Service Requested – <u>Please check one:</u>

□ Acute Rehab □ SNF Rehab/Skilled Nursing □ LTC: Positive Care □ LTC: Palliative
□ LTC: Secure Dementia □ General LTC □ Respite

LHH ADMISSION APPLICATION COVER LETTER

Thank you for considering Laguna Honda Hospital and Rehabilitation Center (Laguna Honda or LHH). 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 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.
- Advance Directives or POLST (if applicable).
- One month of most current nursing notes, physician progress notes, and RT/RD/Wound Care notes (if applicable).
- Complete list of current medications and dosages.
- Completed PASRR screening Level 1 or Level 2 with determination letter/GGRC Level 2 PASRR summary report (if applicable).
- Most recent history & physical and progress notes.
- Most recent radiology and/or lab with findings.
- PPD requirement
    - Single step PPD within 90 days if previous negative PPD documented within 12 months.
    - Two step PPD if no known previous positive and no previous testing within 12 months. First step testing should be applied prior to admission to LHH. If negative, second step should be applied no later than 3 weeks from first step testing. (Okay for LHH to apply 2nd step if needed).
- Chest X-ray requirement
    - Chest X-ray is required for positive PPD result or known previous positive PPD or history of active TB.
    - If the referral is for Acute Rehabilitation, submit chest x-ray result in last 90 days.
- If the referral is for SNF or Acute Rehabilitation services, most recent PT, OT, and SLP 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.
- IV Antibiotics more frequently than Q6H.
    - Q6H antibiotic frequency will require special review by medical staff.
- Any restraint not used for postural support for SNF and LTC.
- 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, illicit drug selling or purchasing,
    - Possession or use of illegal drugs or drug paraphernalia
    - Sexual predation
    - Elopement or wandering not confinable with available elopement protection except for secure memory care

Required supporting documents from Home and Outpatient Agencies:

- Complete list of current medications and dosages
- Most recent history & physical and progress notes within the last 6 months
- Most recent radiology and/or lab with findings and PPD information within 3 months

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: LTC AND SNF REHAB/ SKILLED NURSING REFERRAL CRITERIA GUIDELINE (SKIP TO SECTION B FOR ACUTE REHAB)

Please see page 1-2 for exclusion criteria

The following are criteria for 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):
  - 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).
- □ Wound care: Pressure ulcers, postsurgical wounds, and skin lesions (specify below):
  - Unable to independently perform secondary to cognitive or physical impairments.

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
  - TB
  - 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 conditions 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.
- 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 Occupational Therapy treatment with the following optional discipline:
  - 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 all elements are NOT met, 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 the Chief Executive Officer/ Nursing Home Administrator, Chief Medical Officer/Medical Director, Directors of Nursing 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.
- Any restraint not used for postural support for SNF and LTC.
- 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, illicit drug selling or purchasing, 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 SUBMITTED 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 □ Placement (check all that apply)	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: _____

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

SECTION III: LEVEL OF CARE REQUEST

Service Requested *(SELECT ONE)*

□ LTC: Positive Care
□ LTC: Palliative Care
□ LTC: Secure Dementia Unit
□ General LTC

□ Acute Rehabilitation
□ SNF Rehabilitation/Skilled Nursing
□ Respite-Dates_____

(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 Plan _____
_____
Case Manager _____
Phone _____ Fax _____
Email _____

Was the patient admitted to Skilled Nursing Facility in the last 30 days? □ Yes □ No
Was the patient admitted to Skilled Nursing Facility in the last 60 days? □ Yes □ No

If yes to any of the above questions, please provide the following:

- Date of Admission: _____
- Name of the Skilled Nursing Facility Admitted to: _____
- Please specify how many Medicare SNF days were used / remaining:
  - _____ days used
  - _____ days remaining

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:	**Medical History:** **Surgical History:** **Allergies:** ○ **Full Code** ○ **DNR/DNI** ○ **Advance Directive or POLST (if applicable)**

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

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/Meds 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:**
Wound Care Treatment(s) **□N/A** **□Yes □No** □Copy of Wound/ Note:	**Type(s):** **Location(s):** **Size(s):** **Treatment(s):** **□Wound Vac Setting _____**		
Rehabilitation **□N/A** **□Physical Therapy (REQUIRED)** **Participating □Yes □No □NWB** **Duration:** _____ □Copy of Rehab Eval (PT/OT/SP) and recent notes (within 2 weeks)	**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, and feeding tubes.** **□Yes □No**	**Type(s):**		
Oral suctioning **□Yes □No**	**Suction Frequency:**		
Tracheostomy care **□N/A** **□Yes □No** Copy of RT & Nursing suctioning records	**Shiley #:_____** **□Cuffed □Un-cuffed** **□Inflated** **Rationale: _____** **□Deflated**	**Suction Frequency:**	

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

O2 Requirement: □**N/A** □**Yes** □**No** sat:
O2 System: _____ O2_____
□CPAP □BiPAP □EZPAP
Settings: _____LPM _____

□**Hemodialysis** □**N/A**
Schedule: _____
Location: _____
_____
Access Site & Type:
_____
Transportation: _____

Other Skilled Needs:
□**N/A**

Special Equipment: □**Yes** □**N/A**
□Bariatric □CPM □Special mattress/bed (specify)
□ DME (specify) □Other (specify)

Information should be within 7s: day

Describe Behavior(s):

Antipsychotic Medications:

□Coach □N/A
□Rounding q_____hour N/A

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:

	Positive (Check if Positive)	**Negative** (Check if Negative)
Single step PPD within 90 days if previous negative PPD documented within 12 months (Waived for Acute Rehab referrals) Date_____ Result:_____ Date_____ Result_____		
Two step PPD if no known previous positive and no previous testing within 12 months. First step testing should be applied prior to admission to LHH. If negative, second step should be applied no later than 3 weeks from first step testing. (Okay for LHH to apply 2nd step if needed). 1st test date: _____ Result: _____ 2nd test date:_____ Result: _____		
CXR in the past 90 days: Date: _____ Result:_____ (Required for Positive PPD result or known previous positive PPD or hx of active TB or Acute Rehab referral)		

Precautions

□N/A □Contact □Negative Pressure Isolation □Low Isolation
Type of infection(s): □VRE □C-Diff, stool type: _____ □MRSA □ESBL □TB □CRE □Lice
□Covid Date of PCR or Antigen test: _____
□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 Covid illness □ Yes □ No

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

Have you had a fever or symptoms of lower respiratory illness in the past 14 days? □ Yes □ No

Vaccination

Influenza Date(s): _____
Pneumonia:
Specify_____ Date(s): _____
Covid Date(s): _____

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

PASRR: Completed □ Yes □ No
Level 1 _____
Level 2 with determination letter / GGRC Level 2 PASSR Summary Report _____

	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. Does applicant have history of endangerment or harm to others?	□	□
F. Is applicant currently on □parole □probation; or has □existing warrant	□	□
G. Does applicant have history of fire setting	□	□
H. Psychiatric Condition or Mental Health Diagnosis_____	□	□
I. Suicidal Ideation If YES, □Presently □In the Past	□	□
J. Is applicant on restraints If YES, type:	□	□
K. Applicant □ has a Sitter/Coach □ on Frequent rounding If YES, Indicate Rationale:_____ Frequency:_____ Duration:_____	□	□
L. History of fall: Last fall date:_____ Injury: □Yes □No If Yes, specify_____	□	□
Answer M-S, based on past 30 days		
M. □ Aggressive □ Assaultive □ Combative □ Intrusive	□	□

N. Noisy or disruptive Specify: _____	☐	☐
O. Wanderer	☐	☐
P. Elopement risk	☐	☐
Q. Psychiatric Hold (5150, 5250)	☐	☐
R. Substance Use Disorder History:	☐	☐
Alcohol: Specify Type _____	☐	☐
Drugs: Specify Type _____	☐	☐
Currently using at time of hospitalization If not, when was last used: _____ On treatment: ☐ YES ☐ NO	☐	☐
S. Smoker: If YES, ☐Presently ☐In the Past ☐Unsafe smoking behaviors Specify:_____	☐	☐

ADDITIONAL COMMENTS

HEALTHCARE FACILITY TRANSFER FORM

Use this form for all transfers to an admitting healthcare facility.

Affix patient labels here.

Patient Name (Last, First):		
Date of Birth:	MRN:	Transfer Date:
Receiving Facility Name (if known): _____ Contact Name (optional): _____ Contact Phone (optional): _____		
Sending Facility Name: _____ Contact Name: _____ Contact Phone: _____		

PRECAUTIONS

Patient currently on precautions?	If yes, check all that apply:
☐ **Yes** ☐ **No**	☐ Airborne ☐ Contact ☐ Droplet ☐ Enhanced Standard*

*Long-term care facilities may implement Enhanced Standard Precautions (www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/ESP.aspx) for patients with multidrug-resistant organisms (MDROs) or risk factors for transmission, i.e., gown and glove use for high-contact care activities; such patients may be on Contact Precautions in acute care settings.

ORGANISMS (Include copy of **lab results** with organism ID and antimicrobial susceptibilities.)

☐ **Patient is NOT known to be colonized or infected with any multidrug-resistant or other organisms requiring precautions (*skip section*)**

☐ **Patient has MDRO or other lab results requiring precautions** (record organism(s), specimen source, collection date)

☐ **Exposed to MDRO/other** (record organism(s) and last date(s) of exposure if known)

Organism	Carbapenemase (if applicable)**	Source	Date
☐ *Candida auris* (***C. auris***)			
☐ *Clostridiodes difficile* (***C. diff***)			
☐ *Acinetobacter*, multidrug-resistant (e.g., **CRAB****)			
☐ Carbapenem-resistant Enterobacterales (**CRE****)			
☐ *Pseudomonas aeruginosa,* multidrug-resistant (e.g., **CRPA****)			
☐ Extended-spectrum beta-lactamase (**ESBL**)-producer			
☐ Methicillin-resistant *Staphylococcus aureus* (**MRSA**)			
☐ Vancomycin-resistant *Enterococcus* (**VRE**)			
☐ No organism identified (e.g., molecular screening test**)			
☐ **Other, specify**: (e.g., SARS-CoV-2 (COVID-19), lice, scabies, disseminated shingles (*Herpes zoster*), norovirus, influenza, tuberculosis)			

**Note specific carbapenemase(s) (e.g., NDM, KPC, OXA-23) if known

Affix patient labels here.

CLINICAL STATUS

Patient has any of the following symptoms or clinical status?

☐ **Yes** ☐ **No**

If yes, check all that currently apply:

☐ Cough/uncontrolled respiratory secretions
☐ Vomiting
☐ Acute diarrhea or incontinent stool
☐ Incontinent of urine
☐ Total dependence for activities of daily living
☐ Rash consistent with an infectious process (e.g., vesicular)
☐ Draining wounds [§]
☐ Other uncontained bodily fluid/drainage

ANTIBIOTICS/ANTIFUNGALS

Patient is currently on antibiotics/systemic antifungals?

☐ **Yes** ☐ **No**

If yes, specify:

Antibiotic/Antifungal	Dose	Frequency	Indication	Start Date	Stop Date

DEVICES [§]

Patient currently has any of the following devices?

☐ **Yes** ☐ **No**

If yes, check all that currently apply:

☐ Central line/PICC, Date inserted:
☐ Hemodialysis catheter
☐ Fecal management system
☐ Percutaneous gastrostomy feeding tube
☐ Wound VAC
☐ Tracheostomy
☐ Urinary catheter, Date inserted:
☐ Suprapubic catheter
☐ Mechanical ventilation

IMMUNIZATION STATUS

Patient received immunizations (e.g., Pneumococcal, Influenza, COVID-19) in the past 12 months? (Attach immunization record, if available.)

☐ **Yes (specify below)** ☐ **No**

Vaccine	Date(s)

[§] Risk factors for MDRO transmission per Enhanced Standard Precautions (www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/ESP.aspx)