RESET FORM

Maitri

RESIDENTIAL CARE FOR PEOPLE LIVING WITH AIDS

Dear Colleague,

Thank-you for your interest in the Maitri Residence. Our 15 bed facility is licensed as a Residential Care for the Chronically Ill (RCFCI), providing support to low-income San Francisco residents who are severely debilitated, HIV+, and in need of 24 hour nursing care. Our staffing levels are higher than other RCFCIs, allowing us to fulfill a unique need in the community by focusing exclusively on those with AIDS, in need of hospice, end-of-life or short-term respite/transitional care. We prioritize hospice/end of life beds and fill respite beds thereafter.

An important factor in deciding if Maitri is an appropriate referral is that we do not provide long term care or long term housing.

Please take a few minutes to read the "Maitri Admission Procedures" before reviewing the application and criteria. Please feel free to call with any questions about our program.

Maitri prohibits discrimination based on the fact or perception of race, religion, color, ancestry, age, height, weight, sex, sexual orientation, gender identity, disability, place of birth, creed, national origin, marital status, domestic partner status, or AIDS/HIV status. Maitri is committed to providing access to individuals with limited English proficiency. Maitri will provide accommodation at no cost to any consumer of its services. Please notify the program director of any language accommodation needs.

Sincerely yours,

Crystal E. Russell, LCSW MSPH
Program Director
Maitri Compassionate Care
401 Duboce Ave
SF, CA 94117
415-558-3006
415-558-3010-fax
www.maitrisf.org

Maitri Admission Procedures

We prioritize those in need of hospice/end-of-life care and fill respite beds after. We do not have a set number of hospice/end-of-life beds vs. respite beds: we triage based on need.

1. Before beginning the paperwork:

- [ ] Please call the Intake Coordinator at (415) 558-3006 to check on availability of rooms and review the basics of your client's situation. This may save you a lot of time.

2. If referral is appropriate, complete application:

- [ ] Mail or fax to Maitri: 401 Duboce Ave., San Francisco, CA 94117 • Fax: (415) 558-3010.

3. Each application must include the following:

- [ ] All fields in pages 3–18 must be completed. Ensure all insurance information is current and that doctor's signature and license number are included. *(Exception is page 14; for hospice referrals only.)*
- [ ] Applicant must have a primary physician (MD) located in San Francisco. *Maitri does not have an in-house physician.*
- [ ] History and Physical and/or discharge summary and/or progress notes.
- [ ] Medications list.
- [ ] Tuberculosis (TB) clearance. We require a recent chest x-ray for admission: the x-ray must be taken within one month prior to admission. This need not be done until your client has been accepted at Maitri.

4. Include additional information when applicable and/or available:

- [ ] Provide a copy of a MediCal card or current number (*not social security number*).
- [ ] Provide documented psychological history.
- [ ] Provide DPOA or Advanced Medical Directive paperwork.
- [ ] Provide a copy of San Francisco ID or proof of residency. (Phone or PG&E Bill)
- [ ] Provide proof of income. (Statement from Social Security, bank statement with direct deposit indicated, or copy of check)

5. Upon receipt of the completed application:

I will call to discuss the referral and provide you with an estimated wait time for a bed and/or put your applicant on the waiting list.

6. Once a bed is available:

I will call to either schedule an assessment visit, or arrange for the applicant to visit Maitri for the assessment interview.

***7.* Upon acceptance to Maitri:**

I will inform all involved parties of the admission date and procedures.

Waiting List Policy

1. As noted above, we prioritize hospice/end of life applicants.
2. Wait time for a bed varies. Please feel free to call (415) 558-3006 at any time to check on the status of your referral.
3. If you have indicated you will call me with follow up information, I will await your call. If I have not heard from you in two weeks, I will call and check in.

Criteria for Admission

Take a moment to read and fill out this form before filling out the rest of the application. We hope it will clarify our admissions criteria and the care needs that can be accommodated at Maitri and prevent unnecessary paperwork. Please check off all conditions that apply to your client and read the notes, limitations, and exceptions.

Required Admissions Criteria

All of the following criteria ***must*** be met to become a resident at Maitri.

