Dear Colleague,

Thank-you for your interest in the Maitri Residence. Our 15 bed facility is licensed as an RCFCI (Residential Care for the Chronically Ill), providing support to low income people severely debilitated by AIDS, in need of 24 hour nursing care. Our staffing levels are higher than other RCFCI's, 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 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; I work Monday - Friday from 9:30am-5:30pm. If you have colleagues who would like to refer to us, please share a copy this packet with them or contact Maitri for additional copies.

Sincerely yours,

Maitri Compassionate Care
401 Duboce Ave.
SF, CA 94117
415-558-3000
415-558-3010-fax
aheineman@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 finite 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., SF, CA 94117 FAX: 415-558-3010.

3. Each application must include the following:

☐ All fields in pages 3-18 must be completed. Ensuring all insurance information is current, doctor's signature and license # are included. (Exception is page 10; for hospice referrals only.)

☐ Applicant must have a primary MD located in San Francisco. We do not have an MD in house.

☐ **History and Physical and/or discharge summary and/or progress notes**

☐ **Medication list**.

☐ NOTE: Page 8: TB clearance. We require a chest x-ray for admission, however it must be 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 #.)

☐ Provide documented psych. 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 accounted for, 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 INFORMATION:

1. As noted above, we prioritize hospice/end of life applicants.

2. Wait time for a bed varies. Please feel free to call and check on the status of your referral at any time. #415-558-3006.

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 2 weeks, I will call and check in.

CRITERIA FOR ADMISSION

Take a moment to read and fill out this form before filling out our 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.

ADMISSION: REQUIRED CRITERIA.
• All of the following criteria MUST be met in order to become a resident at Maitri.

CRITERIA	√ all	EXCEPTION	REASON
➲ Income is less than $34,800/year	◦ yes ◦ no	One bed is exempt. Call about availability	HOPWA Contract
➲ Has AIDS or Disabling HIV	◦ yes ◦ no	No Exception	Mission /HOPWA/CARE
➲ Over 18 years of age	◦ yes ◦ no	No Exception	Mission /HOPWA/CARE
➲ Capable of signing admissions agreement	◦ yes ◦ no	If impaired must have Power of Attorney, Next of Kin or Conservator	Legal
➲ San Francisco Resident	◦ yes ◦ no	No Exception	HOPWA/CARE Contract
➲ Has San Francisco MD	◦ yes ◦ no	No Exception. MD must be willing to follow applicant while at Maitri.	HOPWA/CARE Contract

ADMISSION: REFERRAL TYPE.
• Some limitations apply. Choose only one.

LEVEL OF CARE REQUIRED:	Choose One:	NOTES	REASON
HOSPICE: ➲ Has 6-12 month prognosis, agreeing to hospice guidelines of palliative care.	◦ yes ◦ no	Hospice care is provided by an outside hospice organization	Maitri Mission/ Staffing Level
END OF LIFE: ➲ Has similar prognosis as hospice, but is choosing to pursue aggressive treatment, needs 24 hour care and significant help with ADL's	◦ yes ◦ no	Skilled needs must be supervised by an outside home health agency. See next section re: care needs and limitations	Maitri Mission/ Staffing Level
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.	◦ yes ◦ no	Must have 24 hour care needs and identify respite goal prior to admission. See next section re: care needs and limitations.	Maitri Mission

ADMISSION: CARE NEEDS; LIMITATIONS APPLY			
CARE NEEDS REQUIRED	**√ all**	**LIMITATIONS TO ADMISSION**	**REASON**
➲ Requires IV	□ yes □ no	Infusions of short duration only (up to 3hrs). Must be done by an outside home health agency	Staffing Level/ Licensing
➲ Requires hemodialysis	□ yes □ no	Can accommodate ONLY if transport is arranged by : ◦ Outside agency or friend/family *AND* ◦ Can go alone *OR … .* ◦ Has friend/family to escort	Staffing Level/ Lack of Resources
➲ Requires 2 person transfer	□ yes □ no	Admission would depend on our ability to care for safely. *No Hoyer lift*	Staffing Level
➲ Requires daily/frequent outpatient treatment visits	□ yes □ no	Can accommodate ONLY if transport is arranged by : ◦ Outside agency or friend/family *AND* ◦ Can go alone *OR … .* ◦ Has friend/family to escort	Staffing Level/ Lack of Resources
➲ Requires daily/frequent lab work	□ yes □ no	Can accommodate if outside home health agency is used to draw labs	RCFCI Licensing
➲ Requires port or line for infusion	□ yes □ no	Can accommodate if outside home health agency will manage and maintain	RCFCI Licensing
➲ Requires suctioning	□ yes □ no	Non-emergency suction only. *No back-up generator*	Staffing Level
➲ Has diagnosis of MRSA or VRE	□ yes* □ no	***MUST** have letter from MD that treatment was successful and is no longer an infection risk to other residents or staff	Infection Control
➲ Has documented psychiatric history	□ yes* □ no □ assess	*If "yes", documentation of psyche history required. If "assess", may need psychological evaluation or housing evaluation from AIDS Health Project.	Safety / Staffing Level
➲ Has history of evictions from other programs	□ yes* □ no □ assess	May require additional info. from other programs.	Safety
➲ Requires sitters/one to one attention	□ yes □ no	Cannot accommodate unless 24 hour sitters are arranged by family or by MediCal Waiver Program	Safety/ Staffing Mode

