MedStar Good Samaritan Hospital

Senior Housing and Supportive Services

Belvedere Green & Woodbourne Woods

PHYSICIAN'S HEALTH REPORT

This information is required in order to determine my ability to live in an independent setting or if I would require the services provided by the Senior Supportive Services Program such as daily meals, weekly housekeeping, and personal assistance. Senior Supportive Services (Congregate Housing Services) is designed to help the more frail independent person with activities of daily living. Services are provided in a non-medical setting and the program does not provide 24 hour assistance.

"Congregate Housing Services" include congregate meals, housekeeping, laundry, personal assistance services, and service management provided in an apartment building. Services are to promote independent living for an individual 62 years old or older (and, if applicable, a spouse who is 55 or older) who has temporary or periodic difficulty with one or more essential activities of daily living such as feeding, bathing, grooming, dressing, or transferring.

_____ is applying to the Congregate Housing Services Program and has given his/her consent (see attached authorization to release health information) for you to provide us the following medical information. I understand that any information provided by my physician to the Management of Belvedere Green/Woodbourne Woods will be treated with the strictest confidentiality.

The Management of Belvedere Green/Woodbourne Woods recognizes that not all applicants are applying for Congregate Housing Services, and that will be reviewed upon receipt of the completed application.

_____
Signature of Applicant

_____
Address

_____
City/State/Zip Code

_____
Date

BELVEDERE GREEN
1651 East Belvedere Ave.
Baltimore, MD 21239

WOODBOURNE WOODS
1650 Woodbourne Ave.
Baltimore, MD 21239

Phone: 410-433-7255
TTY: 410-323-1794
web: www.MedStarGoodSam.org

EQUAL HOUSING OPPORTUNITY

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Re:_____

Dear Doctor:

The above applicant has applied for residence at Belvedere Green/Woodbourne Woods and identified you as his/her primary physician and gave his/her consent for you to provide the necessary medical information to us.

1. Please list <u>all</u> physical health and mental health diagnoses the applicant is receiving treatment for <u>at the present time</u>.

   _____

   _____

   _____

   _____

2. Please list all prescription drugs the applicant is currently taking.

   _____

   _____

   _____

   _____

   _____

   _____

   Does the applicant require assistance with medications? _____ NO _____YES

   If **YES**, check what applies: ____ Periodic Supervision _____ 24 Hour Supervision

   _____ Measuring _____ Reminding _____ Administering ___ Other

   – if "Other" please explain.

   _____

   _____

3. How many times have you seen this patient during the past 12 months other than as a hospitalized inpatient? _____

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4. During the past 12 months, how many times has this patient been hospitalized? _____

5. Date of latest hospitalization: _____

   What was the reason for the last hospitalization, and is there any significant information regarding this stay?

   _____

   _____

   _____

6. How would you rate this patient's overall physical health at the present time?

   _____ Excellent _____ Good _____ Fair _____ Poor

7. How would you rate this patient's overall mental health at the present time?

   _____ Excellent _____ Good _____ Fair _____ Poor

8. What type of assistance do you feel this person would need to live alone in an apartment?

   Please check all that apply.

   A. Help with Personal Care:

   _____ Eating _____ Dressing _____ Bathing _____ Using toilet

   _____ Bladder/bowel control _____ Other: _____

   B. Help with Mobility: _____ Bed/chair transfer _____ Walking

   _____ Other: _____

   C. Homemaker Services: _____ Housekeeping _____ Laundry _____ Meals

   _____ Other: _____

   D. Does the applicant need more than one hour of any of these services weekly?

   _____ NO _____YES

   If YES, please specify: _____

   E. Does the applicant require: Preparation of Meals _____ NO _____YES

   F. Does the applicant require: Personal Care Services _____ NO _____YES

   G. Does this applicant require 24-hour supervision? _____ NO _____YES

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9. If you have any additional information that is pertinent to the well-being of this applicant, please provide the information below:

_____

_____

_____

_____

_____

Thank you for your assistance.

_____
Physician's Signature

_____
Office Address

_____
City/State/Zip Code

_____
Telephone Number

_____
Date

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I _____ (*applicant or participant name*) hereby authorize _____ (*physician or medical practice name*) to release the health information necessary to fully and accurately complete the attached Congregate Housing Services Program's Physician's Health Report.

My address is:_____
My phone number is: _____
My date of birth is: _____

The congregate housing services provider to which my health information is to be released is:
Name: Management of Belvedere Green/Woodbourne Woods
Address: 1651 E. Belvedere Ave., Baltimore, MD 21239
Phone #: (410) 433-7255

If necessary in my physician's judgment to fully and accurately complete the attached Congregate Housing Services Program's Physician's Health Report, I specifically authorize information about the following to be released under this authorization: (*initial each)*

_____ HIV/AIDS,
_____ Mental health records, and
_____ Drug/alcohol abuse treatment.

This authorization will expire one year from the date it is signed unless a shorter time is indicated here: _____

I understand:

1. That this authorization is voluntary, but I will not be permitted into the Congregate Housing Services Program if I do not complete it.
2. I may receive a copy of this form.
3. I may inspect my protected health information without signing this form.
4. This authorization may be revoked by me at any time, except to the extent that action has been taken prior to receipt of revocation. To revoke this authorization, I understand I must notify _____ (*physician or medical practice name*) in writing.
5. That once information covered by this authorization has been disclosed, COMAR 32.03.04.13.D precludes the congregate housing services provider from re-disclosing the information to any person or agency other than me, my contact person or legal representative, or the Maryland Department of Aging's authorized employees unless:
   (a) I consent in writing to the disclosure; or
   (b) State or federal law or a court order otherwise requires or permits the disclosure.

_____ _____
Applicant or Personal Representative's Signature Date

_____ _____
Witness Signature Date

If signature is other than applicant, explain your authority to act for the applicant (e.g. guardian, health care agent, etc.):

_____
_____