

STATE OF MARYLAND
Department of Human Resources
PROJECT HOME Application

Application for Project Home

Today's Date: _____

I. IDENTIFYING INFORMATION:

Applicant's Name: _____ Phone #: _____

Current Address: _____

DOB: _____ SSN#: _____

Ethnicity: _____ Gender: _____ Marital Status: _____

Name of Spouse or Significant Other: _____

Phone #: _____

Emergency Contact Information:

Name: _____

Address: _____

Primary Phone #: _____ Secondary Phone #: _____

Legal Guardian:

Name: _____

Address: _____

Primary Phone #: _____ Secondary Phone #: _____

II. Current Living Situation

Alone Yes No

Homeless/Shelter
Name: _____ Phone # _____

With Others
Name: _____ Phone # _____

Hospital:
Name: _____ Phone # _____

Supervised Apt/Group Home
Name: _____ Phone # _____

Correctional Facility:
Name: _____ Phone # _____

Other:
Name: _____ Phone # _____

III. REFERRAL INFORMATION:

Reason for Referral: _____

Referral Source: _____
Name Title/Relationship

Agency: _____
Name Phone #

Address: _____

Is the applicant aware of the referral? Yes No Fax #

IV. FINANCIAL INFORMATION:

Sources and Amounts per Month (Please note if pending)

SSI	_____	TCA	_____	Food Stamps	_____
SSDI	_____	VA	_____	Unemployment:	_____
SS	_____	Pension	_____	Rail Road	_____
TDAP	_____	Salary	_____	Other:	_____

Assets and Expenses:

Savings Account #: _____ Bank Name: _____
 Checking Account #: _____ Bank Name: _____
 Burial Account/Trust (Name of Institution) _____
 Life Insurance (Name of Company) _____
 Address: _____
 Phone #: _____ Fax #: _____ Policy #: _____

Is the applicant able to manage his/her own funds?: Yes No
 Does the applicant have a Representative Payee?: Yes No
 Does the applicant have a Power of Attorney?: Yes No

V. MEDICAL INFORMATION

MA #: _____ MA MCO: _____
 Medicare# _____ Medicare MCO: _____

Private Health Insurance: _____

ID#: _____ Phone #: _____

Current Medical Diagnoses: _____

Primary Care Provider: _____
Name

Address: _____

Phone _____ Fax _____ Email _____

Medical Specialist: _____
Name _____ Specialty _____

Address: _____

Phone _____ Fax _____ Email _____

List additional specialists on the back of the application

Medical Hospitalizations (Facilities, dates of admission and discharge, diagnoses):

Date of last medical appointment: _____

Date of last specialty appointment: _____

VI. PSYCHIATRIC INFORMATION:

Current Psychiatric Diagnoses:

Psychiatric Provider: _____ Phone: _____

Address:

Phone _____ Fax _____ Email _____

Therapist _____ Phone: _____

Address:

Phone _____ Fax _____ Email _____

Psychiatric Hospitalizations (facilities, dates of admission and discharge, diagnoses):

Date of last psychiatric appointment: _____

Date of last therapy appointment: _____

History of Suicide: _____ How often: _____ Date of last attempt: _____

VII. MEDICATION INFORMATION

Medication Dosage Frequency Purpose

Medication	Dosage	Frequency	Purpose

Current ability to take medication:

Self Medicates Independently:
With Physical Assistance
Uses Inappropriately
Takes OTC's

With Reminders and Supervision
Non-Compliant
Unable to Self Medicate

Comments or other information:

VIII. DAY TIME ACTIVITIES

PRP:

Address: _____ Phone: _____

Case Manager: _____ FAX: _____

ADULT DAY CENTER:

Address: _____ Phone: _____

Case Manager: _____ FAX: _____

SCHOOL:

Address: _____ Phone: _____

Case Manager: _____ FAX: _____

WORK:

Address: _____ Phone: _____

Case Manager: _____ FAX: _____

OTHER:

Address: _____ Phone: _____

Case Manager: _____ FAX: _____

IX. FORENSIC INVOLVEMENT

Has the applicant ever been arrested? Yes No

Has the applicant ever been convicted? Yes No

Is the applicant currently on Parole or Probation? Yes No

Is or will the applicant be on conditional release? Yes No

Parole or Probation Officer: _____
Name

_____ Address

_____ Phone FAX

Please include all records, documents, etc. that will assist with timely assessment/placement.

