MEDICAL INFORMATION FOR PLACEMENT

The following medical information must be obtained by the admission office before the resident is admitted to Stoddard Baptist Global Care. The medical information below must be less than six months old.

Extra copies must be made of the following documents:

CLINICAL DOCUMENTATION:

A. Current Discharge Summary (Resident must have an updated discharge summary signed by the attending physician. The discharge summary will be reviewed by a registered nurse before the resident is transported to Stoddard Baptist Global Care).
B. Chest X-Ray Report/PPD
C. Chemistry Panel (17)
D. VDRL or RPR
E. CBC with Diff
F. Complete History & Physical Report
   1. Diagnoses
   2. Medications (name, dosage, route and frequency)
   3. Treatments (List type and frequency)
   4. Diet
   5. Physician order to enter nursing home
G. Psyche evaluation if patient on Psychotropic medications
H. Insurance Cards
I. Recent Medical Consultations (if available)

FINANCIAL DOCUMENTATION:

J. Social Security Statement
K. 3 Months bank statements for Long Term Care applicants
L. Income Statements for all applicants

Have physician complete the Prescription Order Form (POF) for Long Term Care Services and Supports and the Pre-Admission Screen/Resident Review for Mental Illness and Mental Retardation. Submit all of the above to the Admission Office.
SEND FAX TO: 202-541-6188
CALL: 202-541-6271/202-541-6149

STODDARD BAPTIST GLOBAL CARE
2601 18TH STREET NE
WASHINGTON, DC 20018
202-541-6271/202-541-6149

LONG TERM CARE APPLICATION

Resident's Name: ______________________________

Current Address: ______________________________

Birth Date: __________ Sex: ________ Age: ________ Marital Status: __________

Birthplace: ______________________ Religion: ______________________

Education/Degree: ______________________ Previous Occupation: ______________________

Spouse's Name: ______________________________

Father's Name: ______________________ Mother's Name: ______________________

Social Security Number: ______________________ Medicare Policy Number: ______________________

Medicaid Policy Number: ______________________ Other Health Insurance: ______________________

Personal Laundry (check one): ________ Facility ________ Family

Funeral Arrangements: ______________________________

Point of Contact: ______________________ Relationship: ______________________

Point of Contact Address: ______________________________

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________

Power of Attorney (check one): ________ Yes ________ No

Does Resident have a Living Will or Advance Directive (check one): _____ Yes _____ No

Second Person to Notify in case of emergency: ______________________________

Relationship: ______________________________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

REFERRAL FOR LONG TERM CARE PLACEMENT

Name: ______________________ DOB: __________ Age: _________
Primary Diagnosis: ____
Secondary Diagnosis: ____
Prognosis: ____
Is patient free of infectious tuberculosis? _______________________
PPD: _________/___________ (Date/Result) CXR: ___________ (Date) _________

Goal of Treatment:

____

____

Medications (List name, dosage, route and frequency):

____

____

____

____

Examiner's Note:

____

____

Ears, Nose, Throat: ____
Eyes: ____
Teeth: ____
Skin/Scars: ____
Heart: ____
Lungs: ____
Abdomen: ____
Extremities: ____
Temperature: ___________ Pulse: _________ Respiration: ________ BP: _________
Weight: __________________ Height: ______________________

Examining Physician: ____
Address: ____
Phone Number: ____

Date: ____

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE
PRESCRIPTION ORDER FORM (POF)
FOR LONG TERM CARE SERVICES AND SUPPORTS

This completed form must be faxed to the Delmarva Foundation at 202-698-2075.

SECTION I: PATIENT INFORMATION

A. **PATIENT D.C. MEDICAID NUMBER (*8 digits*)[t]	B. **NAME (*LAST, FIRST*)	C. **DATE OF BIRTH: ____/____/____
Di. **TELEPHONE NUMBER ____-____-____ Dii. SECONDARY TELEPHONE NUMBER ____-____-____		E. CURRENT ADDRESS
Fi. EMERGENCY CONTACT, NAME ________ Fii. TELEPHONE NUMBER ____-____-____		G. PERMANENT ADDRESS (if different than above)
SPECIAL INSTRUCTIONS/NOTES		

