



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

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

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 lh.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)**

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
- Injections (more than once a day AND unable to independently perform/self-administer secondary to cognitive or physical impairments)
- 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
 - Wound requires daily clinical assessment

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 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Preferred Language:	Resident of City & County of San Francisco: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Nearest Relative:		Address:		
Phone:	Email:	Relationship:		
Emergency Contact:		Phone:		
Decision maker: <input type="checkbox"/> Self If applicant/patient cannot make decisions, indicate individual who can make decision: <input type="checkbox"/> Family <input type="checkbox"/> Surrogate <input type="checkbox"/> Conservator <input type="checkbox"/> DPOA Name _____ TYPE: <input type="checkbox"/> Medical <input type="checkbox"/> Financial <input type="checkbox"/> 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: _____



SECTION III: LEVEL OF CARE REQUEST

Service Requested (SELECT ONE)

- | | |
|--|---|
| <input type="checkbox"/> General SNF | <input type="checkbox"/> Acute Rehabilitation |
| <input type="checkbox"/> SNF Rehabilitation | <input type="checkbox"/> Palliative Care |
| <input type="checkbox"/> Positive Care | <input type="checkbox"/> Secure Dementia Unit |
| <input type="checkbox"/> 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 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:	Medical History:		
Discharge plan:	Surgical History:		Allergies:
	<input type="radio"/> Full Code	<input type="radio"/> DNR/DNI	Other:
REQUIRED INFORMATION (SKILLED NEEDS)	Description(s)	Frequency	Anticipated End/DC Date
<i>Example: IV antibiotics</i>	<i>Vanco 1gm for MRSA</i>	<i>q8hrs</i>	<i>3 weeks – by 6/10/13</i>
IV Antibiotics Treatment(s) <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ID Rec: (COPY needed)	Drug(s):		Start Date:
TPN (standard formulation only) <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Copy of TPN order	Type of IV line(s): Peripheral PICC line _____ Other Line(s): _____		End Date:



Wound Care Treatment(s) <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Copy of Wound/ Note:	Type(s): Location(s): Size(s): Treatment(s): <input type="checkbox"/> Wound Vac														
Rehabilitation <input type="checkbox"/> N/A <input type="checkbox"/> Physical Therapy (REQUIRED) Participating <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NWB Duration: <input type="checkbox"/> 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) <input type="checkbox"/> N/A Management, includes foley, catheters, feeding tubes <input type="checkbox"/> Yes <input type="checkbox"/> No	Type(s):														
Tracheostomy care <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No Copy of RT & Nursing suctioning records	Shiley #: _____ <input type="checkbox"/> Cuffed <input type="checkbox"/> Un-cuffed <input type="checkbox"/> Inflated Rationale: _____ <input type="checkbox"/> Deflated	Suction Frequency:													
O2 Requirement: <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No O2 System: _____ O2 sat: _____ <input type="checkbox"/> CPAP <input type="checkbox"/> BiPAP <input type="checkbox"/> EZPAP Settings: _____	<input type="checkbox"/> Hemodialysis <input type="checkbox"/> N/A Schedule: Location: Access:														
Other Skilled Needs: <input type="checkbox"/> N/A															
Special Equipment: <input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> Bariatric <input type="checkbox"/> Special Mattress/Bed <input type="checkbox"/> CPM <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> DME (specify): _____															
Information should be within 7 days:															
Describe Behavior(s): Antipsychotic Medications: <input type="checkbox"/> Coach <input type="checkbox"/> N/A <input type="checkbox"/> Rounding q____hour N/A <input type="checkbox"/> PPD date: _____ PPD results: _____ <input type="checkbox"/> If PPD, or Palliative/End-of-Life or Acute Rehab referral, provide CXR(within 30 days) Date and Result: 	Date: Date: <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">WBC:</td> <td style="width:50%;">WBC:</td> </tr> <tr> <td>H/H:</td> <td>H/H:</td> </tr> <tr> <td>Na:</td> <td>Na:</td> </tr> <tr> <td>K:</td> <td>K:</td> </tr> <tr> <td>BUN:</td> <td>BUN:</td> </tr> <tr> <td>Cr:</td> <td>Cr:</td> </tr> </table>	WBC:	WBC:	H/H:	H/H:	Na:	Na:	K:	K:	BUN:	BUN:	Cr:	Cr:	Weight: Height: Bowel: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent Bladder: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent	Vital Signs Date: Temp: HR: RR: BP: O2: Pain:
WBC:	WBC:														
H/H:	H/H:														
Na:	Na:														
K:	K:														
BUN:	BUN:														
Cr:	Cr:														



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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turning and Positioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION V: BEHAVIORAL INFORMATION

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

ADDITIONAL COMMENTS/INFORMATION