Please send or fax this application to:

The _____ County Department of Social Services

Address:

City: _____ State: _____ Zip: _____

Phone: _____ FAX: _____

For Internal Use Only

Date Received:

Comments:

STATE OF MARYLAND
Department of Human Resources

Detailed Medical History

Applicant's Name: _____

Yes	No	Condition	Medication
		Orthopedic Dysfunction	
		Heart Trouble	
		Arthritis	
		Stomach Problems	
		Incontinence - Urine/Bowel	
		Diabetes	
		Skin Problems	
		Seizure Disorder	
		Multiple Sclerosis/Parkinsons's	
		Lung Problems	
		Allergies	
		Stroke	
		Bladder/Kidney Problems	
		High Blood Pressure	
		Dementia	
		Apahsia	
		Paralysis	
		Schizophrenia	
		Bi-polar Disorder	
		Depression	
		Anxiety	
		Affective Disorder	
		Tardive Dyskinesia	
		Excessive Weight Loss/Gain	
		Obesity	
		Eating Disorders	
		Dental Problems	
		Hearing Impaired	
		Visions Impaired	
		Organic Brain Syndrome	
		Sleeping Problems	
		Suicidal Ideation	
		Other	

For HIV Applicants:

CDC4 Count: _____

Viral Load _____

Current Medications

STATE OF MARYLAND
Department of Human Resources

Applicant Characteristics

Applicant's Name: _____

The following questions are useful in identifying the most appropriate housing available for the applicant.

Does the applicant smoke? _____ How much? _____
 Does the applicant chew tobacco? _____ How much? _____
 Is dangerous smoking behavior present? _____ Explain: _____
 Is the applicant on a special diet? _____ Describe _____

Does the applicant have allergies? (Please list)

Does the client have a history of the following (please indicate frequency):

	Never	Last 60 days	Past 12 months	Past 2+ years	Comments
Aggressive/Violent Behavior					
Self Abusive Behavior					
Suicidal Ideation					
Suicidal Attempts					
Fire Setting					
Wandering					

Does the applicant prefer: _____ Private Room _____ Semi Private Room

Activities of Daily Living

Specify needs (0-none needed, 1-reminders, 2-prompting, 3-physical assistance)

	None Needed	Reminders	Prompting	Physical Assistance	Comments
Bathing					
Feeding					
Dressing					
Walking					
Transportation					
Budgeting					

List any adaptive equipment needed:

Comments: (any issues – pets, children, access to public transportation etc.)

CONSENT TO RELEASE INFORMATION

I give my consent to release the information on the attached application and any accompanying information to the Baltimore County Department of Social Services in order to assess my eligibility for placement of social services in the **Project Home** or **Adult Foster Care** program.

I further understand that my consent does not commit me to accept a placement and it does not commit the Baltimore County Department of Social Services to provide a placement for me. I may withdraw this consent at any time.

The information will be obtained from/released to:

(Individual/Agency)

THIS CONSENT IS EFFECTIVE FROM THE DATE OF CLIENT'S SIGNATURE BELOW.

