Provider Agreement for Resident Care

Thank you for referring your patient to our RCFCI! Please read and sign acknowledging the following items below:

- The patient's provider and provider team acknowledges that the patient admitted will be at the RCFCI on a short-term basis and evaluated every three months for an appropriateness level of care. (With the exception of Palliative or Hospice residents at Maitri).

- The provider and provider team understands that RCFCI's are not long-term care or long-term housing. Average length of stay is 3-12 months. (With the exception of Palliative or Hospice residents at Maitri).

- The patient's provider and provider team understands that if the RCFCI is no longer able to meet the medical and psychosocial needs of the resident; the provider, the provider team, and the RCFCI will move forward with a safe transition to another placement that is more appropriate for the resident. This includes the provider assisting in expediting a referral to a higher level of care.

- The patient's provider and provider team acknowledges that for optimal care, the RCFCI and the provider will need to collaborate on treatment goals, medications, medical appointments, and continued discharge planning.

- The patient's provider and provider team understands that treatment goals and discharge planning start at admission-and are continued to be assessed. The provider and provider team is expected to attend, at minimum, a care team meeting every two months to discuss treatment goals and discharge planning. (With the exception of Palliative or Hospice residents at Maitri).

Patient Name: _____Provider Name: _____

Provider Signature: _____Date Signed: _____

Peter Claver Community

Catholic Charities

MARIN ◆ SAN FRANCISCO ◆ SAN MATEO

Maitri Compassionate Care

Maitri

PHYSICIAN'S REPORT FOR COMMUNITY CARE FACILITIES

For Resident/Client Of, Or Applicants For Admission To, Community Care Facilities (CCF).

NOTE TO PHYSICIAN:
The person specified below is a resident/client of or an applicant for admission to a licensed Community Care Facility. These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents/clients.

THESE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.
The information that you complete on this person is required by law to assist in determining whether he/she is appropriate for admission to or continued care in a facility.

FACILITY INFORMATION (To be completed by the licensee/designee)

NAME OF FACILITY:			TELEPHONE:
Maitri Compassionate Care			415-558-3000
ADDRESS: NUMBER	STREET	CITY	
401 Duboce Ave	San Francisco	CA 94117	
LICENSEE'S NAME:	TELEPHONE:	FACILITY LICENSE NUMBER:	
Maitri	415-558-3000	385600064	

RESIDENT/CLIENT INFORMATION (To be completed by the resident/authorized representative/licensee)

NAME:			TELEPHONE:
ADDRESS: NUMBER	STREET	CITY	SOCIAL SECURITY NUMBER:
NEXT OF KIN:		PERSON RESPONSIBLE FOR THIS PERSON'S FINANCES:	

PATIENT'S DIAGNOSIS (To be completed by the physician)

PRIMARY DIAGNOSIS:

SECONDARY DIAGNOSIS: | LENGTH OF TIME UNDER YOUR CARE:

AGE:	HEIGHT:	SEX:	WEIGHT:	IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE? ☐ YES ☐ NO

TUBERCULOSIS EXAMINATION RESULTS: ☐ ACTIVE ☐ INACTIVE ☐ NONE | DATE OF LAST TB TEST:

TYPE OF TB TEST USED: | TREATMENT/MEDICATION: ☐ YES ☐ NO If YES, list below:

OTHER CONTAGIOUS/INFECTIOUS DISEASES:
A) ☐ YES ☐ NO If YES, list below:

TREATMENT/MEDICATION:
B) ☐ YES ☐ NO If YES, list below:

ALLERGIES
C) ☐ YES ☐ NO If YES, list below:

TREATMENT/MEDICATION:
D) ☐ YES ☐ NO If YES, list below:

Ambulatory status of client/resident:

1. This person is able to independently transfer to and from bed: ☐ Yes ☐ No

2. For purposes of a fire clearance, this person is considered:

☐ Ambulatory ☐ Nonambulatory ☐ Bedridden

Nonambulatory: A person who is unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or to an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs.
Note: A person who is unable to independently transfer to and from bed, but who does not need assistance to turn or reposition in bed, shall be considered non-ambulatory for the purposes of a fire clearance.

Bedridden: For the purpose of a fire clearance, this means a person who requires assistance with turning or repositioning in bed.

I. PHYSICAL HEALTH STATUS: ☐ **GOOD** ☐ **FAIR** ☐ **POOR**	COMMENTS:			
	YES (Check One)	**NO** (Check One)	ASSISTIVE DEVICE	COMMENTS:
1. Auditory impairment				
2. Visual impairment				
3. Wears dentures				
4. Special diet				
5. Substance abuse problem				
6. Bowel impairment				
7. Bladder impairment				
8. Motor impairment				
9. Requires continuous bed care				

II. MENTAL HEALTH STATUS: ☐ **GOOD** ☐ **FAIR** ☐ **POOR**	COMMENTS:			
	NO PROBLEM	**OCCASIONAL**	**FREQUENT**	IF PROBLEM EXISTS, PROVIDE COMMENT BELOW:
1. Confused				
2. Able to follow instructions				
3. Depressed				
4. Able to communicate				

III. CAPACITY FOR SELF CARE: ☐ **YES** ☐ **NO**	COMMENTS:		
	YES (Check One)	**NO** (Check One)	COMMENTS:
1. Able to care for all personal needs			
2. Can administer and store own medications			
3. Needs constant medical supervision			
4. Currently taking prescribed medications			
5. Bathes self			
6. Dresses self			
7. Feeds self			
8. Cares for his/her own toilet needs			
9. Able to leave facility unassisted			
10. Able to ambulate without assistance			
11. Able to manage own cash resources			

PLEASE LIST OVER-THE-COUNTER MEDICATION THAT CAN BE GIVEN TO THE CLIENT/RESIDENT, AS NEEDED, FOR THE FOLLOWING CONDITIONS:

CONDITIONS	OVER-THE-COUNTER MEDICATION(S)
1. Headache	
2. Constipation	
3. Diarrhea	
4. Indigestion	
5. Others *(specify condition)*	

PLEASE LIST CURRENT PRESCRIBED MEDICATIONS THAT ARE BEING TAKEN BY CLIENT/RESIDENT:

1.	4.	7.
2.	5.	8.
3.	6.	9.

PHYSICIAN'S NAME AND ADDRESS:	TELEPHONE:	DATE:

PHYSICIAN'S SIGNATURE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (TO BE COMPLETED BY PERSON'S AUTHORIZED REPRESENTATIVE)
I hereby authorize the release of medical information contained in this report regarding the physical examination of:

PATIENT'S NAME:

TO (NAME AND ADDRESS OF LICENSING AGENCY):

SIGNATURE OF RESIDENT/POTENTIAL RESIDENT AND/OR HIS/HER AUTHORIZED REPRESENTATIVE	ADDRESS:	DATE: