Service Requested: Please check one

☐ Gen SNF ☐ SNF Rehab ☐ Positive Care ☐ Acute Rehab ☐ Palliative ☐ Secure Dementia ☐ Respite

LHH ADMISSION APPLICATION COVER LETTER

Thank you for considering Laguna Honda Hospital and Rehabilitation Center. For a successful submission, the documents listed below must be completed and signed, if applicable.

- Referral Criteria Guidelines and Admission Application MUST be completed
- A signed "Financial Agreement for Medi-Cal & SSI Recipients, Private Pay or Commercial Insurance"
- A signed Laguna Honda Rules & Responsibilities
- Medicare Secondary Payer Screening Form completed
- A signed Department of Public Health HIPAA Privacy Notice
- If applicable, a copy of the Conservator, Durable-Power of Attorney or Medical Probate is required
- If available, copy of identification card and insurance cards (i.e. Medicare, Medi-Cal, Blue Cross, and/or commercial insurance

Required supporting documents from hospital settings:

- Current hospital Facesheet/Registration Form
- One week of most current nursing notes and progress notes
- Complete list of current medications and dosages
- Most recent history and physical (progress notes)
- Most recent radiology and/or lab with findings
- PPD within a year unless referral is for Palliative Care/End-of-Life care or Acute Rehabilitation
- If the referral is for Palliative/End-of-Life care or Acute Rehabilitation, submit chest x-ray result in last 30 days
- If the referral is for SNF or Acute Rehabilitation services, most recent PT, OT, and SP notes are required
- If applicable, copy of recent psychiatric and/or neuropsychology testing/results

Exclusion Criteria:

- Communicable disease for which appropriate isolation facilities are not available at LHH
- Person under police hold unless 24-hour guards are provided by the Sheriff's Department
- Active substance Use requiring higher level of care as determined by the admission screening process.
- Mental illness or developmental disability requiring an organized program of active psychiatric intervention, according to Title A of the California Administrative Code, paragraph 278.2(1), (b), (c)
- Ventilator dependent
- Active medical problem requiring ICU care
- Primary psychiatric diagnosis without coexisting dementia or other medical diagnosis requiring SNF or acute care
- Highly restrictive restraints such as 4-point soft.
- Significant likelihood of unmanageable behavior due to:
    - Actively suicidal
    - Dangerous to self or others
    - Violent or assaultive behavior
    - Criminal behavior including but not limited to possession of weapons, drug trafficking,
    - Possession or use of illegal drugs or drug paraphernalia
    - Sexual predation

Required supporting documents from Home and Outpatient Agencies:

- Complete list of current medications and dosages
- Most recent history and physical (progress notes)
- Most recent radiology and/or lab with findings and PPD information

Completed application and supporting medical records will need to be faxed to 415-682-5689 or email lhh.referral@sfdph.org

In compliance with the *Hudman v. Kizer* state regulation, before a person is referred to a distinct-part SNF such as Laguna Honda, all efforts should be made to place the person in a freestanding facility.

Laguna Honda is not a contracted provider with any Medicare or Commercial HMO plan. Referring source must obtain pre-authorization and negotiate rates individually for each admission.

This referral is also available via Internet: www.lagunahonda.org and forms may be duplicated as needed for future use. LHH Admission Application and supporting documents from hospitals must be submitted by via email at lhh.referral@sfdph.org. Referrals from community can be submitted by email, fax 415-682-5689, or by hand.

NOTE: If application packet is NOT completely answered and required supporting documents are NOT attached at the time of referral, please do not send referral. Incomplete application packets will not be processed.

Thank you for your cooperation.

SECTION A: GENERAL SNF AND SNF REHAB REFERRAL CRITERIA GUIDELINE (SKIP TO SECTION B FOR ACUTE REHAB)

Exclusion Criteria strictly include:

- ***Communicable disease for which appropriate isolation facilities are not available at LHH***
- ***Person under police hold unless 24-hour guards are provided by the Sheriff's Department***
- ***Active substance use***

The following are criteria for Skilled Nursing services at LHH.
Please check all applicable boxes.

