St. Joseph's Nursing Home
A Ministry of the Sisters Servants of Mary Immaculate

1222 Tugwell Drive ~ Catonsville, MD 21228-5847 ~ Phone: 410-747-0026
Fax: 410-747-0386 ~ TDD: 711 or 1-800-735-2258
Email: stjosephs@stjosephs.net

Dear Family Member / Friend / Prospective Resident

In order to facilitate each resident's admission to St. Joseph's Nursing Home and to comply with federal and state regulations, it is requested that the following paper work be completed and returned prior to admission:

- Application for Admission
- DHMH Pre-Admission Screening & Resident Review form (2 pages) - completed by primary doctor
- Medical History & Admission Examination form (2 pages) - completed by primary doctor
- Social security and picture identification card (front and back)
- All insurance cards (front and back)
- Last 3 bank statements from all accounts with perspective resident's name
- Last 5 years bank statements if applying for Medicaid
- Any other medical or pertinent information so we may understand the level of care that will be required

Please mail the completed forms to:

St. Joseph's Nursing Home
ATTN: Sister Zofia Nieweglowska, RN, DON
Director of Admission
1222 Tugwell Drive
Catonsville, MD 21228

Upon return of these forms to us, the applicant will be put on our waiting list.

Each application for admission will be considered on an individual basis, taking into consideration the behavior and physical condition, her/his comprehensive treatment needs and the ability of St. Joseph's Nursing Home to provide for those needs without jeopardizing the safety of the prospective resident or that of the current residents.

Please feel free to call the Admission Department, Sr. Zofia, with any further questions you may have concerning the admission process at (410) 747-0026.

If you are just beginning your search for long term care, the following is a link to the Maryland Consumer Guide to Long Term Care which you may find helpful: http://mhcc.maryland.gov/consumerinfo/longtermcare/default.aspx

Application for Admission

Date: _____

I. General information concerning applicant:

A. Personal Information:

Name: _____ Home Telephone: (____) _____

Birth date: _____ Age: _____ Previous Occupation: _____

Education _____ Place of Birth: _____U.S. Citizen: □ Yes □ No

Home Address: _____

City: _____ County: _____ State/Zip: _____

Marital Status: _____ Spouse's Name: _____

Religion: _____ Place of Worship: _____

Father's Name: _____Mother's Maiden Name: _____

Referred to St. Joseph's Nursing Home by: _____

Applicant today is at: □ home □ hospital □ nursing home □ other (specify) _____

Name of facility: _____ Phone: (___) _____

Full address and county of facility: _____

Any prior admissions to a Nursing Home? □ Yes □ No

If yes, Name, Address and Dates of Admission: _____

Is applicant aware of the placement decision? □ Yes □ No

Personal physician's name: _____

Address: _____

Telephone: (____) _____ Fax: (____) _____

B. Individual responsible for paying bill:

(Please note: this is usually not the applicant but rather family, power of attorney, or other who has access to the funds of the applicant.)

Name: _____ Relationship to applicant: _____

Home Address: _____

City: _____ State/Zip: _____

Telephone: (Home)-(____) _____ (Business)-(____) _____

C. Additional relatives/contacts:

Name: _____ Relationship to applicant: _____

Home Address: _____

City: _____ State/Zip: _____

Telephone :(Home) (____) _____ (Business) (____) _____

Name: _____ Relationship to applicant: _____

Home Address: _____

City: _____ State/Zip: _____

Telephone: (Home) (____) _____ (Business) (____) _____

D. Power of Attorney/Advance Directives:

Has anyone been appointed Power of Attorney or Guardian? ☐ Yes ☐ No

If so, who? _____

To what extent? _____

Has an Advanced Directive been prepared? ☐ Yes ☐ No

Has a Living Will been prepared? ☐ Yes ☐ No

Please provide copies of documents.

II. Financial information concerning applicant:

Social Security #:_____ Medicare#: _____ ☐ Part A ☐ Part B

Private Insurance (B/C B/S, AARP, etc.):_____ Policy #:_____

Other Insurance: _____ Policy #:_____

A. Monthly income of applicant:

Source *Monthly Amount*

Social Security $_____ Military or Railroad Retirement $_____

Civil Service Retirement $_____ other (specify) _____

Pension $_____ _____ $_____

B. Cash assets in banks, credit unions, savings and financial institutions:

Institution Name: _____ Location: _____

Type of account: _____ Balance in account: $_____

Names listed on account: _____

Institution Name: _____ Location: _____

Type of account: _____ Balance in account: $_____

Names listed on account: _____

C. Real Estate Assets:

Does the applicant own their home? □ Yes □ No If yes, approximate value: $_____

Is the property jointly owned? □ Yes □ No

If yes, name(s) of co-owners: _____

Does the applicant own any additional real property? □ Yes □ No

If yes, approximate value: $_____

D. Life insurance:

Does the applicant have life insurance policies with cash value? □ Yes □ No

If yes, company name: _____

Approximate cash value: $_____ Annuities: $_____

E. Other assets/investments (stocks, bonds, IRA's):

Company name: _____ Approximate value: $_____

Company name: _____ Approximate value: $_____

F. Funeral arrangements:

Has pre-paid funeral arrangements been made for applicant? □ Yes □ No

Funeral home preference (name): _____

G. Medicaid:

Has application for Medical Assistance (Medicaid) been completed on behalf of the applicant?

□ Yes □ No

Medicaid #_____

If the Applicant has applied, what was the date: _____ County: _____

Dept. of Social Services Representative, if known: _____

Representative's Telephone: (____) _____

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 _____

MEDICAL HISTORY AND ADMISSION EXAMINATION

(To be sent by attending physician or done after arrival but before final acceptance of patient)

Family Name	First Name	Attending Physician	Room No.	Admission No.

ADMISSION DIAGNOSIS (state fully): _____

_____

PAST HISTORY:

Typhoid fever no ☐ yes ☐ Year _____ Tuberculosis no ☐ yes ☐ Dates _____

Diabetes no ☐ yes ☐ Mental illness no ☐ yes ☐ Mental hospitalization no ☐ yes ☐ Dates _____

SUMMARY OF PRESENT ILLNESS: _____

_____

_____

_____

Explain if patient is an epileptic _____

Explain if patient has a contagious disease in communicable stage _____

_____

Explain if patient has heart trouble _____

Describe if senile or mentally disturbed _____

_____

If restraints are necessary state type _____

List medications presently being prescribed for applicant _____

_____

_____

List any drug sensitivities _____

State type and degree of disability, if any _____

_____

PROGNOSIS AND GOALS FOR REHABILITATION: _____

_____

REPORTS OF SPECIAL EXAMINATIONS (chest and other x-ray; laboratory such as complete blood count, urinalysis, V.D.R.L. and other serology, sputum, stool, etc.): _____

_____

MEDICAL HISTORY AND ADMISSION EXAMINATION

ADDITIONAL PERTINENT INFORMATION AND MEDICAL COMMENTS:

ABNORMAL PHYSICAL FINDINGS:

RECOMMENDATIONS (for routine medical care, medications, dressings, nursing attention, diet, physical therapy, speech therapy, psychotherapy, etc.):

Hospital or clinic where examination was made

Signature M.D. Date of examination
(EXAMINING PHYSICIAN)

Address Phone No.

(BACK)