Criterion	Exception	Reason
☐ Income is less than $41,000 per year	One bed is exempt. Call about availability.	HOPWA Contract
☐ Has AIDS or Disabling HIV	No exceptions.	Mission/HOPWA/ CARE
☐ Over 18 years of age	No exceptions.	Mission/HOPWA/ CARE
☐ Capable of signing admissions agreement	If impaired, agreement must be signed by next of kin, conservator, or person with power of attorney.	Legal
☐ San Francisco resident	No exceptions.	HOPWA/CARE Contract
☐ Physician (MD) is located in San Francisco.	No exceptions. Physician must be willing to monitor applicant while at Maitri.	HOPWA/CARE Contract

Type of Referral for Admission

Some limitations apply. ***Choose only one*** of the following:

Level of Care Required	Notes	Reason
☐ **Hospice Care** Has 6–12 month prognosis, agreeing to hospice guidelines of palliative care.	Hospice care is provided by an outside hospice organization.	Maitri Mission/ Staffing Level
☐ **End-of-Life Care** Has similar prognosis as hospice but is choosing to pursue aggressive treatment, needs 24-hour care and significant help with ADLs.	Skilled needs must be supervised by an outside home health agency. See next section about care needs and limitations.	Mission/ HOPWA/ CARE
☐ **Short-Term Respite** Has acute, 24-hour care needs on a short-term basis. We begin our respite stays at 3 months and assess for extensions as needed.	Must have 24-hour care needs and identify respite goal prior to admission. See next section about care needs and limitations.	Mission/ HOPWA/ CARE

Care Needs

Limitations apply.

Care required	Limitations to Admission	Reason
☐ Requires intravenous (IV) infusion	Infusions of short duration only (up to 3 hours). Must be administered by an outside home health agency.	Staffing Level/ Licensing
☐ Requires hemodialysis	Can accommodate ***only if***: 1. Transport is arranged by outside agency or friend/family, ***and*** 2. If unable to go alone, has friend/family to escort.	Staffing Level/ Lack of Resources
☐ Requires two-person transfer	Admission would depend on our ability to care for safely. *No Hoyer lift.*	Staffing Level
☐ Requires daily/ frequent outpatient treatment visits	Can accommodate ***only if***: 1. Transport is arranged by outside agency or friend/family, ***and*** 2. If unable to go alone, has friend/family to escort.	Staffing Level/ Lack of Resources
☐ Requires daily/ frequent lab work	Can accommodate if outside home health agency is used to draw labs.	RCFCI Licensing
☐ Requires port or line for infusion	Can accommodate if outside home health agency will manage and maintain	RCFCI Licensing
☐ Requires suctioning	Non-emergency suction only. *No back-up generator.*	Staffing Level
☐ Has diagnosis of MRSA or VRE	Must have letter from physician (MD) stating that treatment was successful and is no longer an infection risk to other residents or staff.	Infection Control
☐ Has documented psychiatric history (or ☐ Assess)	If checked, documentation of psychiatric history required. If "Assess," may need psychological or housing evaluation from AIDS Health Project.	Safety/Staffing Level
☐ Has history of evictions from other programs	May require additional information from other programs.	Safety
☐ Requires sitters/ one-to-one attention.	Cannot accommodate unless 24-hour sitters are arranged by family or by MediCal Waiver Program	Safety/Staffing Mode

Barriers to Admission

If any of the below are checked, Maitri will be unable to accommodate client. No exceptions.

Care required	Exceptions	Reason
☐ Requires restraints	No exceptions.	RCFCI Licensing
☐ Requires peritonial dialysis	No exceptions.	Staffing Model
☐ Requires intravenous feeding (TPN)	No exceptions.	Staffing Model
☐ Requires ventilator	No exceptions.	Staffing Model
☐ Has tracheostomy tube	No exceptions.	Staffing Model
☐ Has stage III or IV pressure ulcer	No exceptions.	RCFCI Licensing
☐ Requires long-term housing placement. *Maitri does not provide long-term housing.*	No exceptions.	Mission
☐ Requires long-term care.	No exceptions.	Mission

