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.

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

- ❑ DD214 or other proof of honorable discharge from Active Duty military
- ❑ Copy of VA Service Connected Disability Letter **–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
  - Must prove three months residency prior to admission to CHVH Skilled Nursing Facility

    --OR--
  - 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 – we DO NOT get medications from the VA
- ❑ Completed Admission Information forms (enclosed)
- ❑ Completed Financial Questionnaire (enclosed) (With Applicable Attachments)
  - Copy of 3 months of bank statements (for all bank accounts, full statements)
  - 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 applicable)
- ❑ Copy of Power of Attorney/Living Will/Advance Directives
- ❑ If applicant is a spouse, include copy of marriage certificate & death certificate (if applicable)
- ❑ Signed consent for Criminal Background Check (enclosed)
- ❑ Signed consent for Criminal Background Disclosure (enclosed)

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

All paperwork including the physician's forms must be completed and turned in before a resident can be admitted to CHVH. If you have any questions about this admissions process, please feel free to contact the Admissions Office at **301-884-8171 ext. 5111 or 5119**. Please complete the admissions packet as quickly as possible and either fax to **833-671-3102**, or mail to the CHVH Admissions office.

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Charlotte Hall, MD 20622

ASSISTED LIVING FOR VETERANS

Rate Sheet / Cost of Care - Effective October 1, 2023

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	$59.69	$1815.57	$3596.15

***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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Charlotte Hall, MD 20622

ASSISTED LIVING FOR NON-VETERANS

Rate Sheet / Cost of Care - Effective October 1, 2023

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**

Veterans

Effective October 1, 2023

	Total Cost per Day	Total Cost per Month (30 days)	Amount VA pays towards **Veteran's** care Day/Month	**Veteran's** Cost per Day	**Veteran's** Cost per Month (30 days)
Skilled Nursing: Private Room	$328.00	$9,840.00	$138.29 $4,148.70	$189.71	$5,691.30
Semi-Private Room	$320.00	$9,600.00	$138.29 $4,148.70	$181.71	$5,451.30
Secured (Dementia) Unit: Private Room:	$342.00	$10,260.00	$138.29 $4,148.70	$203.71	$6,111.30
Semi-Private Room	$335.00	$10,050.00	$138.29 $4,148.70	$196.71	$5,901.30

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

Daily (extra) cost tor specific services:

Decubitus (ulcer) care beyond dressing changes (ie: 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 and 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 bed hold the resident will be billed the full daily room rate each day(ie. $328.00, **not** $189.71).

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: 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 <u>Skilled Nursing Care</u>
Non-Veteran Rates
Effective October 1, 2023

	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 <u>not</u> contribute toward the cost of care for spouses.

The above rates for spouses and veterans include room and board, activities, one haircut per month, cable TV, telephone, incontinence supplies and personal care items (deodorant/toothbrushes/combs/etc.).

Daily (extra) cost tor specific services:

Decubitus (ulcer) care beyond dressing changes (ie: 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 and from medical appointments.

Bed Hold: 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

29449 Charlotte Hall Rd
Charlotte Hall, MD 20622
Telephone: 301-884-8171 e.xt. 5111, 5119
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 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 numb 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)

	Veteran	Spouse
Total Amount in Checking Accounts	☐ $________	☐ $________
Total Amount in Savings Accounts	☐ $________	☐ $________
Total Amount in Other Accounts	☐ $________	☐ $________
Total Amount in Stocks/Bonds/CDs	☐ $________	☐ $________
Total Amount in IRA/KEOGH/401K	☐ $________	☐ $________
Total Life Insurance (Face / Cash Value)	☐ $_____/_____	☐ $_____/_____
Total Amount in Trust	☐ $________	☐ $________
Other ____________	☐ $________	☐ $________

Real Estate:

Address ____

____

Do you have a mortgage payment? ☐ Yes ☐ No Amount: $____________

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

Liabilities:

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

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

Type of Deduction ____________ Amount: $____________

Has the applicant sold, gifted, or transferred any cash, real estate, or personal property within the past 60 months?

☐ Yes ☐ No

If yes, please indicate: Asset Type ____________ Value: $____________

Asset Type ____________ Value: $____________

I agree to furnish, upon request, verification of assets and all sources of income. My spouse and/or designated representative also agree to provide financial information as required to apply for Medicaid benefits. I agree to pay for my cost of care from my income and assets according to current rates set by the State of Maryland as long as I am a resident. In case that available funding cannot cover my cost of care, I agree to comply with the necessary steps in applying for Maryland Medicaid assistance and benefits.

____

Signature Relationship to Applicant Date

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, MINIMIUM 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. b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB:	a. Consumer Financial Protection Bureau 1700 G Street, N.W. Washington, DC 20552 b. Federal Trade Commission: Consumer Response Center - 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 b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations d. Federal Credit Unions	 a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450, Houston, TX 77010-9050 b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480 c. FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106 d. National Credit Union Administration Office of Consumer 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 <u>or</u> 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. 5111 or 5119

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 ______________

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 ______________

Maryland Medical Assistance
Medical Eligibility Review Form #3871B

Part A – Service Requested (*indicates required field)

*1. Requested Eligibility Date ____________ 2. Admission Date ____________

*3. Check Service Type Below:

- ☐ Nursing Facility-please attach PASRR documentation if necessary (see Part F)
- ☐ Program of All-Inclusive Care for the Elderly (PACE) ☐ Brain Injury Waiver
- ☐ Chronic Hospital/Special Hospital vent dependent only (all other CH/SH use 3871) – please attach the Supplemental Ventilator Questionnaire
- ☐ Model Waiver vent dependent only (all other MW use 3871) – please attach the Supplemental Ventilator Questionnaire
- ☐ Medical Adult Day Care (new applicants currently placed in a hospital or nursing facility only)

*4. Check Type of Request

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

*5. Contact Name ____________ *Phone ____________ *Fax ____________

*E-Mail ____________ *Organization/Facility ____________

Part B – Demographics (* indicates required field)

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

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

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

*Address ____________ *City ____________ *State_____ *ZIP ____________ *Phone ____________

Nursing Facility name (if applicable) ____________ Provider # ____________

If in acute hospital, name of hospital ____________

*3. Next of Kin/ Representative

*Last name ____________ *First Name ____________ *MI _____

*Address ____________ *City ____________ *State___ *ZIP ____________ *Phone ____________

*4. Attending Physician

*Last name ____________ *First Name ____________ MI _____

Address ____________ *City ____________ *State_____ *ZIP ____________ *Phone ____________

Part C – Diagnoses

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

Applicant Name ______________________

Part D -- Skilled Services:

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

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

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

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

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

Part E -- Functional Assessment

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

Applicant Name

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

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

14. Brief Interview for Mental Status (BIMS): Was the examiner able to administer the complete interview? If yes, indicate the final score. If no, indicate reason. (Examination should be administered in a language in which the client is fluent.)	☐ Yes Score______ ☐ No Check one of the following: ☐ Hearing Loss ☐ Applicant is rarely/neverunderstood ☐ Language Barrier ☐ Refused ☐ Other (specify)

Behavior (Please answer Yes or No for EACH item.)	**Answer**	
	Y	**N**
15. Wanders (several times a day): Moves with no rational purpose or orientation, seemingly oblivious to needs or safety.	☐	☐
16. Hallucinations or Delusions (at least weekly): Seeing or hearing nonexistent objects or people, or a persistent false psychotic belief regarding the self, people, or objects outside of self.	☐	☐
17. Aggressive/abusive behavior (several times a week): Physical and verbal attacks on others including but not limited to threatening others, hitting, shoving , scratching, punching, pushing, biting, pulling hair or destroying property.	☐	☐
18. Disruptive/socially inappropriate behavior (several times a week): Interferes with activities of others or own activities through behaviors including but not limited to making disruptive sounds, self-abusive acts, inappropriate sexual behavior, disrobing in public, smearing/throwing food/feces, hoarding, rummaging through other's belongings, constantly demanding attention, urinating in inappropriate places.	☐	☐
19. Self-injurious behavior (several times a month): Repeated behaviors that cause injury to self, biting, scratching, picking behaviors, putting inappropriate object into any body cavity, (including ear, mouth, or nose), head slapping or banging.	☐	☐

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

Applicant Name

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

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

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

Part G – Certification

1. Signature of Person Completing Form: ______________________ Date ____________

Printed Name ______________________ Title ______________________

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

Signature of Health Care Professional: ______________________ Date ____________

Printed Name ______________________ Title ______________________

UCA/DHMH Use Only ☐ Approved ☐ Denied Date of Decision ____________
Certification Period ______________________
Signature ______________________ Date Signed ____________
Print Name Title

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

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

Last Name________________ First Name________________ MI______ Date of Birth__________

SSN______________ Sex M___ F___ Actual/Requested Nursing Facility Adm Date__________

Current Location of Individual____

Address____

City/State________________________________ ZIP__________

Contact Person________________ Title/Relationship________________ Tel#__________

A. EXEMPTED HOSPITAL DISCHARGE

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

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

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

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

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

Signature________________________ Title________________ Date__________

****

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

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

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

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

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

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

Name ____________________

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

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

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

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

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

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

D. CATEGORICAL ADVANCE GROUP DETERMINATIONS

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

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

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

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

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

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

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

Name ____________________ Title ____________________ Date ____________________

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

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

Local AERS Office ____________________ Contact Date

CHARLOTTE HALL VETERAN'S HOME/ASSISTED LIVING
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