Maitri

Dear Colleague,

Thank you for your interest in Maitri. 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 know that once medically optimized, residents are expected to return to the community and referrals will be made to the appropriate level of care.

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 Clinical Director of any language accommodation needs.

Maitri

ADMISSION PROCEDURES

We prioritize those in need of hospice/end of life care and fill respite beds after. We do nothave a finite number of hospice/end of life beds vs. respite beds; we triage based on need.

1. **Before beginning the paperwork:**
   Please call **Molly Herzig, Clinical Director at (415) 558-3006** to check on availability ofrooms and review the basics of your client's situation. This may save you a lot of time.

2. **If referral is appropriate, complete application:**
   Fax: 415-558-3010 or Email: **molly.herzig@maitrisf.org** *or* **debra.fila@maitrisf.org**

3. **Required for admission:**

- ☐ ***TB Test completed within 90 days of admission***

  Accepted: PPD skin test; Chest xray; QuantiFERON-TB Gold test.

- ☐ ***COVID-19 Test completed within 3 days of admission***
- ☐ ***Proof of COVID-19 Vaccine (both doses) completed, no exception***

4. **Include additional required information in the application:**

- ☐ ***All pages must be completed.***
- ☐ ***Medication list***
- ☐ ***History and Physical and/or discharge summary and/or progress notes***
- ☐ ***Provide any documented psychiatric/psychological history***
- ☐ ***Provide DPOA or Advanced Medical Directive paperwork***
- ☐ ***Provide a copy of San Francisco DMV ID (or p roof of residency)***
- ☐ ***Provide proof of income (most recent)***
  (Letter from Social Security, bank statement with direct deposit accounted for, or copy of check)
- ☐ ***The 'Physicians Report for Community Care Facilities' MUST be completed by Medical Provider/MD***
  (please see additional attachment)

5. **Upon receipt of the completed application:**
   The Clinical Director and Nurse Case Managers will review the application and discuss appropriateness of applicant for Maitri care. The Clinical Director will contact you to discuss next steps: Either applicant is ineligible based on applicationinformation; additional information may be requested; and an interview date will be scheduled.

6. **Upon acceptance to Maitri:**
   The Clinical Director and/or Nurse Case Managers will inform all involved parties of the admission date and procedures.

Maitri

CRITERIA FOR ADMISSION

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 that apply	EXCEPTION	REASON
➲ Income is less than $63,950/yearly (**2021)**	☐	One bed is exempt. Call about availability	San Francisco, CA HUD Metro FMR Area/HOPWA
➲ HIV+	☐	One bed is exempt, but mustbe hospice	Mission /HOPWA/CARE
➲ Over 18 years of age	☐	No Exception	Mission /HOPWA/CARE
➲ Capable of signing admissions agreement	☐	If impaired must have Power of Attorney, Conservator, or Next of Kin	Legal
➲ San Francisco Resident	☐	No Exception	HOPWA/CARE Contract
➲ Has San Francisco MD	☐	No Exception. **MD must be willing to follow while at Maitri.**	HOPWA/CARE Contract

ADMISSION: REFERRAL TYPE.

- Some limitations apply. Choose only one; **required** to select one.

LEVEL OF CARE REQUIRED:	Choose One:	NOTES	REASON
HOSPICE: ➲ Has 6 month or less prognosis, and agrees to hospice guidelines of palliative care.	☐	Hospice care is provided by outside hospice organizations	Maitri Mission/ Staffing Level
END OF LIFE: ➲ Has similar prognosis as hospice,but is choosing not to elect hospice care, needs 24 hour care.	☐	Skilled needs must be supervisedby an outside home health agency. See next section re: careneeds and limitations	Maitri Mission/ Staffing Level
SHORT TERM RESPITE: ➲ Has acute, 24 hour care needs on ashort term basis. We begin our respite stays at **3 months with disposition plan to return to the community;** we assess for extensions as needed.	☐	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 that apply	LIMITATIONS TO ADMISSION	REASON
➲ Requires IV	☐	Can accommodate only if done by an outside home health agency and generally cannot be of more than 2 hour duration OR must be done at a hospital/clinic	Staffing Level/ Licensing
➲ Requires hemodialysis	☐	Can accommodate ONLY if transport is provided by : ◦ Outside agency or friend/family *OR* ◦ Can go alone	Staffing Level/ Lack of Resources
➲ Requires 2+ person transfer	☐	Admission would depend on our ability to provide care safely	Staffing Level
➲ Requires daily/frequent outpatient treatment visits	☐	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 port or line for infusion	☐	Can accommodate if outside provider or 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, C-Difficile or **COVID-19**	☐	**MUST** have letter from MD that treatment was successful and is no longer an infection risk to other residents or staff	Infection Control
➲ Has mental health issues	☐	*If "yes", documentation of psych history required Or may require psychological	Safety / Staffing Level
➲ Uses an electric wheelchair	☐	Requires additional medical provider information and a signed waiver by resident upon admission at Maitri *(there is a limit of electric wheelchairs allowed at Maitri at one time)*	Safety
➲ Requires sitters/one to one attention	☐	Cannot accommodate unless 24 hour sitters are provided by family	Safety/ Staffing Level

BARRIERS TO ADMISSION: NO EXCEPTIONS FOR PEOPLE NEEDING THE FOLLOWING:

