# Behavioral Health Assisted Living Application Process

## Program Purpose:

The Behavioral Health Assisted Living initiative is designed to provide wrap-around behavioral health services and care coordination to adults with behavioral health conditions who require Assisted Living services. These are individuals who require assistance with daily activities and/or instrumental activities of daily living. These individuals may also have medical conditions that require nursing assessment and delegation and have a mental illness disorder for which they also need access to services and support.

## Program Eligibility:

1. An adult or older adult diagnosed with a serious mental illness who needs assistance with activities of daily living (ADL), instrumental activities of daily living (IADL), and/or other somatic problems requiring nursing assessment and/or delegation.
2. The individual's income shall be less than three times the amount of SSI/SSDI and have assets less than $2,000.
3. The individual is at risk of admission to a state psychiatric hospital or nursing facility, or is being discharged from a state psychiatric hospital.
4. The individual should have Medicaid (MA) or Medicare (MC) to help with applying for the long-term waiver.

## Required Documents for pre-approval:

***(send this with the application)***

- A completed Behavioral Health Assisted Living Application
- HIPAA / ROI form *(attached)*
- Psychiatric evaluation
- A list of current medications
- Proof of income- monthly SSI/SSDI amount award letter, pension, VA disability payments, etc.
- Conditional Release/ Probation Order/ Pretrial Release (if applicable)

## Required Documents after approval:

- Insurance information needed and photocopy of insurance card (if available)
- Guardianship, Power of Attorney, and Representative Payee documents (if applicable)
- Health Care Practitioner Physical Assessment
- MOLST form
- Physician-signed order of current medications, to include the prescriber's instructions
- Signed Assisted Living Resident Agreement
- Benefit Action Plan (State Hospital only)
- *Other documents may be required based which ALF the applicant may reside in*

**Email the complete Behavioral Health Assisted Living Application and pre-approval documents to the jurisdiction of choice, outlined below.**

*Currently, the program capacity is limited and only available in four jurisdictions.*

| | |
|---|---|
| Anne Arundel County Mental Health Agency, Inc | HHughes@aamentalhealth.org |
| Behavioral Health System Baltimore (BHSB) | BHALF@bhsbaltimore.org |
| Mid Shore Behavioral Health, Inc | sjoyce@midshorebehavioralhealth.org |
| St. Mary's County Health Department Behavioral Health Division | Rachele.Huot@maryland.gov |

# Behavioral Health Assisted Living Application

This application can be utilized for admission to Behavioral Health Assisted Living Pilot Programs funded through the Behavioral Health Administration.

Please fill out this document in its entirety with explanations provided for each Activity of Daily Living (ADL), Instrumental Activity of Daily Living (IADL), and behavior.

**Application Date:**

**Person completing the form:**

*(Name and Title)*

**Primary contact information:**

| | |
|---|---|
| **Name** ***(First and Last)*** | |
| **Phone Number** | |
| **Email** | |

| | |
|---|---|
| **Applicant's name** ***(First and Last)*** | |
| **Applicant's date of birth** | |

**Applicants current living setting:**

- ☐ CT Perkins
- ☐ Springfield Hospital
- ☐ TB Finan
- ☐ Homeless
- ☐ Segue
- ☐ Spring Grove Hospital
- ☐ Eastern Shore Hospital Center
- ☐ RRP
- ☐ Home (include address)
- ☐ Other:

**Date of admission to facility (if applicable):**

**Applicant's psychiatric diagnosis:**

*(please include the current psychiatric diagnosis with this form)*

**Applicant's medical diagnosis:**

**Applicant's sex and gender**:

- ☐ Woman or female
- ☐ Man or male
- ☐ Gender non-binary (gender neutral/ not identified as man or women)
- ☐ Transgender woman
- ☐ Transgender man
- ☐ Other:

**Applicant's Race:**

- ☐ White
- ☐ Black or African American
- ☐ Indian or Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander

**Applicant's ethnicity:**

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Not specific

- ☐ **Smoker**
- ☐ **Non-Smoker**

**Applicant's preferred language:**

**Does the applicant require interpreter services?** ☐ Yes ☐ No

**Describe interpreter services needed:**

## *This page for State hospital applicant only*

**Barriers to discharge to independent housing, supported housing or Residential Rehabilitation Program (RRP):**

- ☐ Neurocognitive disorder
- ☐ Requires assistance with activities of daily living
- ☐ Requires assistance with instrumental activities of daily living, beyond the capability of RRP
- ☐ Medical conditions require nursing assessment, delegation, and oversight
- ☐ Swallowing difficulties requiring special food preparation (eg. soft or pureed diet, thickened liquids)
- ☐ Ineligible or denied for HUD housing/affordable housing
- ☐ Lack of family or social support system
- ☐ Undocumented
- ☐ Ineligible for HUD housing
- ☐ Applicant does not have capacity to consent to treatment
- ☐ Applicant unable to self-administer medications
- ☐ Other: _____

## *This page for State hospital applicant only*

**Forensic status upon discharge *(State hospital only)*:**

- ☐ Conditional release
- ☐ Probation
- ☐ Pretrial release
- ☐ None
- ☐ Other:

**Benefits coordinator email:**

*Benefits referral must be made prior to requesting funding for assisted living. Please provide the name of the State Hospital Benefits Coordinator to whom the Applicant has been referred.*

## Entitlements and Legal Documents *(this page required)*

**Monthly estimated income upon discharge:**

**Total estimated financial assets (bank balance, life insurance, retirement account, property and other assets):**

**Does the applicant have a special needs trust or ABLE account?**

☐ Yes ☐ No ☐ Other:

**Does the applicant have any personal bills, such as a cell phone bill or prescription co-pays? (if yes, please write the monthly amount):**

**Documents:**

| | Copy Available | In Process of Obtaining | Available After Discharge | Not Applicable |
|---|---|---|---|---|
| **Birth Certificate** | ☐ | ☐ | ☐ | ☐ |
| **Social Security Card** | ☐ | ☐ | ☐ | ☐ |
| **Permanent Resident Card (Green Card)** | ☐ | ☐ | ☐ | ☐ |
| **State Identification Card** | ☐ | ☐ | ☐ | ☐ |
| **Citizenship Paperwork, if applicable** | ☐ | ☐ | ☐ | ☐ |

**Legal decision maker for applicant:**

- ☐ Applicant (self)
- ☐ POA
- ☐ Surrogate decision maker
- ☐ Representative payee for social security
- ☐ Guardian of property
- ☐ Guardian of person
- ☐ Other:

**Name and contact information for any legal decision maker listed above:**

**Does the applicant have a representative payee? If yes, include name, phone number and email address:**

## Activities of Daily Living (ADLs)

When answering these questions, consider the impact of involuntary movements (e.g. tardive dyskinesia), cognition, medication side effects, and symptoms of mental illness on an individual's ability to perform ADLs. Please provide an explanation if the applicant is Not independent.

**Feeding:**

Setting up, arranging, and bringing food or fluid from the vessel to the mouth

- ☐ Independent (no assistance needed)
- ☐ Requires supervisions, set-up, or minimum cueing to complete task
- ☐ Requires frequent and continuous cueing and coaching to complete task
- ☐ Needs hands on assistance to complete task ***(explanation required)***
- ☐ Other:

**Explain the level of assistance needed with feeding:**

**Eating and swallowing:**

Keeping and manipulating food or fluid in the mouth, swallowing it i.e., moving it from the mouth to the stomach

- ☐ Independent (no assistance needed)
- ☐ Requires supervisions, set-up, or minimum cueing to complete task
- ☐ Requires frequent and continuous cueing and coaching to complete task
- ☐ Needs hands on assistance to complete task ***(explanation required)***
- ☐ Other:

**Explain the level of assistance needed with eating and/or swallowing:**

**Toileting and toilet hygiene:**

Obtaining and using toileting supplies, managing clothing, maintaining toileting position, transferring to and from toileting position, cleaning body, caring for menstrual and continence needs, maintaining intentional control of bowel movements and urination

- ☐ Independent (no assistance needed)
- ☐ Requires supervisions, set-up, or minimum cueing to complete task
- ☐ Requires frequent and continuous cueing and coaching to complete task
- ☐ Needs hands on assistance to complete task ***(explanation required)***
- ☐ Other:

**Explain the level of assistance needed with toileting and toilet hygiene:**

**Bathing:**

Obtaining and using supplies; soaping, rinsing, and drying body parts; maintaining bathing position; transferring to and from bathing positions

- ☐ Independent (no assistance needed)
- ☐ Requires supervisions, set-up, or minimum cueing to complete task
- ☐ Requires frequent and continuous cueing and coaching to complete task
- ☐ Needs hands on assistance to complete task ***(explanation required)***
- ☐ Other:

**Explain the level of assistance needed with bathing:**

**Grooming:**

Feminine hygiene, teeth, make-up, shaving, hair

- ☐ Independent (no assistance needed)
- ☐ Requires supervisions, set-up, or minimum cueing to complete task
- ☐ Requires frequent and continuous cueing and coaching to complete task
- ☐ Needs hands on assistance to complete task ***(explanation required)***
- ☐ Other:

**Explain the level of assistance needed with grooming:**

**Getting Dressed/Changing Clothes:**

- ☐ Independent (no assistance needed)
- ☐ Requires supervisions, set-up, or minimum cueing to complete task
- ☐ Requires frequent and continuous cueing and coaching to complete task
- ☐ Needs hands on assistance to complete task ***(explanation required)***
- ☐ Other:

**Explain the level of assistance needed with getting dressed/changing clothes:**

**Mobility:**

Consider assistance the individual may need walking or using a wheelchair, transferring in and out of bed or a chair, and using stairs.

**Please describe any challenges with using stairs:**

**Functional mobility:**

Moves from place to place

- ☐ Independent (no assistance needed)
- ☐ Requires supervisions, set-up, or minimum cueing to complete task
- ☐ Requires frequent and continuous cueing and coaching to complete task
- ☐ Needs hands on assistance to complete task ***(explanation required)***
- ☐ Other:

**Explain the level of assistance needed with mobility, and please indicate whether accessible housing is required:**

**Bed mobility and transfers:**

Please describe the level of assistance needed to move to and from a lying position, to turn side to side in bed, position their body while in bed, and transfer from bed to chair, chair to toilet, etc.

- ☐ Independent (no assistance needed)
- ☐ Requires supervisions, set-up, or minimum cueing to complete task
- ☐ Requires frequent and continuous cueing and coaching to complete task
- ☐ Needs hands on assistance to complete task ***(explanation required)***
- ☐ Other:

**Please describe any bed mobility or transfer challenges:**

## Instrumental Activities of Daily Living (IADLs)

When answering these questions, consider the impact of involuntary movements (e.g. tardive dyskinesia), cognition, medication side effects, and symptoms of mental illness on an individual's ability to perform IADLs. Please provide an explanation if the applicant is Not independent.

**Meal preparation:**

Planning, preparing, serving meals, and cleaning up food, utensils, pots, and plates after meals

- ☐ Independent (no assistance needed)
- ☐ Requires supervisions, set-up, or minimum cueing to complete task
- ☐ Requires frequent and continuous cueing and coaching to complete task
- ☐ Needs hands on assistance to complete task
- ☐ Other:

**Explain the level of assistance needed with preparing meals:**

**Nutrition management:**

Implementing and adhering to nutrition and hydration recommendations from the medical team, preparing meals to support health goals, participating in health-promoting diet routines