BARRIERS TO ADMISSION: NO EXCEPTIONS			
CARE NEEDS REQUIRED:	**Answer All**	**EXCEPTION**	**REASON**
➲ Requires restraints	□ yes □ no	No Exception	RCFCI Licensing
➲ Requires peritoneal dialysis	□ yes □ no	No Exception	Staffing Model
➲ Requires TPN	□ yes □ no	No Exception	Staffing Model
➲ Requires ventilator	□ yes □ no	No Exception	Staffing Model
➲ Has tracheostomy tube	□ yes □ no	No Exception	Staffing Model
➲ Has stage III or IV pressure ulcer	□ yes □ no	No Exception	RCFCI Licensing
➲ Requires long term housing placement (Maitri is not long term housing)	□ yes □ no	No Exception	Mission
➲ Requires long term care	□ yes □ no	No Exception	Mission

REFERRAL INFORMATION:		
Referred By:		DATE:
Agency/Hospital:		Phone:
Address:		
Pager:	Fax:	Other:
Other #	Other #	

CLIENT INFORMATION:	
Name:	
Ethnicity:	
DOB:	
SSI #:	
Rent Amount: $	
Address:	
City/St/Zip:	
Phone #:	
Phone #:	
Currently at: □ Home □ Other. Please fill out the following: Facility:	
Rm# Contact:	
Phone:	Pgr:
#:	#:
□ Address is same as referral address above. □ Other address:___________________________	
Does client have a primary Home Care Agency? Y N If yes, please fill out the following: Agency:	
Contact:	
Phone:	Pgr:
VM:	#:

CLIENT INFORMATION:

Does the client have housing applications in place? If so, list.

Do you know of other agencies working w/ the client? Y N (Please provide any contact info. you may have)

PSYCHOLOGICAL INFORMATION:

Psych. history w/ dates: □ DOCUMENTATION ATTACHED

Dx: ____

Psych. Provider:____________________________________

Contact:____________________________________

Phone #:____________________________________

Other#:____________________________________

MEDICAL HISTORY:

NOTE: □ Med list and
□ H&P and/or D/C summary required.

Please provide Medical Dx w/dates; Include recent surgeries, infusions.

Code Status:

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?

SUBSTANCE USE:

Please check one:
□ Active: Used within the last 3 months.
□ Recent: Used within last 3-12 months.
□ Remote: Used one year ago or more.
□ Unknown.
□ No significant substance use (social use, never, etc.)
□ Other.

TYPE OF SUBSTANCE(S) USED:

If actively using:

1. How often:________________________________
2. Approx. date of last use?___________________
3. Interested in treatment? ____________________

If use was recent, but not currently active, what helped the client to stop using?

PLEASE CHECK ALL THAT APPLY

SYMPTOMS:
□ Difficulty Swallowing
□ Difficulty Breathing
□ Nausea/Vomiting
□ Pain
□ Rash/Itching
□ Diarrhea

MOBILITY
□ Independent
□ Assistance
□ Wheelchair
□ Bedbound

MENTAL STATE
□ Clear/oriented

Dementia:
□ Mild
□ Moderate
□ Severe ..

