

## Behavioral Health Assisted Living Application Process

**PROGRAM PURPOSE** – The Behavioral Health Assisted Living initiative is designed to provide wrap-around behavioral health services and care coordination to adults with behavioral health conditions who require Assisted Living services. These are individuals who require assistance with daily activities or have medical conditions that require nursing assessment and delegation and have a mental illness disorder for which they will also need to access services and support.

### Program eligibility includes

1. Adult or older adult diagnosed with serious mental illness and needing assistance with activities of daily living (ADL), instrumental activities of daily living (IADL), or other somatic problems requiring nursing assessment and/or delegation
2. Individual's income is less than three times the amount of SSI and assets less than \$2,000
3. The individual is at risk of admission to a state psychiatric hospital, or nursing facility, or discharge from a state psychiatric hospital

Email **the completed Behavioral Health Assisted Living Application** and the supporting documents outlined below to the jurisdiction of choice

- Insurance information (card of available)
- Psychiatric evaluation
- Guardianship or Power of Attorney documents (if applicable)
- Conditional Release/ Probation Order/ Pretrial Release (if applicable)

|   |  |
|---|--|
| Mid Shore Behavioral Health, Inc                                  | <a href="mailto:sjoyce@midshorebehavioralhealth.org">sjoyce@midshorebehavioralhealth.org</a> |
| St. Mary's County Health Department<br>Behavioral Health Division | <a href="mailto:brian.ayres@maryland.gov">brian.ayres@maryland.gov</a>                       |
| Behavioral Health System Baltimore<br>(BHSB)                      | <a href="mailto:BHALF@bhsbaltimore.org">BHALF@bhsbaltimore.org</a>                           |
| Anne Arundel County Mental Health<br>Agency, inc                  | <a href="mailto:HHughes@aamentalhealth.org">HHughes@aamentalhealth.org</a>                   |

Currently, program capacity is limited and only available in four jurisdictions.

**The following information will be required if the applicant is approved for admission**

- [Healthcare Practitioner Form](#)
- [MOLST Form](#)
- Signed Assisted Living Resident Agreement
- Benefit Action Plan ( State hospital only)

## Behavioral Health Assisted Living Application

This application can be utilized for admission to Behavioral Health Assisted Living Pilot Programs funded through the Behavioral Health Administration. Please fill out this document in its entirety with explanations provided for each Activity of Daily Living (ADL), Instrumental Activity of Daily Living (iADL), and behavior.

**Person completing the form:** \_\_\_\_\_  
Name and Title

**Primary contact information:**

|                       |  |
|-----------------------|--|
| Name (First and Last) |  |
| Email                 |  |
| Phone Number          |  |

**Applicant's name:** \_\_\_\_\_ **Application date:** \_\_\_\_\_  
First and Last

**Applicants current living setting:**

- CT Perkins
- Spring Grove Hospital
- Springfield Hospital
- Eastern Shore Hospital Center
- TB Finan
- RRP
- Homeless
- Home
- Segue
- Other: \_\_\_\_\_

**Applicant's date of birth:** \_\_\_\_\_  
Month/Day/Year

**Date of admission to facility (if applicable):** \_\_\_\_\_

**Applicant's psychiatric diagnosis:** \_\_\_\_\_

**Applicant's medical diagnosis:** \_\_\_\_\_

**Applicant's sex and gender identity:**

- Women or female
- Man or male
- Gender non-binary (gender neutral/ not identified as man or women)
- Transgender women
- Transgender man

Other: \_\_\_\_\_

**Applicant's Race:**

- White
- Black or African
- American Indian or Alaskan Native
- Asian
- Native Hawaiian or other pacific islander

**Applicant's ethnicity:**

- Hispanic or Latino
- Not Hispanic or Latino
- Not specific

**Applicant's preferred language:** \_\_\_\_\_

**Does the applicant require interpreter services?**

- Yes
- No

**Describe interpreter services needed:**

**(State hospital applicant only) Barriers to discharge to independent housing, supported housing or Residential Rehabilitation Program (RRP):**

- Neurocognitive disorder
- requires assistance with activities of daily living
- requires assistance with instrumental activities of daily living, beyond the capability of RRP
- medical conditions require nursing assessment, delegation, and oversight
- Swallowing difficulties requiring special food preparation (eg. soft or pureed diet, thickened liquids)
- Ineligible or denied for HUD housing/affordable housing
- Lack of family or social support system
- Undocumented
- Ineligible for HUD housing
- Applicant does not have capacity to consent to treatment
- Applicant unable to self-administer medications
- Other: \_\_\_\_\_

### Entitlements and Legal Documents

Benefits referral must be made prior to requesting funding for assisted living

Please provide the name of the State Hospital Benefits Coordinator to whom the Applicant has been referred.

**Benefits coordinator email** (State Hospital Applicants only): \_\_\_\_\_

**Monthly estimated income upon discharge:** \_\_\_\_\_

**Total estimated financial assets (bank balance, life insurance, retirement account, property and other assets):** \_\_\_\_\_

**Does the applicant have a special needs trust or ABLE account?**

- Yes
- No
- Other: \_\_\_\_\_

**Documents:**

|  | Copy available           | In process of obtaining  | Available after discharge | Not applicable           |
|--|--------------------------|--------------------------|---------------------------|--------------------------|
| Birth certificate                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| Social Security Card                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| Permanent Resident Card (green card)   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| State Identification card              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| Citizenship (paperwork, if applicable) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |

**Forensic status upon discharge** (State hospital only):

- Conditional release
- Probation
- Pretrial release
- None
- Other: \_\_\_\_\_

**Legal decision maker for applicant:**

- Applicant (self)
- POA
- Surrogate decision maker
- Representative payee for social security

- Guardian of property
- Guardian of person
- Other: \_\_\_\_\_

**Name and contact information for any legal decision maker listed above:**

**Activities of Daily Living (ADLs)**

When answering these questions, consider the impact of involuntary movements (e.g. tardive dyskinesia), cognition, medication side effects, and symptoms of mental illness on an individual's ability to perform ADLs.

**Feeding:**

Setting up, arranging, and bringing food or fluid from the vessel to the mouth

- Independent (no assistance needed)
- Requires supervisions, set-up, or minimum cueing to complete task
- Require frequent and continuous cueing and coaching to complete task
- Needs hands on assistance to complete task
- Other: \_\_\_\_\_

**Explain the level of assistance needed with feeding:**

**Eating and swallowing:**

Keeping and manipulating food or fluid in the mouth, swallowing it i.e., moving it from the mouth to the stomach

- Independent (no assistance needed)
- Requires supervisions, set-up, or minimum cueing to complete task
- Require frequent and continuous cueing and coaching to complete task
- Needs hands on assistance to complete task
- Other: \_\_\_\_\_

**Explain the level of assistance needed with eating and/or swallowing:**

**Toileting and toilet hygiene:**

Obtaining and using toileting supplies, managing clothing, maintaining toileting position, transferring to and from toileting position, cleaning body, caring for menstrual and continence needs, maintaining intentional control of bowel movements and urination

- Independent (no assistance needed)
- Requires supervisions, set-up, or minimum cueing to complete task
- Require frequent and continuous cueing and coaching to complete task
- Needs hands on assistance to complete task
- Other: \_\_\_\_\_

**Explain the level of assistance needed with toileting and toilet hygiene:**

**Bathing:**

Obtaining and using supplies; soaping, rinsing, and drying body parts; maintaining bathing position; transferring to and from bathing positions

- Independent (no assistance needed)
- Requires supervisions, set-up, or minimum cueing to complete task
- Require frequent and continuous cueing and coaching to complete task
- Needs hands on assistance to complete task
- Other: \_\_\_\_\_

**Explain the level of assistance needed with bathing:**

**Grooming:**

Feminine hygiene, teeth, make-up, shaving, hair

- Independent (no assistance needed)
- Requires supervisions, set-up, or minimum cueing to complete task
- Require frequent and continuous cueing and coaching to complete task
- Needs hands on assistance to complete task
- Other: \_\_\_\_\_

**Explain the level of assistance needed with grooming:**

**Getting Dressed/Changes Clothes:**

- Independent (no assistance needed)
- Requires supervisions, set-up, or minimum cueing to complete task
- Require frequent and continuous cueing and coaching to complete task
- Needs hands on assistance to complete task
- Other: \_\_\_\_\_

**Explain the level of assistance needed with getting dressed/changing clothes?**

**Mobility**

Consider assistance the individual may need walking or using a wheelchair, transferring in and out of bed or a chair, and using stairs.

**Please describe any challenges with using stairs:**

**Functional mobility:**

Moves from place to place

- Independent (no assistance needed)
- Requires supervisions, set-up, or minimum cueing to complete task
- Require frequent and continuous cueing and coaching to complete task
- Needs hands on assistance to complete task
- Other: \_\_\_\_\_

**Explain the level of assistance needed with mobility, please indicate whether accessible housing is required:**

**Bed mobility and transfers:**

Please describe the level of assistance needed to move to and from lying position, turn side to side in bed, position body while in bed, and transfer from bed to chair, chair to toilet, etc.

- Independent (no assistance needed)
- Requires supervisions, set-up, or minimum cueing to complete task
- Require frequent and continuous cueing and coaching to complete task
- Needs hands on assistance to complete task
- Other: \_\_\_\_\_

### **Instrumental Activities of Daily Living (IADLs)**

When answering these questions, consider the impact of involuntary movements (e.g. tardive dyskinesia), cognition, medication side effects, and symptoms of mental illness on an individual's ability to perform IADLs.

#### **Meal preparation:**

Planning, preparing, and serving meals and cleaning up food, utensils, pots, and plates after meals

- Independent (no assistance needed)
- Requires supervisions, set-up, or minimum cueing to complete task
- Require frequent and continuous cueing and coaching to complete task
- Needs hands on assistance to complete task
- Other: \_\_\_\_\_

#### **Explain the level of assistance needed with preparing meals:**

#### **Nutrition management:**

Implementing and adhering to nutrition and hydration recommendations from the medical team, preparing meals to support health goals, participating in health-promoting diet routines

- Independent (no assistance needed)
- Requires supervisions, set-up, or minimum cueing to complete task
- Require frequent and continuous cueing and coaching to complete task
- Needs hands on assistance to complete task
- Other: \_\_\_\_\_

#### **Explain the level of assistance needed with nutrition management:**

#### **Grocery Shopping:**

Preparing shopping lists ; selecting, purchasing, and transporting items; selecting method of payment and completing payment transactions; managing internet shopping and related use of electronic devices such as computers, cell phones, and tablets

- Independent (no assistance needed)
- Requires supervisions, set-up, or minimum cueing to complete task
- Require frequent and continuous cueing and coaching to complete task
- Needs hands on assistance to complete task
- Other: \_\_\_\_\_

**Explain the level of assistance needed with grocery shopping:**

**Home Management:**

Taking care of possessions and home environment e.g. obtaining and maintaining personal and household possessions/environments by completing laundry, cleaning home, washing dishes, taking out the trash, etc.

- Independent (no assistance needed)
- Requires supervisions, set-up, or minimum cueing to complete task
- Require frequent and continuous cueing and coaching to complete task
- Needs hands on assistance to complete task
- Other: \_\_\_\_\_

**Explain what the level of assistance needed with light chores:**

**Safety and Emergency Maintenance:**

Evaluating situations in advance for potential safety risks; recognizing sudden, unexpected hazardous situations and initiating emergency action, identifying emergency contact numbers

- Independent (no assistance needed)
- Requires supervisions, set-up, or minimum cueing to complete task
- Require frequent and continuous cueing and coaching to complete task
- Needs hands on assistance to complete task
- Other: \_\_\_\_\_

**Explain level of assistance needed with Safety and Emergency Maintenance:**

**Manage Finances:**

- Independent (no assistance needed)
- Requires supervisions, set-up, or minimum cueing to complete task
- Require frequent and continuous cueing and coaching to complete task
- Needs hands on assistance to complete task
- Other: \_\_\_\_\_

**Explain the level of assistance needed with managing finances:**

**Driving and community mobility:**

Planning and moving around in the community using public or private transportation, such as driving, walking, bicycling, or accessing and riding in buses, taxi cabs, ride shares, or other transportation systems

- Independent (no assistance needed)
- Requires supervisions, set-up, or minimum cueing to complete task
- Require frequent and continuous cueing and coaching to complete task
- Needs hands on assistance to complete task
- Other: \_\_\_\_\_

**Explain the level of assistance needed with transportation:**

**Communication management:**

Sending, receiving, and interpreting information using systems and equipment such as writing tools, telephones (including smartphones), keyboards, audiovisual recorders, computers or tablets, communication boards, call lights, emergency systems, Braille writers, telecommunication devices for deaf people, augmentative communication systems, and personal digital assistants

