



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 Form (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:

Qlarant Foundation for Medical Care
Long Term Care Department
28464 Marlboro Avenue
Easton, MD 21601-2732
(410) 822-0697
(410) 822-7971 – 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	<input type="checkbox"/> Medical Day Care	<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> CRF	<input type="checkbox"/> Elderly and Physical Disabilities Waiver
(5) Reason for Referral	<input type="checkbox"/> Initial Placement	<input type="checkbox"/> Transfer from NF to NF or Waiver	<input type="checkbox"/> Conversion to Medicaid	
	<input type="checkbox"/> Return within behold			

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(16) Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(17) Overall Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(18) Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(19) Toilet Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Instrumental Activities of Daily Living (IADLs)			
(20) Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(21) Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(22) Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(23) Money Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(24) Using Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(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 <input type="text"/>

Qlarant Foundation Headquarters
28464 Marlboro Avenue
Easton MD 21601-2732
(410) 822-0697 Phone (410) 822-7971 Fax
1-800-999-3362

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.: _____