TREATMENT:
□ Radiation
□ Wound Care
□ Oxygen
□ Other:

TOILETING:
□ Independent
□ Assistance
□ Incontinent bladder
□ Incontinent bowel
□ Foley Catheter

SMOKER
□ Yes
□ No

SPECIAL NEEDS:
□ Hearing Impaired
□ Sight Impaired
□ Other

HEALTH CARE PROVIDERS:	INSURANCE:
PRIMARY PHYSICIAN: NAME ____________________ Hospital: ____________________ Address, incl ZIP:____________________ ____________________ Office # Fax# ____________________ Pager #: Other# ____________________ **SECONDARY PHYSICIAN. Include supervising MD if above is not MD.** NAME: ____________________ Address, incl. ZIP: ____________________ ____________________ Office # ____________Fax#____________ Pager #: ____________Other# ____________ **PHARMACY PROVIDING MED'S**: Phone#: FAX#: Are there any obstacles in obtaining medications?	□ **Medi-Cal:** Please provide Medi-Cal BIN #, not Social Security # #:____________________ Issue Date:____________________ □ **MediCare**: .#::____________________ □ **Medicare "D"** please provide Prescription plan: □ **Medicare "D"** How administered: □ **Healthy SF #:**____________________ □ **Private Insurance/Other**: If they have private insurance or are self pay, provide all pertinent info:
FOR RESPITE REFERRALS ONLY:	**DURABLE POWER(S) OF ATTORNEY**
Please let us know what your respite goals are for this applicant; when would you expect them to return home?	Please attach copies of current/active appointee(s) or let us know who to contact for a copy. □ **HEALTH CARE**: □ COPY ATTACHED. Name: ____________________ Address: ____________________ City/St/ZIP:____________________ Work # ____________________ Home #____________________
PERSONAL / FAMILY CONTACTS:	
☞**NAME**:____________________ Relationship:____________#:____________ Address:____________________ City:____________ St._____ Zip__________ ☞**NAME**:____________________ Relationship:____________#____________ Address:____________________ City: ____________St.______ Zip __________	□ **FINANCES**: □ COPY ATTACHED. Name: ____________________ Address: ____________________ City/St/ZIP:____________________ Work #____________________ Home #____________________

HEALTH CARE PROVIDER'S CERTIFICATION OF HIV STATUS/AIDS DIAGNOSIS

To: Physician / Health Care Provider Re: Maitri Application

Admission to Maitri requires this information

NAME OF CLIENT:	
HIV STATUS	**T-CELL / VIRAL LOAD COUNTS**
1. Year first tested HIV positive (if known): ______________ 2. Year first diagnosed with AIDS (if known):_____________ 3. Please check appropriate category: □ Yes □ No HIV+ Asymptomatic □ Yes □ No HIV+ Symptomatic □ Yes □ No Disabling HIV □ Yes □ No HIV+ Asymptomatic □ Yes □ No AIDS Diagnosis □ Yes □ No Disabling AIDS Diagnosis	1. T-Cell Information: a. Date of last count:____________ b. Last count #:________________ 2. NADIR of CD4, if known: ____________ 3. Viral Load Information: a. Date of last count:____________ b. Last count#:_________________

♦ **Required Health Care Provider Information (MD, PA, NA)**

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

X____
Date

X ____
License #

X _______________________________________
Signature of Health Care Provider (MD, PA, NP)

X ____
Print Name

X _______________________________________
Phone #

X ____
Address

DOCUMENTATION OF PULMONARY TUBERCULOSIS STATUS

To: Physician/Health Care Provider Re: Maitri Application

NAME OF CLIENT:
PULMONARY TB TEST
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 patients and staff, the following documentation is required: *CXR DATE: ___________ □ Negative. (For Pulmonary TB) □ Positive. (For Pulmonary TB) * The CXR must be within one month of admission
IF PATIENT HAS ACTIVE PULMONARY TB
Patient must have received continuous treatment for at least 2 weeks and show 3 consecutive negative AFB smears prior to admission Date Treatment Started ______________________ Dates of Negative AFB's 1. ________________ 2. ________________ 3. ___________________

X______________________________________
Date

X ______________________________________
License #

X ____________________________________
Signature of Health Care Provider (MD, PA, NP)

X ______________________________________
Print Name

X ____________________________________
Phone #

X ______________________________________
Address

DOCUMENTATION OF TERMINAL ILLNESS FOR HOSPICE CARE

To: Physician/Health Care Provider Re: Maitri Application

COMPLETE FOR HOSPICE ONLY
PROGNOSIS STATEMENT

I certify that

____

Please print name of applicant

Has a prognosis of six months or less and has elected hospice care. Hospice care is palliative, not curative, in
its goals and techniques. The program emphasizes the alleviation of physical symptoms, including pain, and the identification and meeting of emotional and spiritual needs.

X_______________________________________
Date

X _______________________________________
License #

X _____________________________________
Signature of Health Care Provider (MD, PA, NP)

X _______________________________________
Print Name

X _______________________________________
Address

X _______________________________________
Pager #

X _______________________________________
Phone #

X _______________________________________
Fax #

ADMISSIONS AGREEMENT

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

____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.

____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.

____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.

____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.

____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.

____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.

____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.

____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.

____9. I understand that I may voice my concerns regarding the care provided at Maitri to the Program Director of Maitri.

