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 other proof of honorable discharge from Active Duty military
- ❑ Copy of VA Service Connected Disability Letter (if applicable)
- ❑ Proof of Maryland residency (Driver's License, ID, etc)
  - o Must prove two years residency immediately prior to admission to CHVH
    -OR-
  - o Maryland must be listed as the veteran's "Home of Record" on the DD214
- ❑ Completed Admission Information forms (enclosed)
- ❑ Completed Financial Questionnaire (enclosed) (With Applicable Attachments)
  - o Copy of **3** years of bank statements (for all bank accounts, full statements)
  - o Award letters for all monthly incomes, any other pertinent financial information – Social Security, VA benefits, Pensions, etc.
  - o Copy of current statement for CDs, IRAs, 401K, Stocks or other investments
  - o Copy of latest Tax Return
  - o Copy of Life Insurance(s) – Declaration Page or Verification of cash value
  - o Real Estate Information – Most recent Mortgage or Reverse Mortgage statement
- ❑ Copy of all insurance cards front and back (Medicare, and any supplemental insurance)
  - o Medicare A & B are required
  - o Prescription Coverage is required
- ❑ Copy of Insurance Premium Notice – showing currently monthly premium (if any)
- ❑ Garnishment Information
- ❑ Copy of Power of Attorney/Living Will/Advance Directives
- ❑ If applicant is a spouse, include copy of marriage certificate & death certificate (if applicable)
- ❑ If divorced – include copy of divorce decree
- ❑ Signed consent for Criminal Background Check (enclosed)
- ❑ Signed consent for Criminal Background Disclosure (enclosed)
- ❑ Flu and COVID Vaccine Consent Form (enclosed)
  - o Copy of COVID Vaccination Care is required

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. 5111 or 5112.** 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
29449 Charlotte Hall Road
Charlotte Hall, MD 20622

ASSISTED LIVING

Rate Sheet / Cost of Care – Effective April 1, 2022

Veteran's Cost of Care: The Assisted Living Program is based on each individual's monthly income and payment may increase as income increases. The veteran's monthly cost of care includes room and board, as well as medications, activities, 1 haircut per month, Cable TV, local phone calls, incontinence supplies, and personal care items (deodorant, toothbrushes, combs, etc.).

How to Calculate Cost of Care for the Veteran:

Gross Monthly Income
- Health Insurance Payments (up to a max of $200)

Net Monthly Income

Then:

Net Monthly Income
- Monthly Allowance (10% of Net Monthly Income)

Monthly Amount Veteran pays toward their Cost of Care

Cost of Care – Per Day	Cost of Care – Per Month (30 Days)	Daily Per Diem (Benefit) by USVA	Monthly USVA Benefit (30 Days)	Balance of the Cost of Care Per Month
$177.92	$5337.60	$52.23	1,566.90	$3,770.70

HMR of MD LLC will pay the remaining balance of the veteran's cost of care after the veteran's income and VA per diem have been applied.

Any long distance calls made on facility telephones will be billed to the resident.

Cost of Care for Non-Veteran Spouses: Non-Veteran Spouses are responsible for their total cost of care. It is not the same as the veteran's cost of care formula listed above. Approximate cost for spouses **$5,412.00**: (based on a 30-day month)

PLEASE NOTE: The USVA and HMR of MD LLC **do not** contribute toward the cost of care for non-veteran spouses. These above costs are only room and board. Medications and personal supplies (laundry detergent, deodorant, etc.) are additional. Upon admission, spouses are required to pay a 60-day deposit as well as the pro-rated amount for the current month of move-in. In addition, spouses must be able to show that they will be able to pay their total cost of care for at least 6 months.

Assisted Living Bed Hold Policy: If a resident is to transfer to a hospital or skilled nursing facility, CHVH shall keep the resident's bed available for two (2) weeks from the date of transfer at the resident's expense. At the expiration of those two (2) weeks, holding the bed shall be at the sole discretion of CHVH, except that the resident or his/her personal agent may give notice of termination. The resident shall be responsible for all fees until such time as he/she has vacated his/her room.