- ☐ Independent (no assistance needed)
- ☐ Requires supervisions, set-up, or minimum cueing to complete task
- ☐ Require frequent and continuous cueing and coaching to complete task
- ☐ Needs hands on assistance to complete task
- ☐ Other:

**Explain the level of assistance needed with nutrition management:**

**Grocery Shopping:**

Preparing shopping lists; selecting, purchasing, and transporting items; selecting method of payment and completing payment transactions; managing internet shopping and related use of electronic devices such as computers, cell phones, and tablets

- ☐ Independent (no assistance needed)
- ☐ Requires supervisions, set-up, or minimum cueing to complete task
- ☐ Requires frequent and continuous cueing and coaching to complete task
- ☐ Needs hands on assistance to complete task
- ☐ Other:

**Explain the level of assistance needed with grocery shopping:**

**Home Management:**

Taking care of possessions and home environment, e.g. obtaining and maintaining personal and household possessions/environments by completing laundry, cleaning home, washing dishes, taking out the trash, etc.

- ☐ Independent (no assistance needed)
- ☐ Requires supervisions, set-up, or minimum cueing to complete task
- ☐ Requires frequent and continuous cueing and coaching to complete task
- ☐ Needs hands on assistance to complete task
- ☐ Other:

**Explain the level of assistance needed with light chores:**

**Safety and Emergency Maintenance:**

Evaluating situations in advance for potential safety risks; recognizing sudden, unexpected hazardous situations and initiating emergency action, identifying emergency contact numbers

- ☐ Independent (no assistance needed)
- ☐ Requires supervisions, set-up, or minimum cueing to complete task
- ☐ Requires frequent and continuous cueing and coaching to complete task
- ☐ Needs hands on assistance to complete task
- ☐ **Other:**

**Explain the level of assistance needed with Safety and Emergency Maintenance:**

**Managing Finances:**

- ☐ Independent (no assistance needed)
- ☐ Requires supervisions, set-up, or minimum cueing to complete task
- ☐ Requires frequent and continuous cueing and coaching to complete task
- ☐ Needs hands on assistance to complete task ***(explanation required)***
- ☐ Other:

**Explain the level of assistance needed with managing finances:**

**Driving and community mobility:**

Planning and moving around in the community using public or private transportation, such as driving, walking, bicycling, or accessing and riding in buses, taxi cabs, ride shares, or other transportation systems

- ☐ Independent (no assistance needed)
- ☐ Requires supervisions, set-up, or minimum cueing to complete task
- ☐ Requires frequent and continuous cueing and coaching to complete task
- ☐ Needs hands on assistance to complete task
- ☐ Other:

**Explain the level of assistance needed with transportation:**

**Communication management:**

Sending, receiving, and interpreting information using systems and equipment such as writing tools, telephones (including smartphones), keyboards, audiovisual recorders, computers or tablets, communication boards, call lights, emergency systems, Braille writers, telecommunication devices for people who are deaf, augmentative communication systems, and personal digital assistants

- ☐ Independent (no assistance needed)
- ☐ Requires supervisions, set-up, or minimum cueing to complete task
- ☐ Requires frequent and continuous cueing and coaching to complete task
- ☐ Needs hands on assistance to complete task ***(explanation required)***
- ☐ Other:

**Explain the level of assistance needed with communication devices:**

**Health Management:**

Activities related to developing, managing, and maintaining health and wellness routines, including scheduling and attending medical appointments, managing prescription changes and refills, and taking medications

- ☐ Independent (no assistance needed)
- ☐ Requires supervisions, set-up, or minimum cueing to complete task
- ☐ Requires frequent and continuous cueing and coaching to complete task
- ☐ Needs hands on assistance to complete task ***(explanation required)***
- ☐ Other:

**Explain the level of assistance needed with health management:**

**Medication Management:**

Activities related to obtaining prescribed medications, taking medications as prescribed, and reporting response to medications to prescriber