___10. I understand that pets cannot be kept at Maitri. Arrangements can be made for limited pet visits.

___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.

___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.

___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.

___14. I am a resident of San Francisco or I do intend to reside in San Francisco.

___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.

___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

___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.

___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.

___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.

___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.

___21. I understand I must meet weekly with my appointed Social Worker at Maitri.

___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:

X ______________________________	______________________________	______________
RESIDENT SIGNATURE or DPOA	PRINT NAME	DATE
______________________________	______________________________	______________
FACILITY MANAGER SIGNATURE	PRINT NAME	DATE

MAITRI FINANCIAL INFORMATION

Service Fees are 60% of the resident's monthly income. 30% is dedicated to rent and the other 30% 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

Does applicant utilize money management assistance from a friend, family member, agency or other?	
MONEY MANAGEMENT AGENCY OR OTHER:	**CONTACT INFORMATION:**
Name of agency: ______________________________	Phone: ______________________________
Contact: ____________________________________	Phone: ______________________________
SOURCES OF INCOME:	

MONTHLY SOURCE OF INCOME:	AMOUNT OF INCOME:
SSDI: Social Security Disability Insurance	$
SSI: Supplemental security income	$
Social Security Benefits	$
State Disability Benefits	$
Private Disability	$:
Retirement/Pension	$
Other	$
TOTAL:	$

MONTHLY MEDICAL EXPENSES:

MONTHLY MEDICAL EXPENSES	AMOUNT OF EXPENSE
Insurance Premium	$
Medications	$
Other	$
TOTAL	$

I CERTIFY THAT THE INFORMATION ABOVE IS COMPLETE AND ACCURATE

X ______________________________ X ______________________________________

Date Print Name

X ____

Signature of applicant/DPOA/Immediate Family Member

____

AUTHORIZATION TO OBTAIN FINANCIAL INFORMATION: (Optional)

I hereby authorize Maitri to obtain financial information, if I utilize a money management agency or other, in order to determine my room and services fee.

X ______________________________ X ______________________________________

Date Signature of applicant/DPOA/Immediate Family Member

AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

Please note that separate forms must be used 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.

I, ____ (name), 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.

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.

X ____

*Name of Agency (or Individual) to be contacted

X ____ X ______________

Signature of Client or Representative Date

Please note that separate forms must be used for each specified contact

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.

X ____________________________
Date

X ____
Signature or resident or DPOA

X ____
Print Name

DOCUMENTATION OF HOMEBOUND STATUS

To: Physician/Health Care Provider Re: Maitri Application

NAME OF CLIENT: ____

STATEMENT:

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:
- Specifications: ____
____
____

□ Unlimited Homebound:
- Resident can leave facility on their own, without an escort.

X______________________________ Date

X ______________________________ **License #**

X ______________________________ Signature of Health Care Provider (MD, PA, NP)

X ______________________________ Print Name

X ______________________________ Phone #

X ______________________________ Pager #

PROOF OF SAN FRANCISCO RESIDENCY

To: Physician/Health Care Provider
Re: Maitri Application

NAME OF CLIENT: ____

Maitri's licensing requires all potential residents to reside in San Francisco.

1. Statement:

I, ____
am a resident of San Francisco.

2. Verify residency. Check One:

□ My current address is:

____

____

□ I am HOMELESS in San Francisco.
□ I am unable to verify residency; see #4 below.

3. Provide Proof of residency:

□ I have attached a copy of my California Driver's License
□ I have attached a bill (telephone, cable, etc.) with my address.
□ Proof of residency is unavailable. * Please fill out following section.

4. Proof of residency is unavailable:

Applicant must provide signed statement explaining why they do not have proof of residency. This includes homelessness, lack of identification, former SF residence, returning, etc.

□ I do not have proof of residency due to homelessness.

□ I do not have proof of residency due to: ____

____

____

X ______________________________ X ______________________________
DATE SIGNATURE OF RESIDENT OR DPOA

AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

Please note that separate forms must be used 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 Medi-Cal to obtain information regarding your Medi-Cal benefits.

I, ____(name), hereby give my permission to obtain or disclose Medi-Cal benefit information for the purpose of admission to the Maitri residence. This authorization is valid for the duration of the intake process and one year following date of intake if accepted into Maitri.

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.

✗ ____

*Name of Agency (or Individual) to be contacted

✗ ____

Signature of Client or Representative Date

Please note that separate forms must be used for each specified contact