Referral Information

REFERRED BY	DATE
AGENCY/HOSPITAL	PHONE
STREET ADDRESS	CITY, STATE ZIP
PAGER NUMBER	MOBILE PHONE NUMBER
ADDITIONAL PHONE NUMBER (OPTIONAL)	ADDITIONAL PHONE NUMBER (OPTIONAL)

Client Information

PERSONAL INFORMATION		
NAME	ETHNICITY	DATE OF BIRTH
SSI NUMBER	CURRENT RENT PAYMENT	
STREET ADDRESS	CITY, STATE ZIP	
PHONE NUMBER	ADDITIONAL PHONE NUMBER (OPTIONAL)	

☐ Currently residing at home address provided above.
☐ Currently residing at care facility (please provide information below).

CURRENT CARE FACILITY		
CARE FACILITY NAME ☐ SAME AS REFERRAL INFORMATION ABOVE	STREET ADDRESS ☐ SAME AS REFERRAL INFORMATION ABOVE	
ROOM NUMBER	CITY, STATE ZIP ☐ SAME AS REFERRAL INFORMATION ABOVE	
CARE CONTACT NAME	CARE CONTACT PHONE	CARE CONTACT PAGER
ADDITIONAL PHONE NUMBER (OPTIONAL)	ADDITIONAL PHONE NUMBER (OPTIONAL)	

PRIMARY HOME CARE AGENCY (IF AVAILABLE)		
AGENCY NAME		
HOME CARE CONTACT NAME	HOME CARE CONTACT PHONE	HOME CARE CONTACT PAGER
ADDITIONAL PHONE NUMBER (OPTIONAL)	ADDITIONAL PHONE NUMBER (OPTIONAL)	

OTHER SERVICE PROVIDERS	HOUSING APPLICATIONS
PLEASE PROVIDE CONTACT INFO FOR ANY OTHER AGENCIES PROVIDING SERVICES TO CLIENT	PLEASE LIST ANY APPLICATIONS SUBMITTED

Client Health History

MEDICAL INFORMATION

- [ ] Prescription medication list attached (required)
- [ ] H&P and/or D/C summary attached (required)

PLEASE PROVIDE MEDICAL DIAGNOSES (Dx) WITH DATES. INCLUDE RECENT SURGERIES OR INFUSIONS.

PLEASE CHECK ALL THAT APPLY

Symptoms

- [ ] Difficulty swallowing
- [ ] Difficulty breathing
- [ ] Nausea/vomiting
- [ ] Pain
- [ ] Rash/Itching
- [ ] Diarrhea

Treatments

- [ ] Radiation
- [ ] Wound care
- [ ] Oxygen
- [ ] Other:

Mental State

- [ ] Clear/oriented
- [ ] Mild dementia
- [ ] Moderate dementia
- [ ] Severe dementia

Smoker

- [ ] Yes
- [ ] No

Special Needs

- [ ] Hearing impaired
- [ ] Sight impaired
- [ ] Other:

Mobility

- [ ] Independent
- [ ] Assistance required
- [ ] Wheelchair
- [ ] Bedbound

Toileting

- [ ] Independent
- [ ] Assistance required
- [ ] Incontinent bladder
- [ ] Incontinent bowel
- [ ] Foley catheter

PSYCHOLOGICAL INFORMATION

☐ Psychological documention attached

PLEASE PROVIDE PSYCHOLOGICAL DIAGNOSES (Dx) AND HISTORY WITH DATES.

SUBSTANCE USE

Please check one:

- ☐ **Active**: used substance(s) within the last 3 months
- ☐ **Recent**: used substance(s) within the last 3–12 months
- ☐ **Remote**: used substance(s) one year ago or more.
- ☐ No significant substance use (social use, never, etc.)
- ☐ Unknown
- ❒ Other:

Substance(s) used:

IF ACTIVELY USING:

HOW OFTEN?

APPROXIMATE DATE OF LAST USE

INTERESTED IN TREATMENT?

IF USE WAS RECENT, BUT NOT CURRENTLY ACTIVE, WHAT HELPED THE CLIENT STOP USING?

RELEVANT PERSONAL HISTORY

PLEASE PROVIDE RELEVANT PERSONAL HISTORY (FRIENDS/FAMILY INVOLVED, PRIOR LIVING SITUATION, ETC.)