Applicant's Signature _____

Date _____

Legal Guardian's Signature [*If Any*] _____

Date _____

Referral Source _____

Date _____

**THIS RELEASE OF INFORMATION AGREEMENT SHALL BE VALID FOR 6 MONTHS
FROM THE DATE OF SIGNATURE.**

Applicant Name: _____

Date of Birth: _____ Date Completed: _____

PROJECT HOME - Medical and Psychiatric Health Care Practitioner Assessment

PHYSICAL HEALTH

Current Medical Diagnoses:

History of Illness or Hospitalization

Health Status

- Consciousness: Alert Drowsy Oriented x 1 2 3
- Lungs: Normal Short of Breath Cough Congested
- Muscular/skeletal: Normal Stiffness Paralysis Pain Numbness
- Skin: Normal Rashes (Contagious Rash Y N)
- Bladder: Normal Incontinent Unable to Void Catheter
- Bowel: Normal Incontinent Constipation Diarrhea
- Appetite: Good Fair Poor

Activities:	Independent	With Help	Totally Dependent
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uses Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets Out of Bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbs Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ambulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Requires PT/OT? No Yes

If yes: PT/OT Name & Address: _____

PT/OT Schedule: _____

Requires Dialysis? No Yes

If Yes, Dialysis Name & Address: _____

Dialysis Schedule: _____

Applicant Name: _____

Date of Birth: _____ **Date Completed:** _____

Requires Home Health? No Yes

If yes: Home Health Name & Address: _____

Home Health Schedule: _____

Requires Special Equipment or Supplies? No Yes

If yes, describe special equipment or supplies (i.e. diapers, chucks, dialysis supplies, diabetes supplies, cane, walker, etc.): _____

List any allergies or sensitivities for food, medications or environmental factors, and if known, the nature of the problem (rash, anaphylactic reaction, GI symptoms, etc):

Communicable illnesses: Is the applicant free from communicable TB and any other active reportable airborne communicable disease(s)? (Check one) ____ Yes ____ No - If "No", indicate the communicable disease:

Project Home requires verification that the applicant is free from active TB. Which tests were done to verify the applicant is free from active TB:

PPD Date _____ Result _____ mm

Chest X-ray (if PPD positive or unable to administer a PPD) Date _____

Result _____

Does the applicant have a drug resistant infection (ex. MRSA) ____ Yes ____ No

If "Yes", indicate the infection _____

For HIV Infected Applicants: CD4 Count: _____ Viral Load: _____

Primary Medical Care Provider: _____ Phone #: _____

Address: _____ Fax #: _____

Medical Specialist: _____ Specialty: _____

Address: _____ Phone #: _____

(If additional medical specialists, please note on back of application)

Date of Last Medical Appointment: _____ Date of Last Specialty Appt. _____

Medical Hospitalizations (facilities, dates of admission & discharge, diagnoses):

Applicant Name: _____

Date of Birth: _____ **Date Completed:** _____

Risk factors for falls and injury: Identify any conditions about this applicant that increase their 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) _____

Skin condition(s): Identify any current or history of ulcers, rash, skin tears with any standing treatment orders, easy bruising, etc. and their causes:

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 _____ Deaf _____ Uses corrective lenses

_____ Blind R L

Current nutritional status: Height _____ inches Weight _____ lbs.

a) Any weight change gain or loss in past 6 months? Yes No

If "Yes", please explain: _____

b) Is there evidence of

malnutrition/undernutrition? Yes No

dehydration/at risk for dehydration? Yes No

If "Yes", please explain: _____

c) Does the applicant have medical or dental conditions affecting (check all that apply):

___ Chewing ___ Swallowing ___ Eating ___ Pocketing food ___ Gastronomy Tube Fed

d) Note any special dietary needs:

Applicant Name: _____

Date of Birth: _____ Date Completed: _____

MENTAL HEALTH

Current Psychiatric Diagnoses:

History of Psychiatric Illness or Hospitalizations:

Symptoms (Check all that apply):

- Hallucinations Type: _____
 Delusions Explain: _____
 Poor Insight Poor Judgement Obsessions Compulsiveness
 Paranoia Hopelessness Sadness Mania
 Depression Flight of Ideas Restlessness Lethargic