SECTION II: PHYSICIAN/APRN INFORMATION

A. **PROVIDER NAME (*LAST, FIRST*)	B. **DC MEDICAID PROVIDER NUMBER (*8 digits*)
C. **TELEPHONE NUMBER ____-____-____	D. NATIONAL PROVIDER IDENTIFIER NUMBER
E. PROVIDER ADDRESS	F. FAX NUMBER ____-____-____

SECTION III: DETERMINING NEED FOR SERVICES

A. **This patient has the following chronic medical condition(s)/ICD-10 diagnosis(es):	B. **This patient is unable to independently perform the following (*check all that apply*): ☐ Bathing ☐ Dressing ☐ Overall Mobility ☐ Eating ☐ Medication Management ☐ Using Telephone ☐ Housekeeping ☐ Meal Preparation ☐ Toilet Use
C. This patient's condition has changed significantly, as follows:	D. The reason for this referral to services is: (eg. ADHP, PCA, EPD, NH, etc.)

I have personally examined this patient. Based upon my professional opinion, long term care services and supports are medically necessary.

**Signature of Ordering Physician/APRN: ______________________ Date: ____/____/____

****These fields are required for the Department of Health Care Finance to process this form.**

[t] If the individual is new to DC Medicaid and does not yet have a Medicaid number, please note "N/A."

Government of the District of Columbia

Level I Pre-Admission Screen/Resident Review for SMI, ID, or Related Conditions

BENEFICIARY INFORMATION

Last Name:	First:	M.I.:	Gender: ❑ M ❑ F	Medicaid ID:	Social Security Number:
Date of Birth:	Assessment Type: ❑ Preadmission ❑ Significant Physical Change ❑ Significant Mental Change ❑ Suspicion of SMI or ID				

LEGAL STATUS

❑ Commitment ❑ Legal Guardian-Conservator ❑ Legal Representative/POA		Location: ❑ Home ❑ Hospital ❑ Nursing Facility ❑ Other	
Applicant agrees to legal guardian and/or family participation? ❑ Yes ❑ No	Interpreter Required? ❑ Yes ❑ No ❑ Spanish ❑ Amharic ❑ Chinese ❑ Korean ❑ Other	Interpreter Name:	
Legal Guardian/Family Member:	Street Address:		
Telephone:	City:	ST:	ZIP Code:
Power of Attorney:	Street Address:		
Telephone:	City:	ST:	Zip Code:

SECTION A: EXEMPTING CRITERIA■

Beneficiary admitted to nursing facility directly from hospital after receiving acute inpatient care?	❑ Yes ❑ No
Beneficiary requires nursing facility services for the condition he/she received acute inpatient care?	❑ Yes ❑ No
Beneficiary is likely to require less than 30 days nursing facility services?	❑ Yes ❑ No

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud

Print Physician Name:	SIGN HERE Physician Signature	Date:
Title:		

■*Further completion of this form IS NOT NECESSARY if the beneficiary meets all of the exemptions listed in Section A. If exempting criteria is not met, proceed to Section B. Beneficiary is being admitted under the 30-day hospital discharge exemption. If the beneficiary's length of stay exceeds 30 days , the Level II evaluation must be completed no later than the 40th day of admission, on or before the date:*

SECTION B: EVALUATION CRITERIA FOR SERIOUS MENTAL ILLNESS (SMI)♦

1. Does the beneficiary have a known diagnosis of a major mental disorder? If yes, list diagnosis and DSM Code_______________
   ❑ Yes ❑ No ❑ Unknown
2. Does the beneficiary have a diagnosis or evidence of a major mental illness limited to the following disorders: schizophrenia, schizoaffective, mood (bipolar and major depressive type), paranoid or delusional, panic or other severe anxiety disorder; Somatoform or paranoid disorder; personality disorder; atypical psychosis or other psychotic disorder (not otherwise specified); or another mental disorder that may lead to chronic disability? ❑ Yes ❑ No ❑ Unknown. Specify diagnosis based on DSM-5 or current ICD criteria. →
3. Does the beneficiary have a history of any substance-related disorder diagnosis? ❑ Yes ❑ No ❑ Unknown
   Specify diagnosis →

SMI Determination Based Upon: ❑ Documented History ❑ Behavioral Observation ❑ Medications ❑ Individual/Legal Guardian/Family Report

♦*The beneficiary is considered to have a positive serious mental illness (SMI) if (1) questions 1 or 2 in Section B are answered "Yes".* With a positive screen for SMI the beneficiary must be referred to the District of Columbia Department of Behavioral Health for a Level II evaluation.

SECTION C: SYMPTOMS

1. Does the beneficiary have any current or historical significant impairment in functioning related to a suspected or known diagnosis of mental illness? ❑ Yes (❑ Current ❑ Past: When) ❑ No

   Check box preceding description if any subcategories below are applicable:

   ❑ ***Interpersonal functioning***. The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, unstable employment, fear of strangers, avoidance of interpersonal relationships and social isolation.

   ❑ ***Concentration, persistence, and pace***. The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these task.

   ❑ ***Adaptation to change***. The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family or social interactions, agitation, exacerbated signs and symptoms associated with the illness or withdrawal from situations, , self-injurious, self-mutilation, suicidal, physical violence or threats, appetite disturbance, delusions, hallucinations, serious loss of interest, tearfulness, irritability or requires intervention by mental health or judicial system.

2. Within the last two years has the beneficiary (check either and/or both if applicable).

   ❑ experienced one psychiatric treatment episode that was more intensive than routine follow-up care (e.g., had inpatient psychiatric care: was referred to a mental health crisis/screening center; has attended partial care/hospitalization; or has received Program of Assertive Community Treatment (PACT) or integrated Case Management Services); and/or:

   ❑ due to mental illness, experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning while living in the community, or intervention by housing or law enforcement officials?

   Narrative information including dates: ____

   ____

   ____

   ____

   The beneficiary's behaviors/symptoms are stable and not presenting a risk to self or others? ❑ Yes ❑ No

If questions 1 and 2 In Section B are checked "No", but question 1 in Section C is "Yes" and a box is checked in question 2, the Level 1 form must be sent to the District of Columbia Department of Behavioral Health to determine if a Level II evaluation is needed.

SECTION D: INTELLECTUAL DISABILITY** (ID) RELATED CONDITIONS (RC)

1. Does the beneficiary have a diagnosis of ID or related condition (mild, moderate, severe, or profound)? ❑ Yes ❑ No
   List diagnosis (es) or evidence: ____
2. Beneficiary diagnosed with ID prior to age 18? ❑ Yes ❑ No
3. Presenting evidence (cognitive or behavior functions) indicating beneficiary has ID or related condition that has not been diagnosed? ❑ Yes ❑ No
4. Is the beneficiary registered for services with an agency which serves individuals with ID or related conditions? ❑ Yes ❑ No
   a. If Yes, describe the services the beneficiary is receiving: ______________________________
   b. Name of service provider and contact information: ______________________________
   c. If No, is the beneficiary interested in receiving services? ❑ Yes ❑ No
5. Has the beneficiary ever been a resident of a state facility including a state hospital, a state school, or other state facility? ❑ Yes ❑ No ❑ Unknown
   If Yes, indicate the name of the facility and the date(s): ______________________________
6. Does the beneficiary have a current diagnosis, history or evidence of a related condition that may include a severe, chronic disability that is attributable to a condition other than mental illness that results in impairment of general intellectual functioning or adaptive behavior? ❑ Yes ❑ No
   Condition: ❑ autism ❑ seizure disorder ❑ cerebral palsy❑ spina bifida ❑ fetal alcohol syndrome ❑ muscular dystrophy ❑ deaf ❑ blindness ❑ closed head injury ❑ other: ____________________
   Impairment: ❑ mobility ❑ self-care ❑ self-direction ❑ learning ❑ understanding/use of language ❑ capacity for independent living.
   Was the date of onset prior to age 22? ❑ Yes ❑ No If yes, explain: ______________________________

Beneficiary is considered to have a positive screen for ID or related condition if one or more of the above questions in the above section are answered Yes. As a result, the beneficiary must be referred to the District of Columbia Department of Disability Services for Level II evaluation. If all of the questions are answered no, the beneficiary has a negative screen for ID or related condition.

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud.

