning, at least once a day	
3. IV Therapy: Peripheral or central (not including self-administration)	
4. IM/SC Injections: At least once a day (not including self-administration)	
5. Pressure Ulcer Care: Stage 3 or 4 and one or more skin treatments (including pressure-relieving bed, nutrition or hydration intervention, application of dressing and/or medications)	
6. Wound Care: Surgical wounds or open lesions with one or more skin treatments per day (e.g., application of a dressing and/or medications daily)	
7. Tube Feedings: 51% or more of total calories or 500 cc or more per day fluid intake via tube	
8. Ventilator Care: Individual would be on a ventilator all or part of the day	
9. Complex respiratory services: Excluding aerosol therapy, spirometry, postural drainage or routine continuous O2 usage	
10. Parenteral Feeding or TPN: Necessary for providing main source of nutrition.	
11. Catheter Care: Not routine foley	
12. Ostomy Care: New	
13. Monitor Machine: For example, apnea or bradycardia	
14. Formal Teaching/Training Program: Teach client or caregiver how to manage the treatment regime or perform self care or treatment skills for recently diagnosed conditions (**must be ordered by a physician)**	

Table II. Rehabilitation (PT/OT/Speech Therapy services) Must be current ongoing treatment.

Review Item	# Days Required
15. Extensive Training for ADLs. (restoration, not maintenance), including walking, transferring, swallowing, eating, dressing and grooming.	
16. Amputation/Prosthesis Care Training: For new amputation.	
17. Communication Training: For new diagnosis affecting ability to communicate.	
18. Bowel and/or Bladder Retraining Program: Not including routine toileting schedule.	

Part E – Functional Assessment

Review Item	
FUNCTIONAL STATUS: Score as Follows **0 = Independent:** No assistance or oversight required **1 = Supervision:** Verbal cueing, oversight, encouragement **2 = Limited assistance:** Requires hands on physical assistance **3 = Extensive assistance:** Requires full performance (physical assistance and verbal cueing) by another for more than half of the activity. **4 = Total care:** Full activity done by another	**Score Each Item (0-4)**
1. Mobility: Purposeful mobility with or without assistive devices.	
2. Transferring: The act of getting in and out of bed, chair, or wheelchair. Also, transferring to and from toileting, tub and/or shower.	
3. Bathing (or showering): Running the water, washing and drying all parts of the body, including hair and face.	
4. Dressing: The act of laying out clothes, putting on and removing clothing, fastening of clothing and footwear, includes prostheses, orthotics, belts, pullovers.	

Applicant Name _____

5. Eating: The process of putting foods and fluids into the digestive system (including tube feeding).		
6. Toileting: Ability to care for body functions involving bowel and bladder activity, adjusting clothes, wiping, flushing of waste, use of bedpan or urinal, and management of any special devices (ostomy or catheter). This does not include transferring (See transferring item 16 above).		
CONTINENCE STATUS: Score as Follows **0 = Independent:** Totally continent, can request assistance in advance of need, accidents only once or twice a week or is able to completely care for ostomy. **1 = Dependent:** Totally incontinent, accidents three or more times a week, unable to request assistance in advance of need, continence maintained on toileting schedule, indwelling, suprapubic or Texas catheter in use or unable to care for own ostomy.	**Score Each Item (0-1)**	
7. Bladder Continence: Ability to voluntarily control the release of urine from the bladder	1	
8. Bowel Continence: Ability to voluntarily control the discharge of stool from the bowel.	1	
Review Item	**Answer**	
Cognitive Status (Please answer Yes or No for EACH item.)	**Y**	**N**
9. Orientation to Person: Client is able to state his/her name.	☐	☐
10. Medication Management: Able to administer the correct medication in the correct dosage, at the correct frequency without the assistance or supervision of another person.	☐	☐
11. Telephone Utilization: Able to acquire telephone numbers, place calls, and receive calls without the assistance or supervision of another person.	☐	☐
12. Money Management: Can manage banking activity, bill paying, writing checks, handling cash transactions, and making change without the assistance or supervision of another person.	☐	☐
13. Housekeeping: Can perform the minimum of washing dishes, making bed, dusting, and laundry, straightening up without the assistance or supervision of another person.	☐	☐
14. Brief Interview for Mental Status (BIMS): Was the examiner able to administer the complete interview? If yes, indicate the final score. If no, indicate reason. (Examination should be administered in a language in which the client is fluent.)	☐ Yes Score_____ ☐ No Check one of the following: ☐ Hearing Loss ☐ Applicant is rarely/never understood ☐ Language Barrier ☐ Refused ☐ Other (specify)_____	
Behavior (Please answer Yes or No for EACH item.)	**Answer**	
	Y	**N**
15. Wanders (several times a day): Moves with no rational purpose or orientation, seemingly oblivious to needs or safety.	☐	☐
16. Hallucinations or Delusions (at least weekly): Seeing or hearing nonexistent objects or people, or a persistent false psychotic belief regarding the self, people, or objects outside of self.	☐	☐
17. Aggressive/abusive behavior (several times a week): Physical and verbal attacks on others including but not limited to threatening others, hitting, shoving , scratching, punching, pushing, biting, pulling hair or destroying property.	☐	☐
18. Disruptive/socially inappropriate behavior (several times a week): Interferes with activities of others or own activities through behaviors including but not limited to making disruptive sounds, self-abusive acts, inappropriate sexual behavior, disrobing in public, smearing/throwing food/feces, hoarding, rummaging through other's belongings, constantly demanding attention, urinating in inappropriate places.	☐	☐
19. Self-injurious behavior (several times a month): Repeated behaviors that cause injury to self, biting, scratching, picking behaviors, putting inappropriate object into any body cavity, (including ear, mouth, or nose), head slapping or banging.	☐	☐
Communication (Please answer Yes or No for EACH item.)	**Answer**	
	Y	**N**
20. Hearing Impaired even with use of hearing aid: Difficulty hearing when not in quiet setting, understands conversations only when face to face (lip-reading), can hear only very loud voice or totally deaf.	☐	☐
21. Vision Impaired even with correction: Difficulty with focus at close range, field of vision is severely limited (tunnel vision or central vision loss), only sees light, motion, colors or shapes, or is totally blind.	☐	☐
22. Self Expression: Unable to express information and make self understood using any means (with the exception of language barrier).	☐	☐