CARE NEEDS REQUIRED:		NO EXCEPTIONS	REASON
➲ Requires peritoneal dialysis	Cannot admit	**No Exception**	Staffing Model
➲ Requires TPN	Cannot admit	**No Exception**	Staffing Model
➲ Requires ventilator	Cannot admit	**No Exception**	Staffing Model
➲ Has tracheostomy tube	Cannot admit	**No Exception**	Staffing Model
➲ Has stage III or IV pressure ulcer	Cannot admit	**No Exception**	RCFCI Licensing
➲ Requires long term care	Cannot admit	**No Exception**	Mission/ contract obligations
➲ Has Parkinson's or Alzheimer's as **primary diagnosis**	Cannot admit	**No Exception**	RCFCI Licensing

Maitri

Referred By:		Date:
Agency/Hospital:		
Address:		
Phone #:	Fax #:	Pager #:
Cell #:	Other #:	

CLIENT INFORMATION:

Name:

Ethnicity/Race:

DOB:

Social Security #:

Rent Amount: $

Address:

City/St/Zip:

Home Phone #:

Cell Phone #:

Currently at: ☐ Home
☐ Other. Please fill out the following:

Facility: Rm#

Contact:

Phone #: Pgr #:

Address:

Does client have a primary Home Healthcare Agency?If yes, please fill out the following:

Agency:

Contact:

Phone #: Fax #:

Does the client have housing applications in place? If so, list. What is the disposition plan for discharge from Maitri?

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

PERSONAL HISTORY:
Please provide relevant personal history (friends/family involved, prior living situation, etc).

Are there any legal matters pending?

Maitri

FOR RESPITE REFERRALS ONLY:

Please let us know what the respite goals are for this applicant for their short-term treatment plan?

PSYCHIATRIC/MENTAL HEALTH HISTORY:

DIAGNOSIS: _____

Currently in Treatment? _____

Provider Name: _____

Provider Phone: _____

ATTACH:

☐ Psychological documentation

☐ History of hospitalizations

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.)

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?

Maitri

HEALTH CARE PROVIDERS:

PRIMARY PHYSICIAN:

NAME _____

Hospital: _____

Address, ZIP: _____

Office #_____ Fax# _____

Pager #:_____ Other# _____

SECONDARY PHYSICIAN or NP. Include supervising MD if above is not primary MD.

NAME: _____

Address, ZIP: _____

Office #_____ Fax#_____

Pager #:_____ Other# _____

PHARMACY:_____

Phone#:_____ FAX#:_____

PERSONAL / FAMILY CONTACTS:

NAME:_____

Relationship:_____ #:_____

Address:_____

City:_____ St._____ Zip_____

NAME:_____

Relationship:_____ #_____

Address:_____

City:_____ St._____ Zip _____

INSURANCE:

□ **Medi-Cal HMO:** _____

#:_____

□ **Medi-Cal**

#:_____

Issue Date:_____

□ **MediCare**:

#::_____

□ **Medicare "D"** Prescription plan information:

_____

□ **Healthy SF #:**_____

□ **Private Insurance/VA/Other**: _____

#_____

DURABLE POWER(S) OF ATTORNEY

Please attach copies of current/active appointee(s) or let us know who to contact for a copy.

□ **HEALTH CARE**: Please attach copy.

Name:_____

Address:_____

City/St/ZIP:_____

Work # _____

Home #_____

□ **FINANCES**: Please attach copy.

Name:_____

Address:_____

City/St/ZIP:_____

Work #_____

Home #_____

Maitri

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: □ HIV+ □ Disabling HIV □ AIDS □ 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 _____ Pager #

Maitri

Documentation of Terminal Illness for Hospice Care

To: Physician/Health Care Provider Re: Maitri Application

COMPLETE FOR HOSPICE REFERRAL 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_____ Phone #

X _____ Pager #

Maitri

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. **PROOF OF INCOME IS REQUIRED**** with application.

Does applicant utilize money management assistance from a friend, family member or agency?	
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	$
RSDI: Social Security Retirement Benefits	$
SDI: State Disability Benefits	$
Private Disability	$:
Private Retirement/Pension	$
Other	$
TOTAL:	$

MONTHLY EXPENSES:

MONTHLY MEDICAL & RENT EXPENSES	**AMOUNT OF EXPENSE**
Insurance Premium	$
Medications /co-pays	$
Rent	$
TOTAL	$

AUTHORIZATION TO OBTAIN FINANCIAL INFORMATION:
I hereby authorize Maitri to obtain financial information in order to determine my room and services fee.

X _____ _____
Signature of applicant or DPOA Print name

_____
Date

****Acceptable proof of income from within the past <u>6 months</u> only:**

Letter from Social Security
Bank Statement
Deposit Record from Money Management Agency
Copy of Check

Maitri

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 providers and to get information about your physical and mental health.

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.

While it is your right to limit or exclude information from disclosure, this authorization is for full <u>disclosure of all records</u>, 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.

Unless otherwise noted, this authorization expires in one year from the date of signature.

_____

*Name of Agency (or Individual) to be contacted

X_____ X _____

Signature of Client or Representative 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:
Maitri Compassionate Care			415-558-3000
ADDRESS: NUMBER	STREET	CITY	
401 Duboce Ave	San Francisco	CA 94117	
LICENSEE'S NAME:	TELEPHONE:	FACILITY LICENSE NUMBER:	
Maitri	415-558-3000	385600064	

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:

COVID-19 (Most recent test): YES NO

INFLUENZA (Most recent test): YES NO

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	**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	**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): State of California - Department of Social Services
Community Care Licensing
851 Traeger Avenue, Suite 360, San Bruno CA 94066

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