ARE THERE ANY LEGAL MATTERS PENDING?

IS THERE ANY CRIMINAL HISTORY/ INCARCERATIONS?

Client Health Care Providers and Insurance

HEALTH CARE PROVIDERS	
NAME OF PRIMARY PHYSICIAN (MD)	HOSPITAL
STREET ADDRESS	CITY, STATE ZIP
OFFICE PHONE NUMBER	FAX NUMBER
PAGER NUMBER	ADDITIONAL PHONE NUMBER (OPTIONAL)
NAME OF SECONDARY PHYSICIAN	SUPERVISING PHYSICIAN (IF SECONDARY PHYSICIAN NOT MD)
STREET ADDRESS	CITY, STATE ZIP

INSURANCE		
☐ **Medi-Cal**	☐ **Medicare**	☐ **Healthy SF**
MEDI-CAL BIN (NOT SOCIAL SECURITY NO.)	MEDICARE NUMBER	HEALTHY SF NUMBER
MEDI-CAL ISSUE DATE	MEDICARE "D" PRESCRIPTION PLAN	
	MEDICARE "D": HOW ADMINISTERED	
☐ **Private insurance or self-pay**	PROVIDE PERTINENT INFORMATION FOR PRIVATE INSURANCE OR SELF-PAY	

Client Contacts

PERSONAL/FAMILY CONTACTS	
PRIMARY CONTACT NAME	RELATIONSHIP
PHONE NUMBER	ADDITIONAL PHONE NUMBER (OPTIONAL)
STREET ADDRESS	CITY, STATE ZIP
SECONDARY CONTACT NAME	RELATIONSHIP
PHONE NUMBER	ADDITIONAL PHONE NUMBER (OPTIONAL)
STREET ADDRESS	CITY, STATE ZIP

DURABLE POWER(S) OF ATTORNEY (DPOA)	
☐ **Durable Power of Attorney for HEALTH CARE document attached.**	
NAME	
HOME PHONE NUMBER	WORK PHONE NUMBER
STREET ADDRESS	CITY, STATE ZIP
☐ **Durable Power of Attorney for FINANCES document attached.**	
NAME	☐ CHECK HERE IF SAME AS HEALTH CARE DPOA ABOVE AND LEAVE THIS SECTION BLANK
HOME PHONE NUMBER	WORK PHONE NUMBER
STREET ADDRESS	CITY, STATE ZIP

Maitri

Health Care Provider's Certification of HIV Status/AIDS Diagnosis

To: Physician/Health Care Provider

Re: Maitri Application for Admission

Maitri requires the following information for admission of the client named below.

NAME OF CLIENT		
HIV STATUS	**T-CELL, VIRAL LOAD COUNTS**	
YEAR FIRST TESTED HIV POSITIVE (IF KNOWN)	LAST T-CELL COUNT	DATE OF COUNT
YEAR FIRST DIAGNOSED WITH AIDS (IF KNOWN)	NADIR OF CD4 (IF KNOWN)	
Please check the appropriate category: ☐ HIV+ Asymptomatic ☐ HIV+ Symptomatic ☐ Disabling HIV ☐ AIDS Diagnosis ☐ Disabling AIDS Diagnosis	LAST VIRAL LOAD COUNT	DATE OF COUNT

I am treating the above-named person for symptoms/conditions related to HIV/AIDS.

SIGNATURE OF HEALTH CARE PROVIDER (MD, PA, NP)	PRINT NAME
DATE	LICENSE NUMBER
ADDRESS	PHONE NUMBER

Maitri

Health Care Provider's Certification of Pulmonary Tuberculosis Status

To: Physician/Health Care Provider

Re: Maitri Application for Admission

People infected with HIV and people living in group residential facilities are considered to be at high risk for pulmonary tuberculosis. In order to protect our patients and staff, Maitri requires the following information before admitting the client named below.

NAME OF CLIENT			
PULMONARY TUBERCULOSIS TEST			
Chest X-ray (CXR)	DATE	☐ **Negative** for pulmonary tuberculosis ☐ **Positive** for pulmonary tuberculosis	
IF PATIENT HAS ACTIVE PULMONARY TUBERCULOSIS			
Patient must have received continuous treatment for at least 2 weeks and show 3 consecutive negative AFB smears prior to admission.			
DATE TREATMENT STARTED	DATE OF NEGATIVE AFB #1	DATE OF NEGATIVE AFB #2	DATE OF NEGATIVE AFB #3

I affirm the above-provided information is correct.

SIGNATURE OF HEALTH CARE PROVIDER (MD, PA, NP) PRINT NAME

DATE LICENSE NUMBER

ADDRESS PHONE NUMBER

Maitri

Complete for Hospice Only

Health Care Provider's Certification of Terminal Illness for Hospice Care

To: Physician/Health Care Provider

Re: Maitri Application for Admission

Maitri requires the following information for admission of the client named below.

NAME OF CLIENT

Hospice care is palliative, not curative, in its goals and techniques. The Maitri program emphasizes the alleviation of physical symptoms, including pain, and the identification and meeting of emotional and spiritual needs.

The above-named client has a prognosis of six months or less and has elected hospice care.

SIGNATURE OF HEALTH CARE PROVIDER (MD, PA, NP)	PRINT NAME
DATE	LICENSE NUMBER
ADDRESS	PHONE NUMBER

Maitri

ADMISSIONS AGREEMENT

I request admission to Maitri and I acknowledge, consent, and agree to the following:

_____ INITIAL
1. I understand that medical and professional nursing services are provided by Maitri medical staff and other home health agencies under orders of my physician. These services include 24-hour home care aides, 24-hour LVN nursing supervision and 24-hour on call nurses for emergencies.

_____ INITIAL
2. I understand that if my need for medical or nursing care should at any time exceed those services able to be provided by Maitri, or if my condition should stabilize to the point where Maitri services are no longer appropriate, I will be discharged from Maitri and transferred to another appropriate facility or home.

_____ INITIAL
3. I give consent and approval for notations to be made on my Maitri record regarding the care provided at Maitri. In addition, my medical and psychosocial needs will be reviewed by Maitri medical staff, other care providers, and consulting physicians in case conferences. This includes a psychiatrist from AIDS Health Project.

_____ INITIAL
4. I understand that I am required to have a chest x-ray within one month prior to admission, for screening by my physician for pulmonary tuberculosis (TB). This is in compliance with recommendations of the City Department of Public Health. I understand that if the screening should show me to have active TB, I must start on effective medical treatment prior to admission and continue that treatment during my stay.

_____ INITIAL
5. I understand that smoking is not permitted indoors at Maitri and that butane lighters and cartridge refills are prohibited. Outside areas are provided for smoking.

_____ INITIAL
6. I understand that per my medical provider's orders, I may drink alcohol, in my room only, in moderation, and that abuse of alcohol or disruptive behavior may result in discharge from Maitri.

_____ INITIAL
7. I understand that I am not permitted to possess or use weapons, replica weapons, illegal drugs and/or paraphernalia of any kind at Maitri. Illegal activity of any kind will result in discharge.

_____ INITIAL
8. Visiting hours are from 7 AM – 10 PM. I understand that visitors may be limited at any time at my request, and that visitors will be asked to leave if they become disruptive and/or disturb other residents. In special circumstances arrangements can be made for overnight guests with approval of the Program Director.

_____ INITIAL
9. I understand that I may voice my concerns regarding the care provided at Maitri to the Program Director of Maitri.

_____ INITIAL
10. I understand that pets cannot be kept at Maitri. Arrangements can be made for limited pet visits.

_____ INITIAL
11. I understand that my room will be furnished and due to lack of storage I am allowed to bring only items that will safely fit in the room as determined by Maitri staff.

_____ INITIAL
12. I understand that the use of medical marijuana is permitted at Maitri when recommended in writing by my primary-care physician and upon acceptance of the Maitri policies concerning medical marijuana.

_____ INITIAL
13. I understand that Maitri is funded and staffed for residents who are seriously ill and normally homebound and that residents may only leave the building accompanied by a family member, friend, volunteer or staff member, unless otherwise specified by their primary-care provider.

_____ INITIAL
14. I am a resident of San Francisco, or I do intend to reside in San Francisco.

_____ INITIAL
15. I understand that I will pay a monthly fee for room and services equal to 60% of my adjusted income. Fees are due upon admission and monthly by the 5th day. 30% is dedicated to rent and the other 30% of fees is dedicated to offset the cost of high-level care and services at Maitri.

_____ INITIAL
16. I understand that all staff, volunteers and residents are to be treated respectfully. This means no yelling, profanity, or derogatory remarks. Disruptive, threatening, or intimidating behavior can result in discharge from Maitri

_____ INITIAL
17. I understand that Maitri has a Wander Guard alarm system and that if I become confused and considered a safety risk Maitri may require the use of this system. In such an event a signed consent will be obtained from my designated power of attorney for healthcare decisions and my doctor. Maitri's license does require the transfer of residents who cannot be cared for safely to other facilities.

_____ INITIAL
18. I understand personal hygiene is an integral part to my health and overall well being; therefore, I agree to showering or bathing at least once per week.

_____ INITIAL
19. I understand if I am at risk for bed bugs, upon moving into Maitri, the possessions I bring with me are subject to be frozen for two weeks, and I will not be allowed to bring objects from home unless they are frozen at Maitri for two weeks.

_____ INITIAL
20. I understand the use of an electric wheelchair is not allowed in Maitri yet permissible for entering and exiting the building for excursions outside of the residence.

_____ INITIAL
21. I understand I must meet weekly with my appointed Social Worker at Maitri.

_____ INITIAL
22. I understand if I leave without notice for 24 hours, Maitri staff are expected to report a missing persons report to the police.

I acknowledge that I have been given ample opportunity to ask any and all questions concerning Maitri, the care provided, related fees and policies governing Maitri.

PARTIES TO THIS AGREEMENT:

RESIDENT SIGNATURE OR DPOA DATE

FACILITY MANAGER SIGNATURE DATE

FINANCIAL INFORMATION

Service Fees are 60% of the resident's monthly income. Half of the service fee is dedicated to rent and the other half is dedicated to offset the cost of high-level care and services at Maitri. If applicant is applying for respite and wishes to keep their current residence, their rent will be deducted from the Maitri service fee in order to maintain their payments.

Please provide proof of income:

NAME OF CLIENT	
MONEY MANAGEMENT CONTACT (IF NOT CLIENT)	
NAME	PHONE NUMBER
MONEY MANAGEMENT AGENCY (IF NOT INDIVIDUAL)	ADDITIONAL PHONE NUMBER (OPTIONAL)

SOURCES OF INCOME

MONTHLY SOURCE OF INCOME	AMOUNT
Social Security Disability Insurance (SSDI)	**$**
Supplemental Security Income (SSI)	**$**
Social Security Benefits	**$**
State Disability Benefits	**$**
Private Disability	**$**
Retirement/Pension	**$**
Other	**$**
TOTAL	**$** 0.00

MEDICAL EXPENSES	
MONTHLY MEDICAL EXPENSES	AMOUNT
Health Insurance Premium	**$**
Medications	**$**
Other	**$**
TOTAL	**$** 0.00

I certify that the information above is complete and accurate.

APPLICANT SIGNATURE, DPOA OR IMMEDIATE FAMILY MEMBER DATE

PRINT NAME

AUTHORIZATION TO OBTAIN FINANCIAL INFORMATION (OPTIONAL)

I utilize an individual or money management agency to assist with my finances. I hereby authorize Maitri to obtain financial information in order to determine my room and services fee.

APPLICANT SIGNATURE, DPOA OR IMMEDIATE FAMILY MEMBER DATE

PRINT NAME

Maitri

Authorization to Exchange Confidential Information

Please note: *a separate form is required for each specified contact.*

It is the policy of Maitri to hold all information about clients as confidential and to not release information without permission. In order to facilitate your application process we need permission to contact your healthcare providers and to get information about your physical and mental health.

While it is your right to limit or exclude information from disclosure, this authorization is for full disclosure of all records, including diagnosis, treatment, assessment, dates of hospitalizations, mental health/psychiatric conditions, HIV/AIDS testing results, drug and alcohol information, and sexually transmitted disease information.