23. Please provide any additional information that you believe supports that the client's health care needs cannot be safely met outside a nursing facility or in the absence of MADC, PACE, or Waiver services (use an addition sheet if necessary). You are strongly encouraged to use the 3871B Addendum and/or attach medical records for this purpose.

Part F – For Nursing Facility Applicants Only - ID/RC/MI Please Complete the Following

Review Item - If any of the below questions are answered Yes, please complete and attach the full Level I screen (DHMH 4345). If the Level I screen indicates that a Level II evaluation is necessary, please attach either the Categorical Advance Group Determination Form or certification that the person has been approved for admission under PASRR.	**Answer** Y	N
1. Is there a diagnosis or presenting evidence of intellectual disability/related condition (ID/RC), or has the client received services related to intellectual disability/related condition within the past two years?	☐	☐
2. Is there any presenting evidence of mental illness (MI)?	☐	☐
a. If yes, check all that apply. ☐ Schizophrenia ☐ Personality disorder ☐ Somatoform disorder ☐ Panic or severe anxiety disorder ☐ Mood disorder ☐ Paranoia ☐ Other psychotic or mental disorder leading to chronic disability		
3. Has the client received inpatient services for mental illness within the past two years?	☐	☐
4. Is the client on any medication for the treatment of a major mental illness or psychiatric diagnosis? a. If yes, is the mental illness or psychiatric diagnosis controlled with medication?	☐ ☐	☐ ☐
5. Is the client a danger to self or others?	☐	☐

Part G – Certification

1. Signature of Person Completing Form: _____ Date_____

Printed Name_____ Title_____

I certify to the best of my knowledge the information on the form is correct.

Signature of Health Care Professional: _____Date_____

Printed Name_____ Title_____

UCA/DHMH Use Only ☐ Approved ☐Denied Date of Decision_____

Certification Period _____

Signature_____ Date Signed_____

Print Name Title

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
LEVEL I ID SCREEN FOR
MENTAL ILLNESS AND INTELLECTUAL DISABILITY OR RELATED CONDITIONS

Note: This form must be completed for all applicants to nursing facilities (NF) which participate in the Maryland Medical Assistance Program regardless of applicant's payment source.

Last Name_____ First Name_____ MI_____ Date of Birth_____

SSN_____ Sex M___ F___ Actual/Requested Nursing Facility Adm Date_____

Current Location of Individual_____

Address_____

City/State_____ ZIP_____

Contact Person_____ Title/Relationship_____ Tel#_____

A. EXEMPTED HOSPITAL DISCHARGE

1. Is the individual admitted to a NF directly from a hospital after receiving acute inpatient care? Yes [ ] No [ ]

2. Does the individual require NF services for the condition for which he received care in the hospital? Yes [ ] No [ ]

3. Has the attending physician certified before admission to the NF that The resident is likely to require less than 30 days NF services? Yes [ ] No [ ]

IF ALL THREE QUESTIONS ARE ANSWERED YES, FURTHER SCREENING IS NOT REQUIRED (PLEASE SIGN AND DATE BELOW). IF ANY QUESTION IS ANSWERED NO, THE REMAINDER OF THE FORM MUST BE COMPLETED AS DIRECTED.

IF THE STAY EXTENDS FOR 30 DAYS OR MORE, A NEW SCREEN AND RESIDENT REVIEW MUST BE PERFORMED WITHIN 40 DAYS OF ADMISSION.

Signature_____ Title_____ Date_____

****

B. INTELLECTUAL DISABILITY (ID) AND RELATED CONDITIONS (see definitions)

1. Does the individual have a diagnosis of ID or related condition? If yes, specify diagnosis_____ Yes [ ] No [ ]

2. Is there any history of ID or related condition in the individual's past, prior to age 22? Yes [ ] No [ ]

3. Is there any presenting evidence (cognitive or behavior functions) that may indicate that the individual has ID or related conditions? Yes [ ] No [ ]

4. Is the individual being referred by, and deemed eligible for, services by an agency which serves persons with ID or related conditions? Yes [ ] No [ ]

Is the individual considered to have ID or a Related Condition? If the answer is Yes to one or more of the above, check "Yes." If the answers are No to all of the above, check "No." Yes [ ] No [ ]

Name_____

C. SERIOUS MENTAL ILLNESS (MI) (see definitions)

1. Diagnosis. Does the individual have a major mental disorder?
If yes, list diagnosis and DSM Code_____ Yes [ ] No [ ]

2. Level of Impairment. Has the disorder resulted in serious functional limitations in major life activities within the past 3 – 6 months (e.g., interpersonal functioning, concentration, persistence and pace; or adaptation to change? Yes [ ] No [ ]

3. Recent treatment. In the past 2 years, has the individual had psychiatric treatment more intensive than outpatient care more than once (e.g., partial hospitalization) or inpatient hospitalization; or experienced an episode of significant disruption to the normal living situation for which supportive services were required to maintain functioning at home or in a residential treatment environment or which resulted in intervention by housing or law enforcement officials? Yes [ ] No [ ]

Is the individual considered to have a SERIOUS MENTAL ILLNESS? If the answer is Yes to all 3 of the above, check "Yes." If the response is No to one or more of the above, check "No." Yes [ ] No [ ]

If the individual is considered to have MI or ID or a related condition, complete Part D of this form. Otherwise, skip Part D and sign below.

D. CATEGORICAL ADVANCE GROUP DETERMINATIONS

1. Is the individual being admitted for convalescent care not to exceed 120 days due to an acute physical illness which required hospitalization and does not meet all criteria for an exempt hospital discharge (described in Part A)? Yes [ ] No [ ]

2. Does the individual have a terminal illness (life expectancy of less than six months) as certified by a physician? Yes [ ] No [ ]

3. Does the individual have a severe physical illness, such as coma, ventilator dependence, functioning at a brain stem level or other diagnoses which result in a level of impairment so severe that the individual could not be expected to benefit from Specialized Services? Yes [ ] No [ ]

4. Is this individual being provisionally admitted pending further assessment due to an emergency situation requiring protective services? The stay will not exceed 7 days. Yes [ ] No [ ]

5. Is the individual being admitted for a stay not to exceed 14 days to provide respite? Yes [ ] No [ ]

If any answer to Part D is Yes, complete the Categorical Advance Group Determination Evaluation Report and attach. Additionally, if questions 1, 2, or 3 are checked "Yes," or if all answers in Part D are "No," the individual must be referred to AERS for a Level II evaluation.

I certify that the above information is correct to the best of my knowledge. If the initial ID screen is positive and a Level II evaluation is required, a copy of the ID screen has been provided to the applicant/resident and legal representative.

Name_____ Title_____ Date_____

FOR POSITIVE ID SCREENS, NOT COVERED UNDER CATEGORICAL DETERMINATIONS, Check below.

___ This applicant has been cleared by the Department for nursing facility admission.
___ This resident has been assessed for a resident review.

Local AERS Office_____ Contact_____ Date_____

Resident Name _____ Date Completed _____

Date of Birth _____

Health Care Practitioner Physical Assessment Form

This form is to be completed by a primary physician, certified nurse practitioner, registered nurse, certified nurse-midwife or physician assistant. Questions noted with an asterisk are "triggers" for awake overnight staff.