- Affect:** Appropriate Labile Tearful Flat
 Euphoric Anxious Hostile
Appearance: Neat Dirty Disheveled
Voice/Speech: Normal Soft Loud Slow
 Slurred Fast Pressured
Eye Contact: Direct Indirect
Sleep Pattern: Restful Sleep Difficulty Falling Asleep
 Restless Sleep Increased Sleep Time

Suicidal Ideations Present --explain including plan: _____

History of Suicidal Attempts --explain: _____

Homicidal Ideations Present --explain including plan: _____

History of Homicidal Attempts --explain: _____

Is applicant a danger to self? No Yes
Explain if yes: _____

Is applicant a danger to others? No Yes
Explain if yes: _____

Applicant Name: _____
Date of Birth: _____ **Date Completed:** _____

Cognitive/Behavioral Status

- a) Is there evidence of dementia? Yes No
- b) Has the applicant undergone an evaluation for dementia Yes No
- c) Diagnosis (source of dementia) Alzheimer's disease Multi-infarct/Vascular
 Parkinsonism Other _____
- d) Memory: Short Term: Intact Impaired Long Term: Intact Impaired
Orientation Person Place Time
Mini Mental Status Exam (if tested) Date _____ Score _____
Cognitive Level of Functioning Concerns: _____

For each item, circle the appropriate level of frequency or intensity. Use the "Comments" column to provide any relevant details.					
	A	B	C	D	Comments
Cognition					
I) Disorientation	Never	Mild	Moderate	Severe	
II) Impaired recall (recent/distant events)	Never	Occasional	Moderate	Severe	
III) Impaired Judgment	Never	Mild	Moderate	Severe	
IV) Hallucinations	Never	Occasional	Moderate	Severe	
V) Delusions	Never	Occasional	Moderate	Severe	
Communication					
VI) Receptive/expressive aphasia	Never	Mild	Moderate	Severe	
Mood and emotions					
VII) Anxiety	Never	Occasional	Moderate	Severe	
VIII) Depression	Never	Mild	Moderate	Severe	
Behaviors					
IX) Unsafe behaviors	Never	Occasional	Moderate	Severe	
X) Dangerous to self or others	Never	Occasional	Moderate	Severe	
XI) Agitation (Describe behaviors in comments section)	Never	Occasional	Moderate	Severe	

Applicant Name: _____

Date of Birth: _____ **Date Completed:** _____

Does the applicant have any history or current problem related to abuse of prescription, non-prescription, OTC, illegal drugs, alcohol, or inhalants, etc.?

a) Substance: OTC, non-prescription medication abuse or misuse (check one)

1. Recent (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 (last 6 months) Yes No

c) History of non-compliance with prescribed medication

1. Currently Yes No

2. Recent (last 6 months) Yes No

d) Describe misuse or abuse: _____

PHARMACOLOGY

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(If needed, use an additional page for medications)

Ability to self-administer medications:

Project Home is an adult foster care model with a provider living in the home 24/7 and accepting responsibility for supervising and caring for residents. Each provider and resident work with a registered nurse consultant who has been trained in cueing and coaching techniques that ensure compliance with taking prescribed medications. Through individualized health care teaching by the consultant, the ultimate goal is that each resident is able to self-medicate with cueing, coaching, reminders and supervision. In your opinion, would this level of support enable the applicant to self-administer medications?

Yes No If No, Please explain: _____

Applicant Name: _____
Date of Birth: _____ **Date Completed:** _____

HEALTH CARE DECISION MAKING CAPACITY

Based on the preceding review of functional capabilities and physical and cognitive status and limitations, indicate this applicant'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 and 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

This form completed by:

_____ Date _____
Print Name

Signature, Title

Form must be verified for accuracy by Health Care Practitioner:

_____ Date _____
Print Practitioner's Name

Practitioner's Signature, Title