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:

- 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.
- 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	Spring Grove Hospital
Springfield Hospital	Eastern Shore Hospital Center
TB Finan	RRP
Homeless	Home (include address)
Segue	Other:
Date of admission to facility (if appli	cable):

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
	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 Pa	
Applicant's ethnicity:	Not Hispanic or Latino
Hispanic or Latino	Not Hispanic or Latino
Not specific	
Smoker	Non-Smoker
Applicant's preferred language:	
Does the applicant require interpr	eter services?
Describe interpreter services need	ed:

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 u	upon discharge:	
Total estimated financial ass	sets (bank balance, life insurance, retirement accou	nt,
property and other assets):		
Does the applicant have a sp	pecial needs trust or ABLE account?	
Yes No	Other:	

Does the applicant have any personal bills, such as a cell phone bill or prescription copays? (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)
РОА
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:

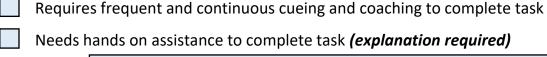
Obtaining and using supplies; soaping, rinsing, and drying body parts; maintaining

bathing position; transferring to and from bathing positions

Independent (no assistance needed)



Requires supervisions, set-up, or minimum cueing to complete task



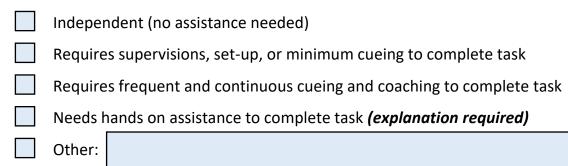
Needs hands on assistance to complete task *(explanation required)*

Other:

Explain the level of assistance needed with bathing:

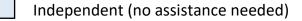
Grooming:

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



Explain the level of assistance needed with grooming:

Getting Dressed/Changing Clothes:



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

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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

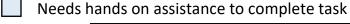


Independent (no assistance needed)

Requires supervisions, set-up, or minimum cueing to complete task



Require frequent and continuous cueing and coaching to complete task



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

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

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

Managing Finances:

Independent (n	o assistance needed)
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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

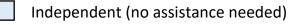
Needs hands on assistance to complete task *(explanation required)*

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



- 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 Other:
 - Needs hands on assistance to complete task (explanation required)

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



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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

Meenakshi G. Brewster, MD, MPH - Health Officer

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 (<u>INITIAL</u> 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 I Treatment/continued care I Review current Care

Payment Insurance application Legal

Other (specify)_____

21580 Peabody Street, P.O. Box 316, Leonardtown, MD 20650 www.SMCHD.org | Facebook.com/SMCHealthDepartment | Twitter: @SMCHD.gox

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
I 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.