

**STATE OF MARYLAND**  
Department of Human Resources  
**PROJECT HOME Application**

Application for Project Home

Today's Date: \_\_\_\_\_

**I. IDENTIFYING INFORMATION:**

Applicant's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Current Address: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN#: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Name of Spouse or Significant Other: \_\_\_\_\_

Phone #: \_\_\_\_\_

Emergency Contact Information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_ Secondary Phone #: \_\_\_\_\_

Legal Guardian:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_ Secondary Phone #: \_\_\_\_\_

**II. Current Living Situation**

Alone  Yes  No

Homeless/Shelter  
Name: \_\_\_\_\_ Phone # \_\_\_\_\_

With Others  
Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Hospital:  
Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Supervised Apt/Group Home  
Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Correctional Facility:  
Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Other:  
Name: \_\_\_\_\_ Phone # \_\_\_\_\_

**III. REFERRAL INFORMATION:**

Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referral Source: \_\_\_\_\_  
Name Title/Relationship

Agency: \_\_\_\_\_  
Name Phone #

Address: \_\_\_\_\_

Is the applicant aware of the referral?  Yes  No Fax # \_\_\_\_\_

**IV. FINANCIAL INFORMATION:**

**Sources and Amounts per Month (Please note if pending)**

SSI	_____	TCA	_____	Food Stamps	_____
SSDI	_____	VA	_____	Unemployment:	_____
SS	_____	Pension	_____	Rail Road	_____
TDAP	_____	Salary	_____	Other:	_____

**Assets and Expenses:**

Savings Account #: \_\_\_\_\_ Bank Name: \_\_\_\_\_  
 Checking Account #: \_\_\_\_\_ Bank Name: \_\_\_\_\_  
 Burial Account/Trust (Name of Institution) \_\_\_\_\_  
 Life Insurance (Name of Company) \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Is the applicant able to manage his/her own funds?:  Yes  No  
 Does the applicant have a Representative Payee?:  Yes  No  
 Does the applicant have a Power of Attorney?:  Yes  No

**V. MEDICAL INFORMATION**

MA #: \_\_\_\_\_ MA MCO: \_\_\_\_\_  
 Medicare# \_\_\_\_\_ Medicare MCO: \_\_\_\_\_

Private Health Insurance: \_\_\_\_\_  
 ID#: \_\_\_\_\_ Phone #: \_\_\_\_\_

Current Medical Diagnoses: \_\_\_\_\_  
 \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_  
 Name \_\_\_\_\_

Address: \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Medical Specialist: \_\_\_\_\_  
 Name \_\_\_\_\_ Specialty \_\_\_\_\_

Address: \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

List additional specialists on the back of the application

Medical Hospitalizations (Facilities, dates of admission and discharge, diagnoses):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of last medical appointment: \_\_\_\_\_

Date of last specialty appointment: \_\_\_\_\_



**VIII. DAY TIME ACTIVITIES**

**PRP:**

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Case Manager: \_\_\_\_\_ FAX: \_\_\_\_\_

**ADULT DAY CENTER:**

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Case Manager: \_\_\_\_\_ FAX: \_\_\_\_\_

**SCHOOL:**

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Case Manager: \_\_\_\_\_ FAX: \_\_\_\_\_

**WORK:**

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Case Manager: \_\_\_\_\_ FAX: \_\_\_\_\_

**OTHER:**

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Case Manager: \_\_\_\_\_ FAX: \_\_\_\_\_

**IX. FORENSIC INVOLVEMENT**

Has the applicant ever been arrested? Yes No

Has the applicant ever been convicted? Yes No

Is the applicant currently on Parole or Probation? Yes No

Is or will the applicant be on conditional release? Yes No

Parole or Probation Officer: \_\_\_\_\_  
Name

\_\_\_\_\_ Address

\_\_\_\_\_ Phone FAX

**Please include all records, documents, etc. that will assist with timely assessment/placement.**

**Please send or fax this application to:**

The \_\_\_\_\_ County Department of Social Services

Address:

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

**For Internal Use Only**

Date Received:

Comments:

**STATE OF MARYLAND**  
**Department of Human Resources**

**Detailed Medical History**

Applicant's Name: \_\_\_\_\_

Yes	No	Condition	Medication
		Orthopedic Dysfunction	
		Heart Trouble	
		Arthritis	
		Stomach Problems	
		Incontinence - Urine/Bowel	
		Diabetes	
		Skin Problems	
		Seizure Disorder	
		Multiple Sclerosis/Parkinsons's	
		Lung Problems	
		Allergies	
		Stroke	
		Bladder/Kidney Problems	
		High Blood Pressure	
		Dementia	
		Apahsia	
		Paralysis	
		Schizophrenia	
		Bi-polar Disorder	
		Depression	
		Anxiety	
		Affective Disorder	
		Tardive Dyskinesia	
		Excessive Weight Loss/Gain	
		Obesity	
		Eating Disorders	
		Dental Problems	
		Hearing Impaired	
		Visions Impaired	
		Organic Brain Syndrome	
		Sleeping Problems	
		Suicidal Ideation	
		Other	

For HIV Applicants:

CDC4 Count: \_\_\_\_\_

Viral Load \_\_\_\_\_

Current Medications

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**STATE OF MARYLAND**  
**Department of Human Resources**

**Applicant Characteristics**

Applicant's Name: \_\_\_\_\_

The following questions are useful in identifying the most appropriate housing available for the applicant.

Does the applicant smoke? \_\_\_\_\_ How much? \_\_\_\_\_  
 Does the applicant chew tobacco? \_\_\_\_\_ How much? \_\_\_\_\_  
 Is dangerous smoking behavior present? \_\_\_\_\_ Explain: \_\_\_\_\_  
 Is the applicant on a special diet? \_\_\_\_\_ Describe \_\_\_\_\_

Does the applicant have allergies? (Please list)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Does the client have a history of the following (please indicate frequency):

	Never	Last 60 days	Past 12 months	Past 2+ years	Comments
Aggressive/Violent Behavior					
Self Abusive Behavior					
Suicidal Ideation					
Suicidal Attempts					
Fire Setting					
Wandering					

Does the applicant prefer: \_\_\_\_\_ Private Room \_\_\_\_\_ Semi Private Room

**Activities of Daily Living**

Specify needs (0-none needed, 1-reminders, 2-prompting, 3-physical assistance)

	None Needed	Reminders	Prompting	Physical Assistance	Comments
Bathing					
Feeding					
Dressing					
Walking					
Transportation					
Budgeting					

List any adaptive equipment needed:

Comments: (any issues – pets, children, access to public transportation etc.)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Application for Project Home  
Admission

## CONSENT TO RELEASE INFORMATION

I give my consent to release the information on the attached application and any accompanying information to the Baltimore County Department of Social Services in order to assess my eligibility for placement of social services in the **Project Home** or **Adult Foster Care** program.

I further understand that my consent does not commit me to accept a placement and it does not commit the Baltimore County Department of Social Services to provide a placement for me. I may withdraw this consent at any time.

The information will be obtained from/released to:

\_\_\_\_\_

(Individual/Agency)

**THIS CONSENT IS EFFECTIVE FROM THE DATE OF CLIENT'S SIGNATURE BELOW.**

Applicant's Signature \_\_\_\_\_

Date \_\_\_\_\_

Legal Guardian's Signature [If Any] \_\_\_\_\_

Date \_\_\_\_\_

Referral Source \_\_\_\_\_

Date \_\_\_\_\_

**THIS RELEASE OF INFORMATION AGREEMENT SHALL BE VALID FOR 6 MONTHS  
FROM THE DATE OF SIGNATURE.**

Applicant Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date Completed: \_\_\_\_\_

**PROJECT HOME - Medical and Psychiatric Health Care Practitioner Assessment**

**PHYSICAL HEALTH**

**Current Medical Diagnoses:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**History of Illness or Hospitalization**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Health Status**

- Consciousness:     Alert             Drowsy     Oriented x 1 2 3
- Lungs:             Normal         Short of Breath     Cough         Congested
- Muscular/skeletal:  Normal         Stiffness     Paralysis     Pain     Numbness
- Skin:              Normal         Rashes (Contagious Rash Y N)
- Bladder:          Normal         Incontinent     Unable to Void     Catheter
- Bowel:            Normal         Incontinent     Constipation     Diarrhea
- Appetite:         Good            Fair             Poor

Activities:	Independent	With Help	Totally Dependent
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uses Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets Out of Bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbs Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ambulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Requires PT/OT?**     No     Yes

If yes: PT/OT Name & Address: \_\_\_\_\_

PT/OT Schedule: \_\_\_\_\_

**Requires Dialysis?**     No     Yes

If Yes, Dialysis Name & Address: \_\_\_\_\_

Dialysis Schedule: \_\_\_\_\_

**Applicant Name:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Date Completed:** \_\_\_\_\_

**Requires Home Health?**  No  Yes  
If yes: Home Health Name & Address: \_\_\_\_\_

Home Health Schedule: \_\_\_\_\_

**Requires Special Equipment or Supplies?**  No  Yes  
If yes, describe special equipment or supplies (i.e, diapers, chucks, dialysis supplies, diabetes supplies, cane, walker, etc.): \_\_\_\_\_

List any allergies or sensitivities for food, medications or environmental factors, and if known, the nature of the problem (rash, anaphylactic reaction, GI symptoms, etc):  
\_\_\_\_\_  
\_\_\_\_\_

Communicable illnesses: Is the applicant free from communicable TB and any other active reportable airborne communicable disease(s)? (Check one) \_\_\_ Yes \_\_\_ No - If "No", indicate the communicable disease:  
\_\_\_\_\_  
\_\_\_\_\_

**Project Home requires verification that the applicant is free from active TB. Which tests were done to verify the applicant is free from active TB:**  
PPD Date \_\_\_\_\_ Result \_\_\_\_\_ mm  
Chest X-ray (if PPD positive or unable to administer a PPD) Date \_\_\_\_\_  
Result \_\_\_\_\_

Does the applicant have a drug resistant infection (ex. MRSA) \_\_\_ Yes \_\_\_ No  
If "Yes", indicate the infection \_\_\_\_\_

**For HIV Infected Applicants:** CD4 Count: \_\_\_\_\_ Viral Load: \_\_\_\_\_  
Primary Medical Care Provider: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Medical Specialist: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

(If additional medical specialists, please note on back of application)  
Date of Last Medical Appointment: \_\_\_\_\_ Date of Last Specialty Appt. \_\_\_\_\_

Medical Hospitalizations (facilities, dates of admission & discharge, diagnoses):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Applicant Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Date Completed:** \_\_\_\_\_

**Risk factors for falls and injury:** Identify any conditions about this applicant that increase their risk of falling or injury (check all that apply):

- orthostatic hypotension  osteoporosis  gait problem  impaired balance  
 confusion  Parkinsonism  foot deformity  pain  assistive devices  
 other (explain) \_\_\_\_\_

**Skin condition(s):** Identify any current or history of ulcers, rash, skin tears with any standing treatment orders, easy bruising, etc. and their causes:

\_\_\_\_\_

\_\_\_\_\_

**Sensory impairments affecting functioning** (check all that apply):

a) Hearing: Left ear: \_\_\_\_\_ Adequate \_\_\_\_\_ Poor \_\_\_\_\_ Deaf \_\_\_\_\_ Uses corrective aid  
Right ear: \_\_\_\_\_ Adequate \_\_\_\_\_ Poor \_\_\_\_\_ Deaf \_\_\_\_\_ Uses corrective aid

b) Vision: \_\_\_\_\_ Adequate \_\_\_\_\_ Poor \_\_\_\_\_ Deaf \_\_\_\_\_ Uses corrective lenses  
\_\_\_\_\_ Blind  R  L

**Current nutritional status:** Height \_\_\_\_\_ inches Weight \_\_\_\_\_ lbs.

a) Any weight change gain or loss in past 6 months?  Yes  No

If "Yes", please explain: \_\_\_\_\_

b) Is there evidence of

malnutrition/undernutrition?  Yes  No

dehydration/at risk for dehydration?  Yes  No

If "Yes", please explain: \_\_\_\_\_

c) Does the applicant have medical or dental conditions affecting (check all that apply):

\_\_\_ Chewing \_\_\_ Swallowing \_\_\_ Eating \_\_\_ Pocketing food \_\_\_ Gastronomy Tube Fed

d) Note any special dietary needs:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Applicant Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date Completed: \_\_\_\_\_

**MENTAL HEALTH**

**Current Psychiatric Diagnoses:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**History of Psychiatric Illness or Hospitalizations:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Symptoms (Check all that apply):**

- Hallucinations      Type: \_\_\_\_\_
- Delusions            Explain: \_\_\_\_\_
- Poor Insight           Poor Judgement       Obsessions             Compulsiveness
- Paranoia               Hopelessness           Sadness                 Mania
- Depression           Flight of Ideas         Restlessness           Lethargic

- Affect:**  Appropriate           Labile                     Tearful                 Flat
- Euphoric                 Anxious                 Hostile
- Appearance:**         Neat                     Dirty                     Disheveled
- Voice/Speech:**  Normal                 Soft                     Loud                     Slow
- Slurred                 Fast                     Pressured
- Eye Contact:**  Direct                 Indirect
- Sleep Pattern:**       Restful Sleep           Difficulty Falling Asleep
- Restless Sleep         Increased Sleep Time

Suicidal Ideations Present --explain including plan: \_\_\_\_\_

History of Suicidal Attempts --explain: \_\_\_\_\_

Homicidal Ideations Present --explain including plan: \_\_\_\_\_

History of Homicidal Attempts --explain: \_\_\_\_\_

Is applicant a danger to self?       No                     Yes

Explain if yes: \_\_\_\_\_

Is applicant a danger to others?     No                     Yes

Explain if yes: \_\_\_\_\_

**Applicant Name:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Date Completed:** \_\_\_\_\_

**Cognitive/Behavioral Status**

- a) Is there evidence of dementia?  Yes  No
- b) Has the applicant undergone an evaluation for dementia  Yes  No
- c) Diagnosis (source of dementia)  Alzheimer's disease  Multi-infarct/Vascular  
 Parkinsonism  Other \_\_\_\_\_
- d) Memory:  
Short Term:  Intact  Impaired    Long Term:  Intact  Impaired  
Orientation  Person  Place  Time  
Mini Mental Status Exam (if tested) Date \_\_\_\_\_ Score \_\_\_\_\_  
Cognitive Level of Functioning Concerns: \_\_\_\_\_

For each item, circle the appropriate level of frequency or intensity. Use the "Comments" column to provide any relevant details.					
	A	B	C	D	Comments
<b>Cognition</b>					
I) Disorientation	Never	Mild	Moderate	Severe	
II) Impaired recall (recent/distant events)	Never	Occasional	Moderate	Severe	
III) Impaired Judgment	Never	Mild	Moderate	Severe	
IV) Hallucinations	Never	Occasional	Moderate	Severe	
V) Delusions	Never	Occasional	Moderate	Severe	
<b>Communication</b>					
VI) Receptive/expressive aphasia	Never	Mild	Moderate	Severe	
<b>Mood and emotions</b>					
VII) Anxiety	Never	Occasional	Moderate	Severe	
VIII) Depression	Never	Mild	Moderate	Severe	
<b>Behaviors</b>					
IX) Unsafe behaviors	Never	Occasional	Moderate	Severe	
X) Dangerous to self or others	Never	Occasional	Moderate	Severe	
XI) Agitation (Describe behaviors in comments section)	Never	Occasional	Moderate	Severe	

Applicant Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Does the applicant have any history or current problem related to abuse of prescription, non-prescription, OTC, illegal drugs, alcohol, or inhalants, etc.?

a) Substance: OTC, non-prescription medication abuse or misuse (check one)

1. Recent (last 6 months)  Yes  No

2. History  Yes  No

b) Abuse or misuse of prescription medication or herbal supplements

1. Currently  Yes  No

2. Recent (last 6 months)  Yes  No

c) History of non-compliance with prescribed medication

1. Currently  Yes  No

2. Recent (last 6 months)  Yes  No

d) Describe misuse or abuse: \_\_\_\_\_

### PHARMACOLOGY

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(If needed, use an additional page for medications)

### Ability to self-administer medications:

Project Home is an adult foster care model with a provider living in the home 24/7 and accepting responsibility for supervising and caring for residents. Each provider and resident work with a registered nurse consultant who has been trained in cueing and coaching techniques that ensure compliance with taking prescribed medications. Through individualized health care teaching by the consultant, the ultimate goal is that each resident is able to self-medicate with cueing, coaching, reminders and supervision. In your opinion, would this level of support enable the applicant to self-administer medications?

Yes  No If No, Please explain: \_\_\_\_\_

**Applicant Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Date Completed:** \_\_\_\_\_

### HEALTH CARE DECISION MAKING CAPACITY

Based on the preceding review of functional capabilities and physical and cognitive status and limitations, indicate this applicant's highest level of ability to make health care decisions:

\_\_\_ a) probably can make higher level decisions (such as whether to undergo or withdraw life-sustaining treatments) that require understanding the nature, probable consequences and burdens and risks of proposed treatment.

\_\_\_ b) probably can make limited decisions that require simple understanding

\_\_\_ c) probably can express agreement with decisions proposed by someone else

\_\_\_ d) cannot effectively participate in any kind of health care decision-making

This form completed by:

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature, Title

Form must be verified for accuracy by Health Care Practitioner:

\_\_\_\_\_  
Print Practitioner's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Practitioner's Signature, Title