- ☐ Independent (no assistance needed)
- ☐ Requires supervisions, set-up, or minimum cueing to complete task
- ☐ Requires frequent and continuous cueing and coaching to complete task
- ☐ Needs hands on assistance to complete task ***(explanation required)***
- ☐ Other:

**Explain the level of assistance needed with medication management:**

***Please include a current list of medications the applicant takes when submitting this form.***

**Symptom and condition management:**

Managing physical and mental health needs, including using coping strategies for illness, trauma history, or societal stigma; managing pain; managing chronic disease; recognizing symptom changes and fluctuations; developing and using strategies for managing and regulating emotions; using community and social supports; navigating and accessing the healthcare system

- ☐ Independent (no assistance needed)
- ☐ Requires supervisions, set-up, or minimum cueing to complete task
- ☐ Require frequent and continuous cueing and coaching to complete task
- ☐ Needs hands on assistance to complete task ***(explanation required)***
- ☐ Other:

**Explain the level of assistance needed with symptom and condition management:**

**Psychiatric Symptoms and Behaviors:**

| | Never | Rarely | Occasionally | Frequently | Usually |
|---|---|---|---|---|---|
| **Auditory Hallucinations** | | | | | |
| **Visual Hallucinations** | | | | | |
| **Delusional Thoughts** | | | | | |
| **Paranoia** | | | | | |
| **Depression** | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **Mood Swings** | | | | | |
| **Isolation/Withdrawal** | | | | | |
| **Confusion/Memory** | | | | | |
| **Problems** | | | | | |
| **Wandering** | | | | | |
| **Anger Outbursts/Rages** | | | | | |
| **Impulsivity** | | | | | |
| **Obsessive Behaviors and/or thoughts** | | | | | |
| **Sleep Disorder** | | | | | |
| **Anxiety/ Panic Attacks** | | | | | |
| **Self-Injurious Behaviors** | | | | | |
| **Suicidal Ideations/Attempts** | | | | | |
| **Homicidal Ideations/ Attempts** | | | | | |
| **Medication Non-Adherence** | | | | | |
| **Apathy** | | | | | |
| **Difficulty organizing tasks** | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **Forgetfulness/ Inattentiveness** | | | | | |
| **Struggles with basic life skills** | | | | | |
| **Difficulty with initiation and/or follow through** | | | | | |
| **Reduction in interest, desires and goals** | | | | | |
| **Polydipsia** | | | | | |

**Explain psychiatric symptoms and the impact on ADLs and IADLs:**

| |
|---|
| |

**Disruptive Behaviors:**

| | Never | Rarely | Occasionally | Frequently | Usually |
|---|---|---|---|---|---|
| **Yells** | | | | | |
| **Demands** | | | | | |
| **Takes Other Possessions** | | | | | |
| **Socially inappropriate behavior (i.e. disrobes, urinates or defecates in public)** | | | | | |
| **Sexually inappropriate behavior (i.e. unwanted touching, public masturbation) Explain disruptive behaviors and impact on ADLs and IADLs** | | | | | |

**Explain disruptive behaviors and impact on ADLs and IADLs:**

| |
|---|
| |

**Combative Behaviors:**

| | Never | Rarely | Occasionally | Frequently | Usually |
|---|---|---|---|---|---|
| **Throws objects indiscriminately** | | | | | |
| **Strikes out, kicks or punches others** | | | | | |
| **Pinches, bites, scratches, pulls hair, spits at others** | | | | | |

**Explain combative behaviors and impact on ADLs and IADLs:**

| |
|---|
| |

**Resistive/Uncooperative Behaviors:**

| | Never | Rarely | Occasionally | Frequently | Usually |
|---|---|---|---|---|---|
| **Declines to wash** | | | | | |
| **Declines to eat** | | | | | |
| **Declines to drink** | | | | | |
| **Declines to care for self** | | | | | |
| **Declines to allow others to assist** | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **Declines to take medications** | | | | | |
| **Declines to comply with safety advice** | | | | | |

