Charlotte Hall Veterans Home
HMR of Maryland, LLC

29449 Charlotte Hall Rd
Charlotte Hall, MD 20622

Admissions Documentation Checklist

Dear Applicant and/or Family:

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

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

- ❑ DD214 or equivalent of honorable discharge from the military
- ❑ Proof of Maryland residency (Driver's license, ID card, etc)
  - Must prove two years residency immediately prior to admission to CHVH - OR -
  - Maryland must be listed as the veteran's "Home of Record" on the DD214
- ❑ Completed Admission Application forms (enclosed)
- ❑ Completed Financial Questionnaire – (enclosed - With Applicable Attachments)
    - Copy of **last 3 months** bank statements (for all bank accounts)
    - CD/IRA/401K Statements (most recent)
    - Stock/investment statements (most recent)
    - Award letters for all monthly incomes, any other pertinent financial information

    Social Security, Pension, Veterans Benefits, etc.
  - Copy of latest Tax return
  - Life Insurance (s) - Declaration page or Verification of cash value
  - Real Estate Information – Mortgage Statement (most recent)
- ❑ Copy of Medical Insurance cards front and back (Medicare, and any supplemental insurance)
  Insurance Premium Notice – showing current monthly premium if any
- ❑ Garnishment Information
- ❑ If spouse, include copy of marriage certificate or death certificate (if applicable)
- ❑ Copy of Power of Attorney/Living Will/Advance Directives
- ❑ Medical Package to be completed by Physician (must be dated within 30 days of admission date)
- ❑ Signed consent for criminal background check (enclosed)
- ❑ Flu Vaccine Consent Form (enclosed)

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

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

Charlotte Hall Veterans Home 29449
Charlotte Hall Road Charlotte Hall,
Maryland 20622 Telephone 301-884-8171
Ext. 1409 FAX 301-263-7194

Applying from: ☐ Home ☐ Hospital _____ ☐ Nursing Home/Assisted Living _____

Requesting placement 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 ☐ Divorced ☐ Widowed ☐ 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
☐ Masons ☐ Knights of Columbus ☐ Elks
☐ 29th Division ☐ Lions Club ☐ DAR
☐ Veterans of Foreign Wars ☐ Moose Lodge ☐ DAV

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 in 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 the 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 _____ _____

Street Address _____

City _____ State _____ Zip _____

Phone #: Home _____ Work _____ Cell _____

Email _____ Send biannual newsletter ☐ Yes ☐ No

Second Contact: Name _____ Relationship _____

Street Address _____

City _____ State _____ Zip _____

Phone #: Home _____ Work _____ Cell _____

Email _____ Send biannual 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 so, please provide a copy***

Is there a living trust? ☐ Yes ☐ No ***If so, 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 Utilization

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 the 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 the case that available funding cannot cover my cost of care, I agree to comply with the necessary steps in applying for Maryland Medicaid assistance and benefits.

X _____

Signature Relationship to Applicant Date

Charlotte Hall Veterans Home — Background Consent

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

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

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

Printed name: _____
First Middle (if none, please check ☐) Last

Other names used: _____

Current and former addresses:

From Mo/Yr	to Mo/Yr (Current)	Street	City	State	Zip

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

_____ Date of Birth

_____ Social Security Number

_____ Driver's license number & state

_____ Name as it appears on license

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

_____ Signature

_____ Date

_____ Facility

_____ HR Representative

Charlotte Hall Veterans Home

Flu Vaccine

INFLUENZA VACCINE

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

☐ **I accept the Influenza Vaccine annually**

Date of last Influenza vaccine: _____

☐ **I decline Influenza vaccine**

Reason for refusal:_____

☐ **I have been given and understand the Center for Disease Control (CDC) Influenza Vaccine Fact sheet**

PNEUMOCOCCAL VACCINE

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

Date of last Pneumococcal Vaccine #13: _____

Date of last Pneumococcal Vaccine #23: _____

☐ **I decline Pneumococcal Vaccine**

Reason for refusal:_____

☐ **I have been given and understand the Center for Disease Control (CDC) Pneumococcal Vaccine Fact sheet**

_____ _____

Signature – Resident and/or Responsible Party **Date**

_____ _____

Witness Signature/Title **Date**

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

Physician Documentation Checklist

When Coming From Home

- Health care Practitioner Form (Included in packet)
- **CHEST X RAY within 30 days prior to admission**
- **LABS within 30 days prior to admission**
  CBC, CMP, TSH, UA
  DIG (if appropriate) Dialntin (if appropriate)
- MI/MR ID Screen (included in packet)
- Physician Order sheet (included in packet)
- Maryland Medical Assistance form 3871 (included in packet)
- Physician's Certification of Competency (included in packet, 1 Dr. only needed
- Immunization record (including influenza and pneumonia)
- Advance Directives / Living Will
- Any consult reports from last 6 months
- Any C & S relating to MRSA, VRE, C-Diff
- Any CT scans, Doppler studies, ECHO within last year
- B12, Folate, Fe studies within last year
- Last EKG
- Any Pending Appointments

Resident Name _____
Date of Birth _____
Date Completed _____

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 of Birth _____
Date Completed _____

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 of Birth _____
Date Completed _____

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 of Birth _____
Date Completed _____

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 of Birth _____
Date Completed _____

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 _____

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

PART 1: IDENTIFYING INFORMATION

- *Patient:* 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 an 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 in a **PERSISTENT 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 or 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

1. Requested Eligibility Date: _____
2. Admission Date _____
3. Facility MA Provider #: _____

4. Check Service Type Below:

- ☐ Nursing Facility
- ☐ Medical Day Care Waiver
- ☐ Waiver for Older Adults
- ☐ Living at Home Waiver
- ☐ PACE
- ☐ Model Waiver vent only dependent (all other MW use 3871)
- ☐ Chronic Hospital vent dependent only (all other CH use 3871)

5. Check Type of Request

- ☐ Initial
- ☐ Conversion to MA (NF)
- ☐ Medicare ended (NF)
- ☐ MCO disenrollment (NF)
- ☐ Readmission – bed reservation exp. (NF)
- ☐ Transfer new provider (NF)
- ☐ Update expired LOC
- ☐ Corrected Date
- ☐ Significant change from previously denied request
- ☐ Recertification (Waivers/PACE only)
- ☐ Advisory (please include payment)

Part B – Demographics

1. Client Name: Last _____First _____ MI _____ Sex: M ☐ F ☐

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

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

Address 1 _____

Address 2 _____

City _____ State _____ ZIP _____ Phone _____

If placed in facility, name of facility _____

If in acute hospital, name of hospital_____

3. Next of Kin/ Representative

Last name _____ First Name _____ MI _____

Address 1 _____

Address 2 _____

City _____ State _____ ZIP _____ Phone _____

4. Attending Physician

Last name _____ First Name _____ MI _____

Address 1 _____

Address 2 _____

City _____ State _____ ZIP _____ Phone _____

Applicant Name _____

Part C – MR/MI Please Complete the Following on All Individuals:

Review Item	Answer Y	Answer N
1. Is there a diagnosis or presenting evidence of mental retardation/related condition, or has the client received MR services within the past two years?	☐	☐
2. Is there any presenting evidence of mental illness? Please note: Dementia/Alzheimer's is not considered a mental illness.	☐	☐
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 D – Diagnoses

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

Part E – 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 (Please indicate the number of days per week each service is required)	# of days service is required/wk. (0-7)
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 (Please indicate the number of days per week each service is required.)	No. of days service is required/wk. (0-7)
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 F – Functional Assessment

Review Item	**Answer**	
Cognitive Status (Please answer Yes or No for EACH item.)	**Y**	**N**
1. Orientation to Person: Client is able to state his/her name.	☐	☐
2. Medication Management: Able to administer the correct medication in the correct dosage, at the correct frequency without the assistance or supervision of another person.	☐	☐
3. Telephone Utilization: Able to acquire telephone numbers, place calls, and receive calls without the assistance or supervision of another person.	☐	☐
4. Money Management: Can manage banking activity, bill paying, writing checks, handling cash transactions, and making change without the assistance or supervision of another person.	☐	☐
5. Housekeeping: Can perform the minimum of washing dishes, making bed, dusting, and laundry, straightening up without the assistance or supervision of another person.	☐	☐
6. 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.) If yes, Score: _____ If 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**
7. Wanders (several times a day): Moves with no rational purpose or orientation, seemingly oblivious to needs or safety.	☐	☐
8. 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.	☐	☐
9. 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.	☐	☐
10. 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.	☐	☐
11. 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.	☐	☐

Applicant Name _____

Communication (Please answer Yes or No for EACH item.)	**Answer** Y	N
12. 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.	☐	☐
13. 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.	☐	☐
14. Self Expression: Unable to express information and make self understood using any means (with the exception of language barrier).	☐	☐

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)**
15. Mobility: Purposeful mobility with or without assistive devices.	
16. Transferring: The act of getting in and out of bed, chair, or wheelchair. Also, transferring to and from toileting, tub and/or shower.	
17. Bathing (or showering): Running the water, washing and drying all parts of the body, including hair and face.	
18. Dressing: The act of laying out clothes, putting on and removing clothing, fastening of clothing and footwear, includes prostheses, orthotics, belts, pullovers.	
19. Eating: The process of putting foods and fluids into the digestive system (including tube feeding).	
20. 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)**
21. Bladder Continence: Ability to voluntarily control the release of urine from the bladder	
22. Bowel Continence: Ability to voluntarily control the discharge of stool from the bowel.	

Part G – Certification

1. Signature of Person Completing Form: _____ Date_____

   Printed Name_____

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

2. Signature of Health Care Professional: _____ Date_____

   Printed Name_____

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
LEVEL I ID SCREEN FOR
MENTAL ILLNESS AND MENTAL RETARDATION 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 <u>NOT</u> 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. MENTAL RETARDATION (MR) AND RELATED CONDITIONS (see definitions)

1. Does the individual have a diagnosis of MR or related condition?
   If yes, specify diagnosis_____ Yes ☐ No ☐
2. Is there any history of MR 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 MR or related conditions? Yes ☐ No ☐
4. Is the individual being referred by, and deemed eligible for services by an agency which serves persons with MR or related conditions? Yes ☐ No ☐

Is the individual considered to have MR or a Related Condition? If the answer is <u>Yes</u> to one or more of the above, check "Yes." If the answers are <u>No</u> 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? Yes ☐ No ☐
   If yes, list diagnosis and DSM IV Code_____

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 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 MR 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, ventilation dependence, functioning at a brain stem level or other diagnoses which results in a level of impairment so severe that the individual could not be expected to benefit from Specialized Services? Yes ☐ No ☐

4. Is the 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 GES 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 GES 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 GES Office _____ Contact _____ Date _____

Charlotte Hall Veterans Home
29449 Charlotte Hall Road
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 spouse/veteran 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 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
   - o Other: _____

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 least important.
   - ___ Distance from relatives
   - ___ Age of building
   - ___ Cost of care
   - ___ Quality of care
   - ___ Size of facility
   - ___ Veteran centered atmosphere
   - ___ Cleanliness of facility

Please provide the date you completed this survey (MM/DD/YY) _____