Charlotte Hall Veterans Home

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.

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

All paperwork including the physician's forms must be completed and turned in before a resident can be admitted to CHVH. If you have any questions about this admissions process, please feel free to contact the Admissions Office at **301-884-8171 ext. 5119 or 5118.** Please complete the admissions packet as quickly as possible and either fax to **833-671-3102**, or mail to the CHVH Admissions office.

The following is a checklist of the materials needed for a complete application:

For Veterans 70% to 100% Service-Connected Disabled Only:

- ❑ DD214 or other proof of honorable discharge from Active Duty military
- ❑ Copy of VA Service Connected Disability Letter
- ❑ Proof of Maryland residency (Driver's License, ID, etc.)
  - Must prove two years residency immediately prior to admission to CHVH Assisted Living **--OR--** Must be in a Skilled Nursing Facility for 3 months immediately prior to admission to CHVH Skilled Nursing
  - Maryland must be listed as the veteran's "Home of Record" on the DD214
- ❑ Copy of all insurance cards front and back (Medicare, and any supplemental insurance)
  - Medicare A & B are required
    - **Social Security** – if under the age of 62 (our minimum age requirement), then Social Security Disability is required along with Medicare Part A & B
  - Prescription Coverage is required
- ❑ Completed Admission Information forms (enclosed)
- ❑ Completed Financial Questionnaire (enclosed) (With Applicable Attachments)
  - Failure to fully disclose all income, assets, & life insurances as required, will result in automatic Admission Denial to our facility
  - Copy of 6 months of bank statements (for all bank accounts, full statements)
  - Current Statement for all IRA/401K/Stocks/Bonds/CD/Certificates
  - Copy of Insurance Premium Notice – showing currently monthly premium (if any)
  - Garnishment Information
- ❑ Copy of Power of Attorney/Living Will/Advance Directives
- ❑ Signed consent for Criminal Background Check (enclosed)
- ❑ Signed consent for Criminal Background Disclosure (enclosed)

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Admissions Documentation Checklist

The following is a checklist of the materials needed for a complete application:

For Veterans 10% to 60% Service-Connected Disabled, Non-Service Connected Disabled Veterans &/or Eligible Spouses:

- ❑ DD214 or other proof of honorable discharge from Active Duty military
- ❑ Copy of VA Service Connected Disability Letter **–OR–** Copy of VA Non-Service Connected Special Monthly Pension Letter (if applicable)
- ❑ Proof of Maryland residency (Driver's License, ID, etc.)
  - Must prove two years residency immediately prior to admission to CHVH Assisted Living **–OR–** Must be in a Skilled Nursing Facility for 3 months immediately prior to admission to CHVH Skilled Nursing
  - Maryland must be listed as the veteran's "Home of Record" on the DD214
- ❑ Copy of all insurance cards front and back (Medicare, and any supplemental insurance)
  - Medicare A & B are required
    - **Social Security** – if under the age of 62 (our minimum age requirement), then Social Security Disability is required along with Medicare Part A & B
  - Prescription Coverage is required
- ❑ Completed Admission Information forms (enclosed)
- ❑ Completed Financial Questionnaire (enclosed) (With Applicable Attachments)
  - Failure to fully disclose all income, assets, & life insurances as required, will result in automatic Admission Denial to our facility
  - Copy of **3 years** of bank statements (for all bank accounts, full statements) **--OR--**Copy of **5 years** of bank statements, if Maryland Medicaid will be required
  - Current Statement for all IRA/401K/Stocks/Bonds/CD/Certificates
  - Award letters for all monthly incomes, any other pertinent financial information – Social Security, VA benefits, Pensions, etc.
    - **Social Security** – if under the age of 62 (our minimum age requirement), then Social Security Disability is required along with Medicare Part A & B
  - Copy of Insurance Premium Notice – showing currently monthly premium (if any)
  - Garnishment Information
- ❑ If applicant is a spouse, include copy of marriage certificate & 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)

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ASSISTED LIVING FOR VETERANS

Rate Sheet / Cost of Care - Effective October 1, 2026

Veteran's Cost of Care: The Assisted Living Program is based on each individual's gross monthly. Monthly payment may be increased as income increases. The veteran's monthly cost of care includes room and board, as well as medications, activities, 1 haircut per month, Cable TV, phone calls, incontinence supplies, and personal care items (laundry detergent, deodorant, toothbrushes, combs, etc.). The Veteran will still be required to pay their Health Insurance Premiums.