**Explain resistance/ uncooperative behaviors and impact on ADLs and IADLs:**

**Describe any other symptoms or behaviors not listed above (if applicable):**

**Additional Information:**

**Sources of information utilized to complete form:**

- ☐ Observation of Applicant
- ☐ Interview with Applicant
- ☐ Applicant records
- ☐ Treatment team meeting notes
- ☐ Other

ST. MARY'S COUNTY HEALTH DEPARTMENT
Meenakshi G. Brewster, MD, MPH - Health Officer

Administration, Records & Health Services: 301 – 475 – 4330
Environmental Health: 301 – 475 – 4321
Medical Assistance Transportation: 301 – 475 – 4296
Maryland Relay Service: 1 – 800 – 735 – 2258
Email: smchd.healthdept@maryland.gov

# AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

Use a separate form for each individual, program, organization or facility with which information may be shared.
Please type or print as clearly and completely as possible.

**1 Patient Name** _____ **Date of Birth**_____

**2 I hereby authorize and request the following party to X release X receive information**

**_St. Mary's County Health Department LBHA_**
Name of individual, program, organization or facility

**21580 Peabody Street, Leonardtown MD 20650**
Address

**3 X to X from the following party** _____
Name of individual, program, organization or facility

_____
Address

**4 The following information (INITIAL all items covered by this authorization):**

____ **Acknowledgment of receipt of services**

____ **Complete program record (includes all items below):**

____Intake assessment ____Treatment plan ____Progress Notes _____Diagnosis

____History/Physical ____Lab Results ____Service/discharge summary

____Medications ____Immunizations ____Identifying Information

____Billing Records ____Photographs, Video, Digital or other images

____Mental Health ____Records from other providers contained in the program record

____Other (specify)_____

_____

**5 The disclosure is for the following purpose(s) (Check all that apply)**

☐ Patient request ☐ Treatment/continued care ☐ Review current Care

☐ Payment ☐ Insurance application ☐ Legal

☐ Other (specify)_____

**6 This authorization expires one year from the date the form is signed unless I indicate an earlier date or event (*must occur sooner than 1 year from the date of my signature*) here:**

Until Date: _____ **OR** Until specific event _____

**7 I understand the following:**

A. By signing this form, I am authorizing that the health information specified in Section 4 be shared between the party named in section 2 and the party named in section 3.

B. I may revoke this authorization at any time by writing to the individual(s), program(s), organization(s) or facility/facilities authorized to release information. If more than one individual, program, organization or facility has been authorized to release information, a written revocation request must be submitted to each party.

C. If an individual, program, organization or facility has already released health information based on this authorization, revoking it will only prevent future disclosure by the party to whom a written revocation has been submitted.

D. My treatment, payment for my treatment, enrollment or eligibility for services/benefits cannot be conditioned on the signing of this authorization, unless authorization is required to determine eligibility for services/benefits.

E. The information disclosed may be subject to redisclosure by the recipient and no longer protected by HIPAA.

**8 Patient Signature _____ Date _____**

**Parent or Personal Representative _____ Date _____**
**Signature (if applicable)**

**If signed by Parent or Personal Representative, please indicate Relationship to Patient**

☐ Parent of Minor Child ☐ Guardian ☐ Authorized Representative

☐ Other: _____

**NOTICE**

**Any individual, program, organization or facility receiving information pursuant to this release is prohibited from redisclosing the information without the express, written consent of the patient. The information disclosed may be used only for the purpose(s) stated above.**

**If the information disclosed pursuant to this authorization contains information pertaining to alcohol or drug abuse treatment, diagnosis of alcohol or drug abuse or any referral for treatment of alcohol or drug abuse, 42 CFR Part 2 prohibits the unauthorized disclosure of these records.**

Any facsimile, copy or photocopy of the authorization shall authorize you to release the requested records.