Print Name:		Date:
Title:		

SECTION E: DEMENTIA*

- ☐ The beneficiary has a diagnosis of dementia (including Alzheimer's disease or related disorder) based on criteria in the DSM-5 or current version of the ICD. (If checked specify DSM-5 or ICD codes:______
- ☐ The following criteria were used to establish the basis for a dementia diagnosis: ☐ Mental Status Exam ☐ Neurological ☐ History Symptoms ☐ Other Diagnostics (specify):______
- ☐ The physician documented dementia as the primary diagnosis **OR** that dementia is more progressed than a co-occurring mental illness diagnosis. Explain documentation and verification: ______

**A primary diagnosis of dementia, including Alzheimer's disease or related disorder IS NOT considered a major mental illness. Dementia applies to beneficiaries with a confirmed diagnosis of dementia that has been documented as a primary diagnosis more progressed than a co-occurring mental illness. If there is no confirmed diagnosis of dementia, check N/A☐. Only if the boxes in front of ALL THREE statements above are checked, is the beneficiary designated as having primary mental illness dementia exclusion. If none of the statements above are checked, then the beneficiary <u>is not</u> designated as having primary mental illness dementia exclusion.*

SECTION F: ADVANCE GROUP DETERMINATION°

1. Is the beneficiary 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 Section A)? ☐ Yes ☐ No
2. Does the beneficiary have a terminal illness (life expectancy of less than six months) as certified by a physician? ☐ Yes ☐ No
3 Does the beneficiary 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 beneficiary could not be expected to benefit from specialized services? ☐ Yes ☐ No
3. Is this beneficiary being provisionally admitted pending further assessment due to an emergency situation requiring protective services? The stay will not exceed 7 days. ☐ Yes ☐ No
4. Provisional Delirium: The presence of delirium in people with known or suspected MI and/or ID precludes the ability to make an accurate diagnosis. The person's Level I Screen and LOC will be updated no greater than 7 calendar days following admission to the NF (a physician signed statement certifying the delirium state must accompany this screen).
5. Is the beneficiary being admitted for a stay not to exceed 14 days to provide respite? ☐ Yes ☐ No

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud.

Print Name:		Date:

°If the beneficiary is considered to have SMI, ID or RC, complete this section. Otherwise, skip this section and complete Section G. If any questions in this section are checked yes, there is no need for a Level II referral. ↑

SECTION G: RESULTS OF SMI/ID (CHECK ALL THAT APPLY)

- ❑ Beneficiary has negative screen for serious mental illness and no further action is necessary.
- ❑ Beneficiary has negative screen for ID or related conditions and no further action is necessary.
- ❑ Beneficiary has a positive screen for serious mental illness and a PASRR referral Level II evaluation, psycho-social assessment, history and physical and Level of Care (LOC) has been forwarded to DBH for review. Date:
- ❑ Beneficiary has a possible positive screen and the Level I form has been forwarded to DBH for review. Date:
- ❑ Beneficiary has a positive screen for intellectual disability and has been referred to DDS for a Level II evaluation. Date:
- ❑ Notice of referral for Level II, if applicable, distributed to Beneficiary/Representative ❑ Yes ❑ No Date :

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud

Print Name:		Date:

The District of Columbia Department on Disability Services is the contact agency for a **Level II** evaluation:

Shirley Quarles-Owens, RN MSN
Supervisory Community Health Nurse
DC Department on Disability Services
Developmental Disabilities Administration
Health and Wellness Unit
Independence Square Building
250 E Street, SW
Washington, DC 20024
202-730-1708 (office)
202-730-1841 (fax)
202-615-8268 (mobile)
shirley.quarles-owens@dc.gov

The District of Columbia Department of Behavioral Health is the contact agency for **Level II** evaluations:

Chaka A. Curtis, RN
Psychiatric Nurse / PASRR Coordinator
Division of Integrated Care
DC Department of Behavioral Health
64 New York Ave NE - Room 310
Washington, DC 20002
202-673-6450 (office)
202-671-7626 (fax)
202-439-1143 (mobile)
chaka.curtis@dc.gov

For individuals who wish to be enrolled in a Medicaid-certified nursing facility, please fax this form along with the Prescription Order Form to the Delmarva Foundation. The fax # is (202) 698-2075.