Daily Skilled Nursing

□ Tracheostomy care & suctioning (unable to independently perform/self-administer secondary to cognitive or physical impairments)
□ Tube feeding (unable to independently perform/self-administer secondary to cognitive or physical impairments)
□ IV therapy (specify below):
  - More than once a day
  - Unable to receive IV therapy in the community

□ Total Parenteral Nutrition (TPN) – standard formulation only
□ Blood Sugar Checks that cannot be managed in the community (specify below):
  - Unable to independently perform/self-administer secondary to cognitive or physical impairments
  - Unstable (requires frequent medication adjustment)

□ Dressing changes of postsurgical wounds and skin lesions (specify below):
  - Unable to independently perform secondary to cognitive or physical impairments AND must be more than once a day dressing change

Continuous Close Observation (that cannot be managed in the community)

□ Medical condition requiring monitoring of (specify below):
  - Vital signs every 8 hours by a licensed clinical staff
  - Daily intake and output by a licensed clinical staff
  - Pain control needs on a continuous basis for terminally ill patients

□ Medication management requiring clinical assessment, evaluation and Directly Observed Therapy (DOT) for treatment of (specify below):
  - Hepatitis C
  - HIV/AIDS
  - Chemotherapy

□ Daily supervision for safety and elopement behavior secondary to dementia-related cognitive limitations requiring a secure unit

Rehabilitation Services and Training in Self-Care Activities

□ To facilitate discharge planning (e.g. gait and ambulation training, self-administration of medications, colostomy care, etc.)
□ Daily assistance with ADLs secondary to physical or mental impairments that exceeds what can be arranged with community services (must have three or more items listed below needing extensive to total assistance; specify below):
  - Assistance with mobility
  - Eating
  - Dressing
  - Toileting
  - Personal hygiene

- □ **For SNF Rehab:** Physical Therapy 5 times/week and additional rehabilitation services (OT/SP).
- □ **Secure Memory Care**
    - Residents who are mobile;
    - Residents assessed by a physician as having serious cognitive impairment which prevents the resident from making medical decisions for him/herself;
    - Residents assessed by clinical staff as being at risk for unsafe wandering or elopement; and
    - Resident who has a conservator or surrogate decision maker that agrees to placement of the resident in a secured setting, or who is a ZSFG patient or LHH resident with a conservatorship proceeding pending and the intended conservator does not disagree with placement of the resident in a secured setting.

If NONE of the above criteria are selected, DO NOT PROCEED with the application.
The applicant/patient does not meet skilled nursing criteria for admission.

SECTION B: ACUTE REHABILITATION REFERRAL CRITERIA GUIDELINE

The following are criteria for ACUTE REHABILITATION services at LHH.

- □ Patient requires Physical Therapy AND treatment by one or more of the following disciplines:
    - Occupational Therapy
    - Speech Therapy
- □ Documentation supports that patient is participating and progressing in therapy
- □ Documentation supports that the patient will be able to tolerate 3 hours of therapy per day
- □ A discharge disposition has been identified and is available at the time of completion of acute rehabilitation

ALL elements above MUST be met for acute rehabilitation candidacy. If not all elements are made, consider Section A.

LHH cannot adequately care for prospective residents with the following:

- Communicable diseases for which isolation rooms are unavailable
- In police custody unless approved by CMO, CEO, Chief Nursing Officer (CNO) or designees
- Ventilator
- Medical problem requiring Intensive Care Unit care
- Primary psychiatric diagnosis without coexisting dementia or other medical diagnosis requiring SNF or acute care
- Highly restrictive restraints
- Significant likelihood of unmanageable behavior endangering the safety or health of another resident, such as:
    - Actively suicidal
    - Violent or assaultive behavior
    - Criminal behavior including but not limited to possession of weapons, drug trafficking, possession or use of illegal drugs or drug paraphernalia
    - Sexual predation
    - Elopement or wandering not confinable with available elopement protections

ALL FINANCIAL AND MEDICAL INFORMATION MUST BE COMPLETED AND SUPPORTING DOCUMENTS SUMITTED FOR REFERRAL REVIEW

SECTION I: APPLICANT/PATIENT'S INFORMATION AND DEMOGRAPHIC

Last Name:	First Name:	MI:
Date of birth: Birthplace:	SSN:	Gender: Age:
Ethnicity/Race:	Marital Status:	If married, name of spouse:
Street Address:	City:	State and Zip Code:
Primary Phone:	Alternate Phone:	Religious Preference:
Speaks English: □ Yes □ No	Preferred Language:	Resident of City & County of San Francisco: □ Yes □ No
Nearest Relative:	Address:	
Phone:	Email:	Relationship:
Emergency Contact:	Phone:	

Decision maker: □ Self If applicant/patient cannot make decisions, indicate individual who can make decision: □ Family □ Surrogate □ Conservator □ DPOA Name _____ TYPE: □ Medical □ Financial □ Both	Address: Phone:
Applicant's prior living situation:	

SECTION II: ELIGIBILITY INFORMATION

Government Insurance Benefits

Medicare Eligible □ Yes □ No ID Number _____

Medi-Cal Eligible □ Yes □ No ID Number _____

Presumptive Medi-Cal □ Yes □ No ID Number _____

If Presumptive Medi-Cal – Submit a copy of Medi-Cal Application with all verifications.

Commercial Insurance/HMO

Carrier Name _____ Policy/Group # _____

Contact Name _____ Phone _____

Name of Insured _____ Union local, if applicable _____

	Patient	Spouse/Domestic Partner
Employer/Source of Income		
Employer Address		
Employer Phone #		
Monthly Income		

Assets: _____

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SECTION III: LEVEL OF CARE REQUEST

Service Requested *(SELECT ONE)*

□ General SNF
□ SNF Rehabilitation
□ Positive Care
□ Respite - Dates _____

□ Acute Rehabilitation
□ Palliative Care
□ Secure Dementia Unit

(Please be advised that the permitted Respite Care stay is up to a maximum of 4 weeks per admission and a maximum of 6 weeks per year. If accepted, admission day may be a day or few days before or after requested date.)

Referring Facility _____ Date of Referral _____

Discharge Planner _____

Phone _____ Pager _____

Email : _____

Patient/Applicant's Current Level of Care

□ **SNF** □ **Acute** □ **Acute Rehab** □ **Home** □ **Custodial** □ **ER**

If applicant is in skilled nursing facility now, please also indicate acute dates below:

SNF Admission Date_____Acute Admission Date_____ ER Admission Date: _____

SECTION IV: MEDICAL INFORMATION

Current Diagnoses: **Discharge plan:**	**Medical History:** **Surgical History:** **Allergies:** ○ **Full Code** ○ **DNR/DNI** **Other:**		
REQUIRED INFORMATION (SKILLED NEEDS)	**Description(s)**	**Frequency**	**Anticipated End/DC Date**
Example: IV antibiotics	*Vanco 1gm for MRSA*	*q8hrs*	*3 weeks – by 6/10/13*
IV Antibiotics Treatment(s) □**N/A** □**Yes** □**No** □ID Rec: (COPY needed) **TPN (standard formulation only)** □**N/A** □**Yes** □**No** □Copy of TPN order	**Drug(s):** **Type of IV line(s):** **Peripheral** **PICC line** _____ **Other Line(s):** _____		**Start Date:** **End Date:**

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Wound Care Treatment(s) □**N/A** □**Yes** □**No** □Copy of Wound/ Note:	**Type(s):** **Location(s):** **Size(s):** **Treatment(s):** □**Wound Vac**		
Rehabilitation □**N/A** □**Physical Therapy (REQUIRED)** **Participating** □**Yes** □**No** □**NWB** **Duration:** _____ □Copy of Rehab Eval (PT/OT/SP) and recent notes (within 3 days)	**Current Status:** **PT: ____X/week** **OT: ____X/week** **ST: ___X/week**	**Rehab Plan:** **PT:____/week** **OT:____/week** **ST:____/week**	**Start Date:** **End Date:**
Tube(s) and Drain(s) □**N/A** **Management, includes foley, catheters, feeding tubes** □**Yes** □**No**	**Type(s):**		
Tracheostomy care □**N/A** □**Yes** □**No** Copy of RT & Nursing suctioning records	**Shiley #:**_____ □**Cuffed** □**Un-cuffed** □**Inflated** **Rationale:** _____ □**Deflated**	**Suction Frequency:**	
O2 Requirement: □**N/A** □**Yes** □**No** O2 System: _____ O2 sat: _____ □CPAP □BiPAP □EZPAP Settings:_____		□**Hemodialysis** □**N/A** Schedule: Location: Access:	
Other Skilled Needs: □**N/A**			
Special Equipment: □**Yes** □**N/A** □Bariatric □Special Mattress/Bed □CPM □Other (specify):_____ □DME (specify): _____			
Information should be within 7 days:			
Describe Behavior(s): Antipsychotic Medications: □Coach □N/A □Rounding q____hour N/A □PPD date: _____ PPD results:_____ □If PPD, or Palliative/End-of-Life or Acute Rehab referral, provide CXR(within 30 days) Date and Result:	Date: Date: WBC: / WBC: H/H: / H/H: Na: / Na: K: / K: BUN: / BUN: Cr: / Cr:	Weight: Height: Bowel: □Continent □Incontinent Bladder: □Continent □Incontinent	Vital Signs Date: Temp: HR: RR: BP: O2: Pain:

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Precautions: □N/A □Contact □Negative Pressure Isolation □Low Isolation
Type of infection(s): □VRE □C-Diff, stool type: _____ □MRSA □ESBL □TB □CRE □Lice
□Bed bugs □Scabies □Other:_____Specify Site:_____
Travelled outside of US in past 12 months: □Yes □No. If YES, indicate where:_____
Have you had a close contact with a person known to have 2019-nCoV **illness** □ Yes □ No
Have you had a fever or symptoms of lower respiratory illness in the past 14 days? □ Yes □ No

Current Description of ADLs Needs (check applicable box)

ADLS	Independent	Assisted	Dependent
Bathing	□	□	□
Feeding	□	□	□
Walking	□	□	□
Dressing	□	□	□
Toileting	□	□	□
Transferring	□	□	□
Turning and Positioning	□	□	□

SECTION V: BEHAVIORAL INFORMATION

	YES	NO
A. Criminal History	□	□
B. Is applicant a Registered Sex Offender	□	□
C. Does applicant have history of use of weapons	□	□
D. Does applicant have history of property destruction	□	□
E. Is applicant currently on □parole □probation; or has □existing warrant	□	□
F. Does applicant have history of fire setting	□	□
G. Psychiatric Condition or Mental Health Diagnosis_____	□	□
H. Suicidal Ideation If YES, □Presently □In the Past	□	□
I. Is applicant on restraints If YES, type:	□	□
J. Does applicant have a sitter/coach If YES, rationale:	□	□
Answer K-M, based on past 30 days		
K. Aggressive/assaultive/combative/or intrusive behavior	□	□
L. Noisy or disruptive	□	□
M. Elopement risk	□	□
N. Psychiatric Hold (5150, 5250)	□	□
O. Substance Use Disorder History: Specify type Alcohol_____ Drugs _____ Currently using at time of hospitalization _____	□	□
P. Smoker: If YES, □Presently □In the Past	□	□

ADDITIONAL COMMENTS/INFORMATION

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