Please note the following before filling out this form: Under Maryland regulations an assisted living program may not provide services to a resident who, at the time of initial admission, as established by the initial assessment, requires: (1) More than intermittent nursing care; (2) Treatment of stage three or stage four skin ulcers; (3) Ventilator services; (4) Skilled monitoring, testing, and aggressive adjustment of medications and treatments where there is the presence of, or risk for, a fluctuating acute condition; (5) Monitoring of a chronic medical condition that is not controllable through readily available medications and treatments; or (6) Treatment for a disease or condition that requires more than contact isolation. An exception to the conditions listed above is provided for residents who are under the care of a licensed general hospice program.

1.* Current Medical and Psychiatric History. Briefly describe recent changes in health or behavioral status, suicide attempts, hospitalizations, falls, etc., within the past 6 months.

2.* Briefly describe any past illnesses or chronic conditions (including hospitalizations), past suicide attempts, physical, functional, and psychological condition changes over the years.

3. Allergies. List any allergies or sensitivities to food, medications, or environmental factors, and if known, the nature of the problem (e.g., rash, anaphylactic reaction, GI symptom, etc.). Please enter medication allergies here and also in Item 12 for medication allergies.

4. Communicable Diseases. Is the resident free from communicable TB and any other active reportable airborne communicable disease(s)?

(Check one) ☐ Yes ☐ No If "No," then indicate the communicable disease: _____

Which tests were done to verify the resident is free from active TB?

PPD Date: _____ Result:_____mm

Chest X-Ray (if PPD positive or unable to administer a PPD) Date: _____ Result_____

Resident Name _____ Date Completed _____

Date of Birth _____

5. History. Does the resident have a history or current problem related to abuse of prescription, non-prescription, over-the-counter (OTC), illegal drugs, alcohol, inhalants, etc.?

(a) Substance: OTC, non-prescription medication abuse or misuse
1. Recent (within the last 6 months) ☐ Yes ☐ No
2. History ☐ Yes ☐ No

(b) Abuse or misuse of prescription medication or herbal supplements
1. Currently ☐ Yes ☐ No
2. Recent (within the last 6 months) ☐ Yes ☐ No

(c) History of non-compliance with prescribed medication
1. Currently ☐ Yes ☐ No
2. Recent (within the last 6 months) ☐ Yes ☐ No

(d) Describe misuse or abuse: _____
_____

6.* Risk factors for falls and injury. Identify any conditions about this resident that increase his/her risk of falling or injury (check all that apply): ☐ orthostatic hypotension ☐ osteoporosis ☐ gait problem ☐ impaired balance ☐ confusion ☐ Parkinsonism ☐ foot deformity ☐ pain ☐ assistive devices ☐ other (explain)

_____

7.* Skin condition(s). Identify any history of or current ulcers, rashes, or skin tears with any standing treatment orders. _____

_____

8.* Sensory impairments affecting functioning. (Check all that apply.)

(a) Hearing: Left ear: ☐ Adequate ☐ Poor ☐ Deaf ☐ Uses corrective aid
Right ear: ☐ Adequate ☐ Poor ☐ Deaf ☐ Uses corrective aid

(b) Vision: ☐ Adequate ☐ Poor ☐ Uses corrective lenses ☐ Blind (check all that apply) - ☐ R ☐ L

(c) Temperature Sensitivity: ☐ Normal ☐ Decreased sensation to: ☐ Heat ☐ Cold

9. Current Nutritional Status. Height _____inches Weight _____lbs.

(a) Any weight change (gain or loss) in the past 6 months? ☐ Yes ☐ No

(b) How much weight change? _____lbs. in the past _____ months (check one) ☐ Gain ☐ Loss

(c) Monitoring necessary? (Check one.) ☐ Yes ☐ No

If items (a), (b), or (c) are checked, explain how and at what frequency monitoring is to occur: _____
_____

(d) Is there evidence of malnutrition or risk for undernutrition? ☐ Yes ☐ No

(e)* Is there evidence of dehydration or a risk for dehydration? ☐ Yes ☐ No

(f) Monitoring of nutrition or hydration status necessary? ☐ Yes ☐ No

If items (d) or (e) are checked, explain how and at what frequency monitoring is to occur: _____
_____

(g) Does the resident have medical or dental conditions affecting: (Check all that apply)
☐ Chewing ☐ Swallowing ☐ Eating ☐ Pocketing food ☐ Tube feeding

(h) Note any special therapeutic diet (e.g., sodium restricted, renal, calorie, or no concentrated sweets restricted): _____
_____

(i) Modified consistency (e.g., pureed, mechanical soft, or thickened liquids): _____
_____

(j) Is there a need for assistive devices with eating (If yes, check all that apply): ☐ Yes ☐ No
☐ Weighted spoon or built up fork ☐ Plate guard ☐ Special cup/glass

(k) Monitoring necessary? (Check one.) ☐ Yes ☐ No

If items (g), (h), or (i) are checked, please explain how and at what frequency monitoring is to occur:
_____

Resident Name _____ Date Completed _____

Date of Birth _____

10.* Cognitive/Behavioral Status.

