ATTACHMENT T – INFECTION CONTROL REPORTING FORM

Attachment T Infection Control Reporting Forms

ISOLATION UTILIZATION REPORT													
REGION: JESSUP	DATE: Aug 2009												
INMATE NAME	DPSCS/ DOC NUMBER	SOURCE FACILITY	ISOLATION FACILITY	GENDER/ RACE	ADMISSION DATE	ADMISSION DIAGNOSIS	SPUTUM date / result 1	SPUTUM date / result 2	SPUTUM date / result 3	CXR date / result	HIV status / date	DISCHARGE DATE	DISCHARGE DIAGNOSIS

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STD REPORT

DATE: Aug 2009

REGION: JESSUP

FOR THE MONTH	BBCF	CLF	EPRU	JPRU	MCIJ	MCIW	JCI	PATX	BPRUW	SMPRU	HTBC	TOTAL
# RPR TEST												
# REACTIVE RPR												
# FEMALE												
# MALE												
# OF NEW REACTIVE CASES												
# RPR TEST CONFIRMED BY H.D. FOR PAST POSTIVE & TREATMENT												
# RPR TREATMENT INITIATED												
# RPR TREATMENTS COMPLETED												
# RPR TREATMENTS REFUSED												
# GC TEST												
# (+) GC RESULTS												
# GC TREATMENT INITIATED												
# GC TREATMENT COMPLETED												
# CHLAMYDIA TEST												
# (+) CHLAMYDIA RESULTS												
# (+) CHLAMYDIA TREATMENTS INITIATED												
# (+) CHLAMYDIA TREATMENTS COMPLETED												

Name	Note

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HEPATITIS C REPORT												
DATE: Aug 2009												
REGION: JESSUP												
	BBCF	CLF	EPRU	JPRU	MCIJ	MCIW	JCI	PATX	BPRUW	SMPRU	HTBC	TOTAL
# HCV TESTS PERFORMED (for the month)												
# HCV TESTS POSITIVE (for the month)												
# HCV CONFIRMED BY VIRAL RNA (for the month)												
Total # INMATES HCV positive (Cumulative)												
# WITH HX OF SUBSTANCE ABUSE(Cumulative)												
# WITH HX OF DEPRESSION (Cumulative)												
# ENROLLED IN CHRONIC CARE CLINIC (Cumulative)												
# Co-INFECTED INMATES HCV/HIV (Cumulative)												
# Co-INFECTED INMATES HCV/HBV (cumulative)												
# Co-INFECTED INMATES HCV/HAV (Cumulative)												
# RECEIVING TWINRIX VACCINE (for the month)												
# SVR (for the month)												
# EVR (for the month)												

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# RECEIVING LFTs (for the month)												
# RECEIVING VIRAL LOAD (for the month)												
# RECEIVING GENOTYPE (for the month)												
# HAD GI/ID CONSULT(for the month)												
#PRESENTED TO PANEL (for the month)												
# HAD LIVER BIOPSY (for the month)												
# HAD CT/ULTRASOUND(for the month)												
# APPROVED FOR ANTIVIRAL THERAPY(for the month)												
# INMATES COMPLETING THERAPY(for the month)												
# INMATES DISCONTINUING THERAPY(for the month)												

Pt. Initials and DOC #	**Tx. Regimen**	**Start Date**	**# of Weeks**			

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IMMUNIZATION REPORT

DATE: Aug 2009

REGION: JESSUP

FOR THE MONTH	BBCF	CLF	EPRU	JPRU	MCIJ	MCIW	JCI	PATX	BPRUW	SMPRU	HTBC	TOTAL
# TWINRIX 1ST DOSE												
# TWINRIX 2ND DOSE												
# TWINRIX 3RD DOSE												
# PNEUMOCOCCAL VACCINE												
# INFLUENZA VACCINATIONS												
# INFLUENZA REFUSALS												
# OTHER IMMUNIZATIONS												
# OTHER REFUSALS												
OTHERS												
TETANUS												
HEP B												

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HIV REPORT

Date: Aug 2009

REGION: JESSUP

	BBCF	CLF	EPRU	JPRU	MCIJ
# HIV (+) INMATES(cumulative)					
FROM ABOVE, TOTAL AIDS DEFINED BY CDC CLASSIFICATION OR CD4 <200/14%(cumulative)					
TOTAL HIV (+) ON HAART THERAPY(cumulative)					
# CLINICAL HIV TESTS (for the month)					
# HIV (+) RESULTS(for the month)					
# HIV VOLUNTARY TESTS (for the month)					
# VOLUNTARY HIV(+) RESULTS (for the month)					
# INMATES OFFERED HIV EDUCATION (for the month)					
# INMATES REFUSED TESTING WITHOUT EXPLANATION (for the month)					
# INMATES REFUSED TESTING DUE TO PREVIOUS POSITIVE (for the month)					
# HIV CD4 TEST(for the month)					
# HIV VIRAL LOADS DONE (for the month)					
# UNDECTABLE VIRAL LOADS FROM ABOVE (for the month)					
# OF DETECTABLE VIRAL LOAD (for the month)					
# OF ABOVE ON HAART(for the month)					
Total # of inmates w/undetectable VL.(Cumulative)					

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TOTAL# OF INMATES ABOVE ON HAART THERAPY(Cumulative)					
# of HIV inmates presented to JHH (for the month)					
# of newly diagnosed HIV inmates offered treatment (for the month)					