How to Calculate Cost of Care for the Veteran:

Gross Monthly Income
- Health Insurance Premiums
Equals Veterans Net Monthly Income

Then:

Net Monthly Income
- Monthly Allowance (10% of Net Monthly Income)
Monthly Amount Veteran pays toward their Cost of Care

COST OF CARE PER DAY	COST OF CARE PER MONTH (* 30.4166 DAYS)	CURRENT DAILY VA PER DIEM RATE	CURRENT MONTHLY VA PER DIEM (*30.4166 DAYS)	CURRENT AL RESIDENT MONTHLY PAYMENT
$177.92	$5411.72	$66.24	$2014.79	$3396.93

***Per month is broken-down by taking 365 days in a year divided 12 months = 30.4166 Days**

Local Medical Transportation: There is a flat rate fee of $28.00 for using CHVH Transportation Services to & from medical appointments.

Assisted Living Bed Hold Policy: If a resident is to transfer to a hospital or skilled nursing facility, CHVH shall keep the resident's bed available for two (2) weeks from the date of transfer at the resident's expense of $177.92 per day. At the expiration of those two (2) weeks, holding the bed shall be at the sole discretion of CHVH, except that the resident or his/her personal agent may give notice of termination. The resident shall be responsible for all fees until such time as he/she has vacated his/her room.

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ASSISTED LIVING FOR NON-VETERANS

Rate Sheet / Cost of Care - Effective October 1, 2026

Cost of Care for Non-Veteran Spouses: Non-Veteran Spouses are required to have a minimum monthly income of $6000. Non-Veteran Spouses are responsible for their total cost of care.

PLEASE NOTE: The MDVA **DOES NOT** contribute toward the cost of care for non-veteran spouses. The above costs are only room and board. Medications and personal supplies (laundry detergent, deodorant, etc.) are additional. Upon admission, spouses will pay the pro-rated amount for the current month of move-in. They are still required to pay their Health Insurance Premiums.

How to Calculate Cost of Care for Non-Veteran Spouses:

COST OF CARE PER DAY	COST OF CARE PER MONTH (* 30.4166 DAYS)
$177.92	$5411.72

***Per month is broken-down by taking 365 days in a year divided 12 months = 30.4166 Days**

Local Medical Transportation: There is a flat rate fee of $28.00 for using CHVH Transportation Services to & from medical appointments.

Assisted Living Bed Hold Policy: If a resident is to transfer to a hospital or skilled nursing facility, CHVH shall keep the resident's bed available for two (2) weeks from the date of transfer at the resident's expense of $177.92 per day. At the expiration of those two (2) weeks, holding the bed shall be at the sole discretion of CHVH, except that the resident or his/her personal agent may give notice of termination. The resident shall be responsible for all fees until such time as he/she has vacated his/her room.

Charlotte Hall Veterans Home

Rates for Skilled Nursing Care for VETERANS

Effective October 1, 2026

	Total Cost per Day	Total Cost Per Month (30 Days)	Amount VA pays towards Veterans Care (Day/Month)	Veteran's Cost Per Day	Veteran's Cost Per Month (30 Days)
Skilled Nursing: Private Room	**$328.00**	**$9,840.00**	**$153.47 $4,604.10**	**$174.53**	**$5,235.90**
Semi-Private Room	**$320.00**	**$9,600.00**	**$153.47 $4,604.10**	**$166.53**	**$4995.90**
Secured (Dementia) Unit: Private Room	**$342.00**	**$10,260.00**	**$153.47 $4,604.10**	**$188.53**	**$5,655.90**
Semi-Private Room	**$335.00**	**$10,050.00**	**$153.47 $4,604.10**	**$181.53**	**$5,445.90**

The above rates for Veterans include room and board, activities, 1 hair cut per month, cable TV, telephone, incontinence supplies, and personal care items (i.e. deodorant, toothbrushes, combs, etc.)

Daily (extra) cost for specific services:

Decubitus (ulcer) care beyond dressing changes (i.e: wound vac, specialty beds) $20.50
Tube Feeding – Medicare $40.00
Central intravenous line care $67.50
Aerosol/oxygen care $5.75
Peripheral intravenous line care $24.25
Suctioning $56.75

Additional Charges: Rehabilitation therapies ordered by your physician (physical, Occupational, and Speech), medical supplies, medication and other pharmaceutical supplies, psychiatric services, diagnostic services (lab, X-ray) physician services.

Local Medical Transportation: There is a flat rate fee of $28.00 for using CHVH Transportation Services to & from medical appointments.

Current Federal VA Program Policy: The Federal VA Program does not pay per diem for hospital leave exceeding 10 days per hospital stay. On the 11th day of the bed hold, the resident will be billed the full daily room rate each day (i.e: $328.00 **NOT** $179.29).

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

Bed Hold Policy: It is our policy to hold your bed for you if you are out of the facility. To hold the bed, the resident will continue to be billed per their current payment agreement for the first 10 days out of the facility. After day 10, the resident will be billed the full daily room rate, as noted above, if they wish to continue the bed hold.

Charlotte Hall Veterans Home

Rates for Skilled Nursing Care for NON-VETERANS

Effective October 1, 2026

	Total Cost per Day	Total Cost Per Month (30 Days)
Skilled Nursing: Private Room	**$328.00**	**$9,840.00**
Semi-Private Room	**$320.00**	**$9,600.00**
Secured (Dementia) Unit: Private Room	**$342.00**	**$10,260.00**
Semi-Private Room	**$335.00**	**$10,050.00**

Please note: the VA does NOT contribute toward the cost of care for Spouses.

The above rates for Non-Veterans include room and board, activities, 1 hair cut per month, cable TV, telephone, incontinence supplies, and personal care items (i.e. deodorant, toothbrushes, combs, etc.)

Daily (extra) cost for specific services:

Decubitus (ulcer) care beyond dressing changes (i.e: wound vac, specialty beds) $20.50
Tube Feeding – Medicare $40.00
Central intravenous line care $67.50
Aerosol/oxygen care $5.75
Peripheral intravenous line care $24.25
Suctioning $56.75

Additional Charges: Rehabilitation therapies ordered by your physician (physical, Occupational, and Speech), medical supplies, medication and other pharmaceutical supplies, psychiatric services, diagnostic services (lab, X-ray) physician services.

Local Medical Transportation: There is a flat rate fee of $28.00 for using CHVH Transportation Services to & from medical appointments.

Bed Hold Policy: It is our policy to hold your bed for you if you are out of the facility. To hold the bed, the resident will be billed the Total Cost per Day for each day of the Bed Hold. If you do not wish to hold the bed, you must notify the facility.

Charlotte Hall Veterans Home

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Charlotte Hall, MD 20622
Telephone: 301-884-8171 ext. 5119, 5118
Fax: 833-671-3102

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 _____ Gender_____ Mother's Maiden Name _____

Marital Status ☐Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Legal Date of Separation or Divorce _____

Military Records Information

Branch of Service_____

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 # _____

Part A Start Date: _____ Part B Start Date: _____

Are you enrolled in a Prescription Plan? ☐ 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*

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: _____

Signature Relationship to Applicant Date

Financial Information

The Charlotte Hall Veterans Home, in its financial planning, must have information about the financial ability of ea 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 nu 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 sponse 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 incom 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

Name-Based Criminal Background History Record Information Consent/Inquiry Form

I hereby authorize Charlotte Hall Veterans Home to conduct an inquiry for
Agency/Company

PruittHealth (company) with the purpose(s) listed below and receive any Georgia and/or national criminal background history record information as authorized by state and federal law.

Full Name (print)			
AKA name(s)			
Address			
Sex	Race	Date of Birth	Social Security Number

I, _____, give consent to the above-named entity to perform periodic criminal history background checks for the duration of my employment.

Please be advised that if any other AKA names are provided for this criminal background check with regards to you, or if any other AKA names are identified by a credit bureau as belonging to you if a credit report is included in this background check, your signature on this form constitutes your consent for these names to also be checked as part of this specific request.

_____ _____

Signature Date

Purpose Code Used: (check only one code

	E - Employment
	N - Working with Elderly
	W - Working with Children
	R - Resident

Additional AKA Names :

Revised October 2023

CRIMINAL BACKGROUND CHECK ADDRESS FORM
(to be used for no other purposes)

List your previous places of residences for the last 10 years in chronological order from current to oldest. Complete a second address form if needed.

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: ____/____/_____(mm/dd/yyyy) Social Security #: ___-___-____

Driver's License Number: _____ State of Issue: _____

PRINT NEATLY AND CLEARLY, MINIMUM 10 YEARS REQUIRED

Current:

Street Address: _____

City: _____ State: _____ Zip: _____

Year From: _____ Year To: _____

Previous:

Street Address: _____

City: _____ State: _____ Zip: _____

Year From: _____ Year To: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Year From: _____ Year To: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Year From: _____ Year To: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Year From: _____ Year To: _____

BACKGROUND CHECK AUTHORIZATION DOCUMENT

By signing below, I authorize the Company to order my background check. I understand that, as allowed by law, the Company may rely on this authorization to order additional background reports without asking me for my authorization again during my residency.

For the purpose of preparing a background check for the Company, and only for that specific purpose, and subject to all laws protecting my information and individual privacy, I also authorize the following to disclose to the CRA the information needed to compile the report: my past or present employers; learning institutions, including colleges and universities; law enforcement and all other federal, state and local agencies; federal, state and local courts; the military; credit bureaus; testing facilities and motor vehicle records agencies. By signing below, I acknowledge the information that can be disclosed to the CRA, if and only as allowed by law, includes information concerning my employment and earnings history, education, credit history, motor vehicle history, criminal history, military service, and professional credentials and licenses.

Last Name _____ First _____ Middle _____

Maiden/Other Names _____ Years Used _____

Social Security Number _____

Driver's License Number _____ State _____

FOR IDENTIFICATION PURPOSES ONLY: Date of Birth ____/____/____
(Month / Day / Year)

_____ ____/____/____
Signature Today's Date (Month/Day/Year)

THE REMAINDER OF THIS DOCUMENT IS INTENTIONALLY LEFT BLANK.

BACKGROUND CHECK DISCLOSURE DOCUMENT

PruittHealth, Inc. (the "Company") may order a "consumer report" (a background report) on you in connection with your admission application, and if you are reviewed, the Company may order additional background reports on you for admission purposes.

The Company may order an "investigative consumer report." Such reports typically include information from personal interviews, most commonly from an applicant's prior employers and references.

The background report may contain information concerning your character, general reputation, personal characteristics, mode of living and criminal history. Information may be obtained from private and public record sources, and fro investigative consumer reports, from personal interviews as noted above.

You have the right to request more information about the nature and scope of an investigative consumer report, if any, by contacting the Company's Partner Services Department at (770) 279-6200 option 3.

THE REMAINDER OF THIS DOCUMENT IS INTENTIONALLY LEFT BLANK.

Para informacion en espanol, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, D.C. 20552.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under 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 reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identity theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.

  In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.
- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.
- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINESS	CONTACT
1.a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates.	a. Consumer Financial Protection Bureau 1700 G Street, N.W. Washington, DC 20552
b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB:	b. Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above:	
a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks	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 owned or controlled by foreign banks, and organizations operating under section 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 Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, S.E. Washington, DC 20590
4. Creditors Subject to the Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 395 E. Street, S.W. Washington, DC 20423
5. Creditors Subject to the Packers and Stockyards Act, 1921	Nearest Packers and Stockyards Administration area supervisor
6. Small Business Investment Companies	Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, SW, 8th Floor Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission 100 F St., N.E. Washington, DC 20549
8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations	Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090
9. Retailers, Finance Companies, and All Other Creditors Not Listed Above	FTC Regional Office for region in which the creditor operates or Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357

MEDICAL PAPERWORK IS TO BE COMPLETED BY A DOCTOR or PHYSICIAN

Fax to 833-671-3102

Attn: Admissions Department

OR

Completed paperwork may be mailed to:

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

If there are any questions, please call Admissions:

301-884-8171

Ext. 5119 or 5118

Physician Documentation Checklist

When coming from Home:

- Health Care Practitioner Form 4506 (included in packet)
  (Due within 30 days for Assisted Living/60 days for Nursing prior to admission)
- Maryland Medical Assistance Form DHMH 3871B (included in packet)
- Dept. of Health and Mental Hygiene PASRR Form DHMH 4345 (included in packet)
- Charlotte Hall Veteran's Home Infection Control Form (included in packet)
- Chest X-Ray (within 60 days for Nursing/30 days for Assisted Living - prior to admission)
- LABS (within 30 days for Assisted Living/60 days for Nursing - prior to admission)
  - CBC & CMP
  - Coumadin, Digoxin, Dilantin (if applicable)
- Immunization record (including COVID vaccine, influenza and pneumonia)
- Advance Directives / Living Will
- Any consult & reports from last 6 months
- Any C & S relating to MRSA, VRB, C-Diff (if applicable)
- Any pending appointments

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

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

Resident Name _____ Date Completed _____

Date of Birth _____

Health Care Practitioner Physical Assessment Form

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

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

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

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

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

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

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

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

PPD Date: _____ Result: _____ mm

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

Resident Name _____ Date Completed _____

Date of Birth _____

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

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

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

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

(d) Describe misuse or abuse: _____

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

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

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

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

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

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

9. Current Nutritional Status. Height _____ inches Weight _____ lbs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Resident Name _____ Date Completed _____

Date of Birth _____

10.* Cognitive/Behavioral Status.

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

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

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

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

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

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

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

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

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

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

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

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

☐ (a) Independently without assistance

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

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

_____ _____

Print Name Date

_____

Signature of Health Care Practitioner

Resident Name _____ Date Completed _____

Date of Birth _____

PRESCRIBER'S MEDICATION AND TREATMENT ORDERS AND OTHER INFORMATION

Allergies (list all): _____

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

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

Prescriber's Signature _____ Date _____

Office Address _____ Phone _____

Form 4508
Revised 8-15-09

Resident Name _____ Date Completed _____

Date of Birth _____

PRESCRIBER'S MEDICATION AND TREATMENT ORDERS AND OTHER INFORMATION

Allergies (list all): _____

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

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

Prescriber's Signature _____ Date _____

Office Address _____ Phone _____

Form 4506
Revised 9-15-09

Maryland Medical Assistance
Medical Eligibility Review Form #3871B

Part A – Service Requested (*indicates required field)

*1. Requested Eligibility Date _____ 2. Admission Date ___

*3. Check Service Type Below:

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

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

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

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

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

*4. Check Type of Request

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

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

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

☐ Advisory (please include payment)

*5. Contact Name _____ *Phone _____ *Fax _____

*E-Mail _____ *Organization/Facility _____

Part B – Demographics (* indicates required field)

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

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

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

*Address _____ *City _____ *State _____ *ZIP _____ *Phone _____

Nursing Facility name (if applicable) _____ Provider # _____

If in acute hospital, name of hospital _____

*3. Next of Kin/ Representative

*Last name _____ *First Name _____ *MI _____

*Address _____ *City _____ *State ____ *ZIP ____ *Phone _____

*4. Attending Physician

*Last name _____ *First Name _____ MI _____

Address _____ *City _____ *State _____ *ZIP _____ *Phone _____

Part C – Diagnoses

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

Applicant Name _____

Part D – Skilled Services:

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

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

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

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

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

Part E – Functional Assessment

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

Applicant Name

5. **Eating:** The process of putting foods and fluids into the digestive system (including tube feeding).	
6. **Toileting:** Ability to care for body functions involving bowel and bladder activity, adjusting clothes, wiping, flushing of waste, use of bedpan or urinal, and management of any special devices (ostomy or catheter). This does not include transferring (See transferring item 16 above).	
CONTINENCE STATUS: Score as Follows 0 = **Independent:** Totally continent, can request assistance in advance of need, accidents only once or twice a week or is able to completely care for ostomy. 1 = **Dependent:** Totally incontinent, accidents three or more times a week, unable to request assistance in advance of need, continence maintained on toileting schedule, indwelling, suprapubic or Texas catheter in use or unable to care for own ostomy.	**Score Each Item (0-1)**
7. **Bladder Continence:** Ability to voluntarily control the release of urine from the bladder	1
8. **Bowel Continence:** Ability to voluntarily control the discharge of stool from the bowel.	1

Review Item	Answer Y	Answer N
Cognitive Status (Please answer Yes or No for EACH item.)		
9. **Orientation to Person:** Client is able to state his/her name.	☐	☐
10. **Medication Management:** Able to administer the correct medication in the correct dosage, at the correct frequency without the assistance or supervision of another person.	☐	☐
11. **Telephone Utilization:** Able to acquire telephone numbers, place calls, and receive calls without the assistance or supervision of another person.	☐	☐
12. **Money Management:** Can manage banking activity, bill paying, writing checks, handling cash transactions, and making change without the assistance or supervision of another person.	☐	☐
13. **Housekeeping:** Can perform the minimum of washing dishes, making bed, dusting, and laundry, straightening up without the assistance or supervision of another person.	☐	☐

14. **Brief Interview for Mental Status (BIMS):** Was the examiner able to administer the complete interview? If yes, indicate the final score. If no, indicate reason. (Examination should be administered in a language in which the client is fluent.)	☐ Yes Score_____ ☐ No Check one of the following: ☐ Hearing Loss ☐ Applicant is rarely/never understood ☐ Language Barrier ☐ Refused ☐ Other (specify)_____

Behavior (Please answer Yes or No for EACH item.)	Answer Y	Answer 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	Answer N
20. **Hearing Impaired even with use of hearing aid:** Difficulty hearing when not in quiet setting, understands conversations only when face to face (lip-reading), can hear only very loud voice or totally deaf.	☐	☐
21. **Vision Impaired even with correction:** Difficulty with focus at close range, field of vision is severely limited (tunnel vision or central vision loss), only sees light, motion, colors or shapes, or is totally blind.	☐	☐
22. **Self Expression:** Unable to express information and make self understood using any means (with the exception of language barrier).	☐	☐

Applicant Name

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

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

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

Part G – Certification

1. Signature of Person Completing Form: _____ Date _____

Printed Name _____ Title _____

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

Signature of Health Care Professional: _____ Date _____

Printed Name _____ Title _____

UCA/DHMH Use Only ☐ Approved ☐ Denied Date of Decision _____

Certification Period _____

Signature _____ Date Signed _____

Print Name Title

CHARLOTTE HALL VETERAN'S HOME/ASSISTED LIVING
Infection control transfer form

Please attach copies of latest culture reports and susceptibilities if available

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

Address of Home Residence	Phone

—OR—

Name/Address of Sending Facility	Sending Unit	Sending Facility Phone

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

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

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

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

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

Antibiotic and dose	Treatment for:	Start date	Stop date

Vaccine History	Date administered (if known)	Year administered (if exact date not known)	Lot and brand (if known)
Influenza			
Pneumococcal 23			
Prevnar 13			
COVID 19			
Other			

Printed Name of person completing form	Signature	Date