(a)* Is there evidence of dementia? (Check one.) ☐ Yes ☐ No

(b) Has the resident undergone an evaluation for dementia? ☐ Yes ☐ No

(c)* Diagnosis (cause(s) of dementia): ☐ Alzheimer's Disease ☐ Multi-infarct/Vascular ☐ Parkinson's Disease ☐ Other

(d) Mini-Mental Status Exam (if tested) Date _____ Score _____

10(e)* Instructions for the following items: For each item, circle the appropriate level of frequency or intensity, depending on the item. Use the "Comments" column to provide any relevant details.

Item 10(e)	A	B*	C*	D*	Comments
Cognition					
I. Disorientation	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	
II. Impaired recall (recent/distant events)	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	
III. Impaired judgment	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	
IV. Hallucinations	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	
V. Delusions	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	
Communication					
VI. Receptive/expressive aphasia	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	
Mood and Emotions					
VII. Anxiety	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	
VIII. Depression	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	
Behaviors					
IX. Unsafe behaviors	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	
X. Dangerous to self or others	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	
XI. Agitation (Describe behaviors in comments section)	☐ Never	☐ Occasional	☐ Regular	☐ Continuous	

10(f) Health care decision-making capacity. Based on the preceding review of functional capabilities, physical and cognitive status, and limitations, indicate this resident's highest level of ability to make health care decisions.

☐ (a) Probably can make higher level decisions (such as whether to undergo or withdraw life-sustaining treatments that require understanding the nature, probable consequences, burdens, and risks of proposed treatment).

☐ (b) Probably can make limited decisions that require simple understanding.

☐ (c) Probably can express agreement with decisions proposed by someone else.

☐ (d) Cannot effectively participate in any kind of health care decision-making.

11.* Ability to self-administer medications. Based on the preceding review of functional capabilities, physical and cognitive status, and limitations, rate this resident's ability to take his/her own medications safely and appropriately.

☐ (a) Independently without assistance

☐ (b) Can do so with physical assistance, reminders, or supervision only

☐ (c) Need to have medications administered by someone else

_____ _____

Print Name Date

_____

Signature of Health Care Practitioner

Resident Name _____ Date Completed _____

Date of Birth _____

PRESCRIBER'S MEDICATION AND TREATMENT ORDERS AND OTHER INFORMATION

Allergies (list all): _____

Note: Does resident require medications crushed or in liquid form? Indicate in 12(a) with medication order. If medication is ***not*** to be crushed please indicate.

12(a) Medication(s). Including PRN, OTC, herbal, & dietary supplements. Include dosage route (p.o., etc.), frequency, duration (if limited).	12(b) All related diagnoses, problems, conditions. Please include all diagnoses that are currently being treated by this medication.	12(c) Treatments (include frequency & any instructions about when to notify the physician). Please link diagnosis, condition or problem as noted in prior sections.	12(d) Related testing or monitoring. Include frequency & any instructions to notify physician.

Prescriber's Signature _____ Date _____

Office Address _____ Phone _____

Resident Name _____ Date Completed _____

Date of Birth _____

PRESCRIBER'S MEDICATION AND TREATMENT ORDERS AND OTHER INFORMATION

Allergies (list all): _____

Note: Does resident require medications crushed or in liquid form? Indicate in 12(a) with medication order. If medication is ***not*** to be crushed please indicate.

12(a) Medication(s). Including PRN, OTC, herbal, & dietary supplements. Include dosage route (p.o., etc.), frequency, duration (if limited).	12(b) All related diagnoses, problems, conditions. Please include all diagnoses that are currently being treated by this medication.	12(c) Treatments (include frequency & any instructions about when to notify the physician). Please link diagnosis, condition or problem as noted in prior sections.	12(d) Related testing or monitoring. Include frequency & any instructions to notify physician.

Prescriber's Signature _____ Date _____

Office Address _____ Phone _____