You may revoke your consent at any time.

You have the right to a copy of this authorization.

Your confidential information is protected by the Federal Privacy Act and California law.

I hereby give my permission to obtain or disclose my private health information for the purpose of admission to the Maitri residence. This authorization is valid for the duration of the intake process.

NAME OF AGENCY OR INDIVIDUAL TO BE CONTACTED

APPLICANT SIGNATURE, DPOA OR IMMEDIATE FAMILY MEMBER DATE

Maitri

Notice of Non-Discrimination

Maitri prohibits discrimination based on the fact or perception of race, religion, color, ancestry, age, height, weight, sex, sexual orientation, gender identity, disability, place of birth, creed, national origin, marital status, domestic partner status, or AIDS/HIV.

Maitri is committed to providing access to individuals with limited English proficiency. Maitri will provide accommodation at no cost to any consumer of its services. Please notify the intake coordinator of any language accommodation needs.

APPLICANT SIGNATURE, DPOA OR IMMEDIATE FAMILY MEMBER DATE

PRINT NAME

Maitri

Health Care Provider's Certification of Homebound Status

To: Physician/Health Care Provider

Re: Maitri Application for Admission

NAME OF CLIENT

Maitri is funded and staffed for residents who are seriously ill and considered homebound: they may leave the building only if they are accompanied by a family member, friend, volunteer or staff member, unless otherwise specified by their primary-care physician.

For the health and safety of our residents, we prefer, but do not require, all new residents to be on "homebound" status. If, at any point the resident would like to change their status, the Maitri RN would contact their physician to discuss the appropriateness of the request.

As the primary care provider, you can specify the status level of your patient, knowing the status can be changed at any time:

Please check ONE of the following:

☐ **Homebound:** Resident cannot leave building unless accompanied by an escort.

☐ **Limited Homebound:** Resident can leave facility for short distances and/or at the discretion of the charge nurse on duty, depending on specifications of primary physician detailed below:

SIGNATURE OF HEALTH CARE PROVIDER (MD, PA, NP)	PRINT NAME
DATE	LICENSE NUMBER
PHONE NUMBER	PAGER NUMBER

Maitri

Proof of San Francisco Residency

To: Physician/Health Care Provider

Re: Maitri Application for Admission

NAME OF CLIENT

Maitri's licensing requires all potential residents to reside in San Francisco. Please select one of the following options and provide the documents requested:

☐ **I am a resident of San Francisco living at the following address:**

and I have attached the following proof of residency:

- ☐ **A copy of my California Driver's License**
- ☐ **A bill (telephone, cable, etc.) with my home address.**

☐ **I am homeless in San Francisco.**

☐ **I am unable to prove residency in San Francisco and have attached a signed statement explaining why I do not have proof of residency.** Reasons might include homelessness, lack of identification, former San Francisco residence, returning, etc.

APPLICANT SIGNATURE, DPOA OR IMMEDIATE FAMILY MEMBER DATE

PHYSICIAN'S REPORT FOR COMMUNITY CARE FACILITIES

For Resident/Client Of, Or Applicants For Admission To, Community Care Facilities (CCF).

NOTE TO PHYSICIAN:
The person specified below is a resident/client of or an applicant for admission to a licensed Community Care Facility. These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents/clients.

THESE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.
The information that you complete on this person is required by law to assist in determining whether he/she is appropriate for admission to or continued care in a facility.

FACILITY INFORMATION (To be completed by the licensee/designee)

NAME OF FACILITY: | TELEPHONE:

ADDRESS: NUMBER | STREET | CITY

LICENSEE'S NAME: | TELEPHONE: | FACILITY LICENSE NUMBER:

RESIDENT/CLIENT INFORMATION (To be completed by the resident/authorized representative/licensee)

NAME: | TELEPHONE:

ADDRESS: NUMBER | STREET | CITY | SOCIAL SECURITY NUMBER:

NEXT OF KIN: | PERSON RESPONSIBLE FOR THIS PERSON'S FINANCES:

PATIENT'S DIAGNOSIS (To be completed by the physician)

PRIMARY DIAGNOSIS:

SECONDARY DIAGNOSIS: | LENGTH OF TIME UNDER YOUR CARE:

AGE: | HEIGHT: | SEX: | WEIGHT: | IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE? ☐ **YES** ☐ **NO**

TUBERCULOSIS EXAMINATION RESULTS: ☐ ACTIVE ☐ INACTIVE ☐ NONE | DATE OF LAST TB TEST:

TYPE OF TB TEST USED: | TREATMENT/MEDICATION: ☐ **YES** ☐ **NO** If YES, list below:

OTHER CONTAGIOUS/INFECTIOUS DISEASES:
A) ☐ **YES** ☐ **NO** If YES, list below:

TREATMENT/MEDICATION:
B) ☐ **YES** ☐ **NO** If YES, list below:

ALLERGIES
C) ☐ **YES** ☐ **NO** If YES, list below:

TREATMENT/MEDICATION:
D) ☐ **YES** ☐ **NO** If YES, list below:

Ambulatory status of client/resident:

1. This person is able to independently transfer to and from bed: ☐ Yes ☐ No

2. For purposes of a fire clearance, this person is considered:

☐ Ambulatory ☐ Nonambulatory ☐ Bedridden

Nonambulatory: A person who is unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or to an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs.
Note: A person who is unable to independently transfer to and from bed, but who does not need assistance to turn or reposition in bed, shall be considered non-ambulatory for the purposes of a fire clearance.

Bedridden: For the purpose of a fire clearance, this means a person who requires assistance with turning or repositioning in bed.

I. PHYSICAL HEALTH STATUS: ☐ **GOOD** ☐ **FAIR** ☐ **POOR**	COMMENTS:			
	YES ***(Check One)***	**NO** ***(Check One)***	ASSISTIVE DEVICE	COMMENTS:
1. Auditory impairment				
2. Visual impairment				
3. Wears dentures				
4. Special diet				
5. Substance abuse problem				
6. Bowel impairment				
7. Bladder impairment				
8. Motor impairment				
9. Requires continuous bed care				

II. MENTAL HEALTH STATUS: ☐ **GOOD** ☐ **FAIR** ☐ **POOR**	COMMENTS:			
	NO PROBLEM	**OCCASIONAL**	**FREQUENT**	IF PROBLEM EXISTS, PROVIDE COMMENT BELOW:
1. Confused				
2. Able to follow instructions				
3. Depressed				
4. Able to communicate				

III. CAPACITY FOR SELF CARE: ☐ **YES** ☐ **NO**	COMMENTS:		
	YES ***(Check One)***	**NO** ***(Check One)***	COMMENTS:
1. Able to care for all personal needs			
2. Can administer and store own medications			
3. Needs constant medical supervision			
4. Currently taking prescribed medications			
5. Bathes self			
6. Dresses self			
7. Feeds self			
8. Cares for his/her own toilet needs			
9. Able to leave facility unassisted			
10. Able to ambulate without assistance			
11. Able to manage own cash resources			

PLEASE LIST OVER-THE-COUNTER MEDICATION THAT CAN BE GIVEN TO THE CLIENT/RESIDENT, AS NEEDED, FOR THE FOLLOWING CONDITIONS:

CONDITIONS	OVER-THE-COUNTER MEDICATION(S)
1. Headache	
2. Constipation	
3. Diarrhea	
4. Indigestion	
5. Others *(specify condition)*	

PLEASE LIST CURRENT PRESCRIBED MEDICATIONS THAT ARE BEING TAKEN BY CLIENT/RESIDENT:

1.	4.	7.
2.	5.	8.
3.	6.	9.

PHYSICIAN'S NAME AND ADDRESS:	TELEPHONE:	DATE:

PHYSICIAN'S SIGNATURE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (TO BE COMPLETED BY PERSON'S AUTHORIZED REPRESENTATIVE)
I hereby authorize the release of medical information contained in this report regarding the physical examination of:

PATIENT'S NAME:

TO (NAME AND ADDRESS OF LICENSING AGENCY):

SIGNATURE OF RESIDENT/POTENTIAL RESIDENT AND/OR HIS/HER AUTHORIZED REPRESENTATIVE	ADDRESS:	DATE: