Stoddard Baptist NURSING HOME

Dear Applicant:

Thank you for your interest in Stoddard Baptist Nursing Home (SBNH). The following information should be submitted to the Admissions Office for nursing home placement at Stoddard.

1. Have the applicant's physician complete the test listed below (#5) and complete the enclosed: a) Referral for Medicaid Level of Care From (2 pages); b) Referral for Long Term Care Placement for and c) Pre-Admission Screen/Resident Review for Mental Retardation Form (2 pages).

2. Please return all completed forms to the Admissions Office at Stoddard.

3. If the applicant is eligible for Medicaid, Stoddard will submit all completed forms to:

   Delmarva Foundation for Medical Care
   Long Term Care Department
   9240 Centrevile Road
   Easton, MD 21601
   (410) 820-0697
   (800) 469-6851 – Fax

4. If the applicant is not eligible for Medicaid, i.e., private pay, you only need to return the forms to the Admissions Office.

5. CBC
   Chemistry Profile
   Chest X-ray
   EKG
   RPR
   Urinalysis

Please note: The above laboratory reports should be within 60 days of application.

If you have any questions concerning this application, please feel free to contact the Admissions' Office at (202) 328-7400, ext. 1307 or 1309.

District of Columbia – Department of Health
Referral for Medicaid Level of Care

1._____/_____/_____ (2) SS#_____-_____-_____ (3) MA #_____

(4) Certification Requested	☐ Medical Day Care	☐ Nursing Facility	☐ CRF	☐ Elderly and Physical Disabilities Waiver
(5) Reason for Referral	☐ Initial Placement ☐ Return within behold	☐Transfer fro NF to NF or Waiver	☐ Conversion to Medicaid	

Part A

(6) Name of Individual_____
Last First MI

(7) Permanent Address (include name of NF, is applicable)_____

_____

(8) Phone (_____) _____- _____ (9) DOB _____/_____/_____ (10) Sex_____

(11) Martial Status – Please Circle One: Single, Married, Divorced, Widowed

(12) Responsible Party/Next of Kin_____
Last First

(13) Address_____

(14) Present Location of Individual (Name and Address of Hospital/NF/Community if different from above

_____

Part B – Individual Profile (Referring Source – Health Care Professional to complete)
Code X = Yes – (Please only check one level of assistance per activity)

	Independent (Needs no help)	Supervision or Limited Assistance (Needs oversight, encouragement or cueing **OR** highly involved in activity but needs assistance)	Extensive Assistance or Totally Dependent (May help but cannot perform without help from staff **OR** cannot do for self at all)
Activities of Daily Living (ADLs)			
(15) Bathing	☐	☐	☐
(16) Dressing	☐	☐	☐
(17) Overall Mobility	☐	☐	☐
(18) Eating	☐	☐	☐
(19) Toilet Use	☐	☐	☐
Instrumental Activities of Daily Living (IADLs)			
(20) Medication Management	☐	☐	☐
(21) Meal Preparation	☐	☐	☐
(22) Housekeeping	☐	☐	☐
(23) Money Management	☐	☐	☐
(24) Using Telephone	☐	☐	☐

(25) Person Completing Form_____ (26) Title_____

(27) Telephone Number (_____)_____-_____ (28) Date Signed _____/_____/_____

(29) ☐ See Attached_____

Part C

Physician's Certification – I attest that this patient no longer requires acute care and is in need of the above services.

(30) Physician's Name_____ (31) Signature_____

(32) Address _____ (33) Phone (_____) _____-_____

_____

_____

(34) Date _____/_____/_____

Part D – To be completed by Agent

(35) Level of Care_____ (36) Days Assigned_____

(37) Authorized Signature_____(38) Date _____/_____/_____

(39) Comments _____

_____

Part E – (Receiving Facility Completes)

(40) Payment Start Date Requested _____/_____/_____ (41) Facility/Agency Name _____

(42) Signature_____ (43) Title_____

(44) Date _____/_____/_____ (45) Bed Hold Days Remaining

Delmarva Foundation of the District of Columbia, Inc.
1620 L Street, N.W.
Suite 1275
Washington, DC 20036
(202) 49-6568 Phone (202) 293-3253 Fax
1-800-469-6851

REFERRAL FOR LONG TERM CARE PLACEMENT

Name_____ DOB_____Age_____

Primary Diagnosis:_____

Secondary Diagnosis:_____

Prognosis:_____

Is patient free of infectious tuberculosis?_____

PPD _____/_____ (Date/Result) CXR_____ (Date)

Goal of treatment:

_____

_____

Medications (List name, dosage, route and frequency)

_____

_____

_____

_____

Examiners Note:

_____

_____

Ears, Note, Throat: _____
Eyes:_____
Teeth:_____
Skin/scars:_____
Heart:_____
Lungs:_____
Abdomen:_____
Extremities:_____
Temperature: _____ Pulse_____Respirations_____BP_____
Weight: _____ Height:_____

Date:_____

Examining Physician:_____
Address:_____

_____

Phone No.:_____