- Independent (no assistance needed)
- Requires supervisions, set-up, or minimum cueing to complete task
- Require frequent and continuous cueing and coaching to complete task
- Needs hands on assistance to complete task
- Other: \_\_\_\_\_

**Explain the level of assistance needed with communication devices:**

**Health Management:**

Activities related to developing, managing, and maintaining health and wellness routines, including scheduling and attending medical appointment, managing prescription changes and refills, and taking medications

- Independent (no assistance needed)
- Requires supervisions, set-up, or minimum cueing to complete task
- Require frequent and continuous cueing and coaching to complete task

- Needs hands on assistance to complete task
- Other: \_\_\_\_\_

**Explain the level of assistance needed with health management:**

**Medication Management:**

Activities related to obtaining prescribed medications, taking medications as prescribed, and reporting response to medications to prescriber

- Independent (no assistance needed)
- Requires supervisions, set-up, or minimum cueing to complete task
- Require frequent and continuous cueing and coaching to complete task
- Needs hands on assistance to complete task
- Other: \_\_\_\_\_

**Explain the level of assistance needed with medication management:**

**Symptom and condition management:**

Managing physical and mental health needs, including using coping strategies for illness, trauma history, or societal stigma; managing pain; managing chronic disease; recognizing symptom changes and fluctuations; developing and using strategies for managing and regulating emotions; using community and social supports; navigating and accessing the healthcare system

- Independent (no assistance needed)
- Requires supervisions, set-up, or minimum cueing to complete task
- Require frequent and continuous cueing and coaching to complete task
- Needs hands on assistance to complete task
- Other: \_\_\_\_\_

**Explain the level of assistance needed with symptom and condition management:**

**Psychiatric Symptoms and Behaviors:**

|                                     | Never                    | Rarely                   | Occasionally             | Frequently               | Usually                  |
|-------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Auditory Hallucinations             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Visual Hallucinations               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Delusional Thoughts                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Paranoia                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mood Swings                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Isolation/Withdrawal                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Confusion/Memory Problems           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Wandering                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anger Outbursts/Rages               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Impulsivity                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Obsessive Behaviors and/or thoughts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep Disorder                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anxiety/ Panic Attacks              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Self-Injurious Behaviors            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Suicidal Ideations/Attempts         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Homicidal Ideations/Attempts        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Medication Non-Adherence            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Apathy                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty organizing tasks         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Forgetfulness/ inattentiveness      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

|  |                          |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Struggles with basic life skills                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty with initiation and/or follow through | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reduction in interest, desires and goals         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Polydipsia                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Explain psychiatric symptoms and the impact on ADLs and IADLs:**

**Disruptive Behaviors:**

|  | Never                    | Rarely                   | Occasionally             | Frequently               | Usually                  |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Yells  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Demands  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Takes other possessions  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Socially inappropriate behavior (i.e. disrobes, urinates or defecates in public) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexually inappropriate behavior (i.e. unwanted touching, public masturbation)    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Explain disruptive behaviors and impact on ADLs and IADLs                        |                          |                          |                          |                          |                          |

**Combative Behaviors:**

|  | Never                    | Rarely                   | Occasionally             | Frequently               | Usually                  |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Throws objects indiscriminately                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Strikes out, kicks or punches others                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pinches, bites, scratches, pulls hair, spits at others | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Explain combative behaviors and impact on ADLs and IADLs**

|                  |
|------------------|
| <br><br><br><br> |
|------------------|

**Resistive/Uncooperative Behaviors:**

|                                       | Never                    | Rarely                   | Occasionally             | Frequently               | Usually                  |
|---------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Declines to wash                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Declines to eat                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Declines to drink                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Declines to care for self             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Declines to allow others to assist    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Declines to take medications          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Declines to comply with safety advice | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Explain resistance/ uncooperative behaviors and impact on ADLs and IADLs:**

|                  |
|------------------|
| <br><br><br><br> |
|------------------|

**Describe any other symptoms or behaviors not listed above (if applicable):**

|                  |
|------------------|
| <br><br><br><br> |
|------------------|

**Additional Information:**

**Sources of information utilized to complete form:**

- Observation of Applicant
- Interview with Applicant
- Applicant records
- Treatment team meeting notes
- Other