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:

- 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 DD-214
- DD-214 or equivalent showing an honorable discharge from Active Duty military
- Copy of VA Service Connected Disability Letter (if applicable)
- Copy of Driver's license, ID card, etc
- 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 statement (most recent)
  - Stock/investment statement (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)
  - Medicare A & B are required
  - Either Medicare Part D or Prescription Coverage is also required
- 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 and COVID Vaccine Consent Form (enclosed)
  - Copy of COVID Vaccination Card (if applicable)

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. 5111 or 5112.** 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 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 EBI (Address: 700 Red Brook Blvd, Owings Mills, MD 21117. Telephone 800- 324-7700), upon providing proper identification, to obtain copies of any reports furnishedto Company by EBI and to request the nature and substance of all information in its files on me at the time of myrequest, including the sources of information. EBI will also disclose the recipients of any such reports on me which EBI 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 EBI. I may view EBI's privacy policy at: https://www.ebiinc.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**

Authorization

Authorization: By signing below, you authorize: (a) Employment Background Investigations, Inc. (EBI) to request information about you from any public or private information source; (b) anyone to provide in- formation about you to EBI (c) EBI 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 relatedto your admission to the Charlotte Hall Veterans Home. EBI 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 asthe 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		

Some government agencies and other information sources require the following information whenchecking for records. BGC 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** _____

Updated

***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

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting

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

- **You must be told if information in your file has been used against you. Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.**
- **You have the right to know what is in your file. You may request and obtain all the information about you in the files of a consumer re- porting 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 na-tionwide 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 inaccu-rate, 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 re-port information it has verified as accurate.**
- **Consumer reporting agencies may not report outdated negative information. In most cases, a consumer reporting agency may notreport 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 ac- cess.**
- **You must give your consent for reports to be provided to employers. A consumer reporting agency may not give out information aboutyou to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not re- quired 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 "pre- screened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and ad- dress from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8688.**
- **You may seek damages from violators. If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher ofinformation 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 assetsof over $10 billion and their affiliates.	a. Bureau of Consumer Financial Protection 1700 G Street NW Washington, DC 20552
b. Such affiliates that are not banks, savings associations, or creditunions also should list, in addition to the Bureau:	b. Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357

Updated

a. National banks, federal savings associations, and federal branchesand federal agencies of foreign banks	a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050
b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and insured state branches of foreign banks), commercial lending companies ownedor controlled by foreign banks, and organizations operating undersection 25 or 25A of the Federal Reserve Act	b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480
c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations	c. FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106
d. Federal Credit Unions	d. National Credit Union Administration Office of Consumer Protection (OCP) Division of Consumer Compliance and Outreach (DCCO) 1775 Duke Street Alexandria, VA 22314
3. Air carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Department of Transportation 400 Seventh Street SW Washington, DC 20590
4. Creditors Subject to Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 1925 K Street NW Washington, DC 20423
5. Creditors Subject to Packers and Stockyards Act	Nearest Packers and Stockyards Administration area supervisor
6. Small Business Investment Companies	Associate Deputy Administrator for Capital AccessUnited States Small Business Administration 406 Third Street, SW, 8th Floor Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission 100 F St NE Washington, DC 20549
8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations	Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090
9. Retailers, Finance Companies, and All Other Creditors Not Listed Above	FTC Regional Office for region in which the creditor operates or Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357

ADDITIONAL INFORMATION ABOUT THE FAIR CREDIT

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 hoursfor 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.**

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 VACCINE

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

Date of last Prevnar 13 Vaccine: _____ ☐ Unknown

Date(s) of last Pneumovax 23 Vaccine: _____ ☐ 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 VACCINE

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

Date of first COVID-19 Vaccine injection: _____ ☐ Unknown

Date of second COVID-19 Vaccine injection: _____ ☐ 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 #

Updated

INFLUENZA, PNEUMOCOCCAL, AND COVID-19 IMMUNIZATION EDUCATION

EDUCATION INFORMATION ON VACCINES

Benefits of Flu Vaccine:

- Your immunity levels will be 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 #

Updated

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) _____

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.

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 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**	
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).	☐	☐

Applicant Name _____

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	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

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 _____