STATE OF MARYLAND
Department of Human Resources
PROJECT HOME Application

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: _____
Fax #

Is the applicant aware of the referral? ☐ Yes ☐ No

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 Institutuion) _____

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 (facilites, dates of admission and discharge, diagnoses):

Date of last psychiatric appointment: _____

Date of last therapy appoinment: _____

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

VII. MEDICATION INFORMATION

Medication	Dosage	Frequency	Purpose

Current ability to take medication:

Self Medicates Independently:		With Reminders and Supervision	
With Physical Assistance		Non-Compliant	
Uses Inappropritately		Unable to Self Medicate	
Takes OTC's			

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 condictional 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

Chemical Dependency Information

Applicant's Name: _____

Substance	Date of Last Use	Frequency	How Used
Alcohol			
Amphetamines			
Barbituates/Tranquilizers			
Codein			
Cocaine			
Heroin			
Inhalants			
LSD			
Marijuana			
Mescaline			
Methadone			
Morphine			
Opium			
PCP			
Quaaludes			
Tobacco			
Other			
Other			

Please give a brief summary of the applicant's history of chemical dependency treatment (type of treatment - AA, NA, detox, intensive outpatient, long term inpatient, name of facilities). Please include dates of admission and discharge.

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	☐	☐	☐
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Uses Toilet	☐	☐	☐
Gets Out of Bed	☐	☐	☐
Climbs Stairs	☐	☐	☐
Ambulation	☐	☐	☐
Grooming	☐	☐	☐

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:

_____ _____
Print Name Date

_____
Signature, Title

Form must be verified for accuracy by Health Care Practitioner:

_____ _____
Print Practitioner's Name Date

_____
Practitioner's Signature, Title