CHARLOTTE HALL VETERANS HOME
Rates for Skilled Nursing Care
Effective April 1, 2022

	Spouse's cost per day	Spouse's cost per month (30 days)	Amount VA pays toward veteran's care day/month	Veteran's cost per day	Veteran's cost per month (30 days)
Skilled nursing: Private room:	$316.41	$9,492.30	$121.00 $3,630.00	$195.41	$5,862.30
Semi-private: (2 to room)	$307.90	$9,237.00	$121.00 $3,630.00	$186.90	$5,607.00
Secured (dementia) unit: Private room:	$330.14	$9,904.20	$121.00 $3,630.00	$209.14	$6,274.20
Semi-private: (2 to room)	$323.25	$9,697.50	$121.00 $3,630.00	$202.25	$6,067.50

Please note: The VA does not contribute toward the cost of care for spouses.

The above rates for spouse's and veterans include room and board, activities, 1 hair cut per month, cable TV, incontinence supplies and personal care items (deodorant/toothbrushes/combs/etc.). Private pay, Medicare and Medicaid payment accepted.

Daily (extra) cost for specific services:

Decubitus (ulcer) care including dressing changes. .	$ 20.50
Tube feeding – Medicare	$ 40.00
Communicable disease care	$ 135.00
Central intravenous line care	$ 67.50
Class a support surface (special mattress)	$ 29.00
Class b support surface (special mattress)	$ 116.00
Aerosol/oxygen care	$ 5.75
Peripheral intravenous line care	$ 24.25
Suctioning	$ 56.75

Additional charges: Rehabilitation therapies ordered by your physician (Physical, Occupational, and Speech), medical supplies, medication and other pharmaceutical supplies, psychiatric services, diagnostic services (lab, X-ray) physician services, and long distance phone calls. No charge for local phone calls.

Local Medical Transportation:
Prince Frederick: $26.55 Leonardtown: $22.44 Waldorf: $22.13

Current Federal VA Program Policy: The Federal VA Program does not pay per diem for hospital leave exceeding 10 days per hospital stay. On the 11th day of bed hold the resident will be billed the full room rate. i.e. $316.14 **not** $121.00

The Federal VA Program allows for up to 12 days of leave per calendar year (for reasons other than a hospital stay which is explained above). If a resident exceeds this limit, they will be billed the full room rate for bed holds.

Bed Hold: It is our policy to hold your bed for you if you are out of the facility. If you do not wish to reserve your bed, you must inform the business office and remove all personal items within 24 hours of leaving the premises.

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

Authorization

Authorization: By signing below, you authorize: (a) Global HR Research (GHRR) to request information about you from any public or private information source; (b) anyone to provide in- formation about you to GHRR to provide us **(HMR of Maryland, LLC)** 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 to the Charlotte Hall Veterans Home. GHRR 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.

By signing below, you acknowledge receipt of these documents.

Printed name: _____
First Middle (☐ none) Last

Other names used (including Maiden name): _____

Current and former addresses:

from Mo/Yr	to Mo/Yr	Street	City, State & Zip
	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. GHRR 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 _____

Print Name (Individual granting authorization) _____ Date _____

Signature (Individual granting authorization) _____ Admissions Representative _____

DISCLOSURE FOR CONSUMER REPORTS

In connection with my application for tenancy with Company, I understand consumer reports will be requested by the Company. These reports may include, but are not limited to, address history, criminal records, credit (as allowed by law), motor vehicle records, employment, education, license verification, workers' compensation claims, professional sanctions, civil judgments and other public record information. These records may be obtained from federal, state and other agencies that maintain such records.

In addition, investigative consumer reports (gathered from personal interviews) to gather information regarding my work, character, general reputation, personal characteristics and mode of living (lifestyle) may be obtained.

If I am accepted as a tenant, I understand that the Company can use this disclosure and following authorization to continue to obtain such consumer reports throughout my tenancy.

Print Name (Individual granting authorization)	Date
Signature (Individual granting authorization)	**Admissions Representative**

ADDITIONAL INFORMATION REGARDING YOUR RIGHTS

I understand that I have the right to make a request to Global HR Reasearch (GHRR) (Address: 9530 Marketplace Road, Ste. 301, Fort Myers, FL 33912. Telephone 800-790-1205), upon providing proper identification, to obtain copies of any reports furnished to Company by GHRR and to request the nature and substance of all information in its files on me at the time of my request, including the sources of information. GHRR will also disclose the recipients of any such reports on me which GHRR has retained and previously furnished. I understand that I can dispute, at any time, any information that is inaccurate in any type of report issued by GHRR. I may view GHRR's privacy policy at: https://ghrr.com/privacy-policy

Personal information in driving records means information that identifies you, such as your photograph, social security number, driver's license number, address, telephone number and medical or disability information relating to any license restrictions. **Highly restricted personal information** includes your photograph or image, social security number, medical or disability information relating to any license restriction. 18 U.S.C. §2725.

Print Name (Individual granting authorization)	Date
Signature (Individual granting authorization)	**Admissions Representative**

IMMUNIZATION CONSENT FORM

INFLUENZA VACCINE

ALLERGY TO EGGS: YES NO (circle one) *If egg allergy present, flu vaccine will not be administered.

☐ **I accept the Influenza vaccine annually.**

Date of last Influenza vaccine: _____ ☐ Unknown

☐ **I decline the Influenza vaccine.**

Reason for refusal: _____

☐ **I have been given and understand the Center for Disease Control Influenza Vaccine Fact Sheet.**

PNEUMOCOCCAL VACCINES

☐ **I accept the Pneumococcal vaccines as ordered by my physician.**

Date of Prevnar 13 (PCV13) vaccine: _____ ☐ Unknown
Date of Vaxneuvance (PCV15) vaccine: _____ ☐ Unknown
Date of Prevnar20 (PCV20) vaccine: _____ ☐ Unknown
Date(s) of Pneumovax 23 vaccine(s): _____ ☐ Unknown

☐ **I decline the Pneumococcal vaccines.**

Reason for refusal: _____

☐ **I have been given and understand the Center for Disease Control Pneumococcal Vaccine Fact Sheet.**

COVID-19 VACCINES

☐ **I accept the COVID-19 vaccines as ordered by my physician.**

Date of first COVID-19 vaccine: _____ ☐ Unknown
Date of second COVID-19 vaccine: _____ ☐ Unknown
Date(s) of additional COVID-19 vaccine(s): _____ ☐ Unknown
Brand of COVID-19 vaccine(s): _____ ☐ Unknown

☐ **I decline the COVID-19 vaccine series.**

Reason for refusal: _____

☐ **I have been given and understand the COVID-19 Vaccine Fact Sheet.**

_____ _____
Resident or Resident Representative Signature Date

_____ _____
Witness Signature and Title Date

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

INFLUENZA, PNEUMOCOCCAL, AND COVID-19 IMMUNIZATION EDUCATION

EDUCATION INFORMATION ON VACCINES

Benefits of Flu Vaccine:

- Your immunity levels are greatly increased
- The possibility of acquiring flu is greatly decreased
- Your chances of spreading the flu are greatly reduced

Benefits Pneumonia Vaccines:

- Your immunity levels are greatly increased
- Your chances of developing pneumonia are greatly decreased

Benefits COVID-19 Vaccines:

- Your immunity levels are greatly increased
- Your chances of developing COVID-19 are greatly decreased
- Your chances of spreading COVID-19 are greatly reduced

Risks/Side Effects of Vaccines:

- You could develop a fever after vaccination
- You could develop aches and become fatigued
- You could develop soreness, redness, or swelling at the injection site
- You could possibly have severe reactions (anaphylaxis, respiratory arrest, etc.) after vaccination

Additional vaccine-specific benefits, side effects, and the latest vaccine information can be found by visiting www.cdc.gov/vaccines.

Resident or Resident Representative Signature _____ Date _____

Witness Signature and 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.
   - o 20 to 40
   - o 40 to 60
   - o 60 to 80
   - 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
   - o A spouse of a veteran
4. Where will the veteran/spouse be admitted from?
   - o Home
   - o Hospital
   - o Assisted Living Facility
   - o Nursing Home Facility
   - o Rehabilitation Center
   - o Other: _____
5. What service(s) will the veteran/spouse require?
   - o Assisted Living
   - 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?
   - o Less than 6 months
   - o Less than 1 year
   - o 1 to 5 years
   - o 5 to 10 years
   - o More than 10 years
7. How did you first learn about Charlotte Hall Veterans Home?
   - o Newspaper advertisement
   - o Magazine advertisement
   - o Senior resource guide
   - o Television advertisement
   - o Internet advertisement including Facebook
   - o Charlotte Hall Veterans Home website
   - o Other: _____
   - o Patient Information Guide
   - o Newcomers and Chamber of Commerce resource guide
   - o Relative or friend
   - o Veterans Service Organization
   - o Case Manager or Social Worker
   - o Conference or Convention
8. How were you referred to Charlotte Hall Veterans Home for this tour/admission?
   - o Hospital, Nursing Home, or Assisted Living staff (*please circle to identify*)
   - o Home Health Agency
   - o Friend or family
   - o Veterans Service Organization
   - o Self-researched
   - o 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/30 days for Assisted Living prior to Admissions)
- Physician Certification of Competency (Included/only 1 doctor needed)
- Maryland Medical Assistance Form DHMH 3871B (Included)
- Dept. of Health and Mental Hygiene PASRR form DHMH 4345 (Included)
- Chest X-Ray (within 60 days for Nursing/30 days for Assisted Living – prior to Admissions)
- Labs (within 60 days for Nursing/30 days for Assisted Living – prior to Admissions)
    - CBC, CMP, TSH, UA
    - Coumadin, Digoxin, Dilantin (if applicable)
- Immunization Record (including COVID vaccine, influenza and pneumonia)
- Advance Directives / Living Wills
- Any consults reports from the last 6 months
- Any C&S relating to MRSA, VRE, or C-Diff
- Any CT scans, Doppler studies, ECHO within last year
- B12, Folate, Fe studies within last year
- Last EKG
- Any pending appointments

When coming from a Hospital/Nursing Home/Assisted Living:

The Admissions team will coordinate with the current facility to obtain the medical documentation required for admission.

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 _____

Form 4506
Revised 9-15-09

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 _____

Form 4506
Revised 9-15-09

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 dependentonly (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 previouslydenied 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** Y	N
Cognitive Status (Please answer Yes or No for EACH item.)		
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/neverunderstood ☐ 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).	☐	☐

Applicant Name _____

13. 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	Answer 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

CHARLOTTE HALL VETERAN'S HOME/ASSISTED LIVING

Facility to facility infection control transfer form

Please attach copies of latest culture reports and susceptibilities if available

Resident/Patient Last Name	First Name	Middle Initial	Date of Birth
			/ /

Name/Address of Sending Facility	Sending Unit	Sending Facility Phone

Is the patient/resident currently on isolation? _____ YES _____ NO
Type of isolation (please check all that apply) ___ Contact ___ Droplet ___ Airborne ___ other – explain: _____

Does patient/resident currently have an infection, colonization OR a history of multidrug-resistant organism (MDRO) or other organism of epidemiological significance?	Active Infection (Check if YES)	Treatment (Check if YES)	Colonization or history (Check if YES)
Methicillin-resistant Staphylococcus Aureus (MRSA)			
Vancomycin-resistant Enterococcus (VRE)			
Clostridium difficile			
Acinetobacter, multidrug resistant			
Extended Spectrum B-Lactamase (ESBL)			
Carbapenemase resistant Enterobacteriaceae (CRE)			
Other:			

Does the patient/resident currently have any of the following? (Check all that apply)

___ cough of requires suctioning
___ suprapubic catheter
___ tracheostomy
___ open wounds
___ vomiting
___ diarrhea
___ fever
___ OTHER: _____
___ Central line/PICC – insert date: _____
___ urinary catheter – insert date: _____
___ gastrostomy tube

Is the patient/resident currently on antibiotics? _____ YES _____ NO

Antibiotic and dose	Treatment for:	Start date	Stop date

Vaccine History	Date administered if known	Lot and brand if known	Year administered (if exact date not known)
Influenza			
Pneumococcal 23			
Prevnar 13			
other			

***** COVID-19 MEDICARE WAIVER: Was the purpose of this discharge to SNF without the inpatient stay related to the conservation of bed space for COVID-19 PHE or to limit the opportunity for further COVID-19 transmission?**

_____ YES _____ NO _____ N/A (3 Midnight in-patient requirement was met)

Printed Name of person completing form	Signature	Date