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MCIW	JCI	PATX	BPRUW	SMPRU	HTBC	TOTAL

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Newly Diagnosed HIV Patients					Aug-09	
Clinical Test Date	Doc#	Name	Facility	Comment	Release Date	
NONE						
Voluntary Testing Date	Doc#	Facility	Comment	Release Date	Confirmatory Results	Comments
NONE						

Transfers to Other Regions									
Patient Name	Doc#	Tx Regime	Tx Start Date	VL	Transfer to/date	Transfer from/date	Date Presented to JHH	Release Date	Comments

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REPORTABLE

DATE: Aug 2009

REGION: JESSUP

FOR THE MONTH	BBCF	CLF	EPRU	JPRU	MCIJ	MCIW	MHC	MCHA	PATX	BPRUW	SMPRU	HTBC	TOTAL
MUMPS													
ECTO-PARASITES													
VARICELLA (Chicken Pox)													
MEASLES													
ZOSTER													
OTHER													

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TUBERCULOSIS REPORT

DATE: Aug 2009

REGION: JESSUP

	BBCF	CLF	EPRU	JPRU	MCIJ	MCIW	JCI	PATX	BPRUW	SMPRU	HTBC	TOTAL
# PROPOSED FOR ANNUAL TB TEST												
# OF PAST POSITIVES												
TOTAL ANNUAL PPD PLANTED												
# & % ANNUAL PPD CONVERSIONS												
# OF INMATES LTBI EVAL-UATED (XRAY, SX SCREEN)												
# & % CANDIDATES FOR TLI												
# & % INMATES STARTED ON TLI (for the month)												
TOTAL # ON TLI (cumulative)												
# COMPLETING TLI (cumulative)												
# TLI REFERED TO LHD (for the month)												
# INTAKES EVALUATED FOR PPD (for the month)												
# & % INTAKE LTBI												
# & % OF INTAKE LTBI EVALUATED (XRAY / SX												
TOTAL # INTAKE PPD PLANTED												
# & % INTAKE LTBI THAT ARE CANDIDATES FOR TLI												
# & % INTAKE STARTED ON TLI												
# & % INTAKE TLI COMPLETED												

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# INTAKE TLI REFERRED TO LHD												
# CONTACT INVESTIGATIONS												
CONTACT TRACING TESTING												
# CONVERSIONS FROM CONTACT TRACINGS												
# 851 FORMS SENT TO DPSCS												
# 4501 FORMS SENT TO DPSCS												
# NONADHERANCE REPORTED TO DPSCS												
# APPENDEX 14 SENT TO Dr. Randall												
# TB R/O IN RESP. ISOLATION												
# ABOVE HIV POSITIVE												
# ABOVE HCV POSITIVE												
# NEW ACTIVE TB CASES												
# COMPLETING ACTIVE TB TX												
# ACTIVE TX D/C 2° HEPATOTOXICITY												
# TLI D/C 2° HEPATOTOXICITY												
# TX RESISTANT												

Inmates who tested positive: (current month)

Name	DOC #	Site	Disposition

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Inmates on active Tx: Initials & DOC # (cumulative)	Facility	Week Completed	

Inmates on TLI: Initials & DOC # (cumulative)	Facility	Week Completed	

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MRSA REPORT

DATE: Aug 2009

REGION: JESSUP

FOR THE MONTH	BBCF	CLF	EPRU	JPRU	MCIJ	MCIW	JRH	JCI	PATX	BPRUW	SMPRU	HLTBC	TOTAL
# CULTURES DONE													
# CONFIRMED MRSA (+)													
# CONFIRMED OTHER INFECTION (+) (MSSA)													
# MRSA INFIRMARY ADMISSIONS													
# MRSA ISOLATIONS													
# MRSA SINGLE CELL													
# MRSA COHORTS													
# MRSA ON ANTIBIOTICS													
# OTHER INFECTIONS ON ANTIBIOTICS													
# MRSA ON EMPIRIC THERAPY													
# MRSA WARM SOAKS THERAPY													
# RECEIVED FROM HOSPITAL													
# WITH RECENT SURGERY													
# OTHER INFECTIONS FROM HOSP. (SPECIFY TYPE OF INFECTION)													
# WITH RECENT SURGERY													

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ATTACHMENT U – MEDICAID ELIGIBILITY FORMS

Date Signed Application Received in Local Department **MUST BE DATE STAMPED**

MARYLAND DEPARTMENT OF HUMAN RESOURCES
FAMILY INVESTMENT ADMINISTRATION

APPLICATION PART II: Eligibility Determination Document For One Person

PLEASE PRINT ALL ANSWERS

☐ **I wish to apply for:** ☐ Cash Assistance ☐ Medical Assistance ☐ Food Stamps ☐ Other, list:_____	☐ **I am currently receiving:** ☐ Cash Assistance ☐ Medical Assistance: ID#_____ ☐ Food Stamps ☐ Other, list:_____	Do you have unpaid medical bills now? ☐ YES ☐ NO

1. IDENTIFYING INFORMATION

Last Name	First Name	Middle Name	Jr., III, etc.	Maiden/Other Name

What language do you speak?	Do you need an interpreter? ☐ YES ☐ NO
Are you visually impaired ☐ YES ☐ NO	Are you hearing impaired? ☐ YES ☐ NO

2. ADDRESS Where do you live?

Number Street	Apt No.	Floor No.	Telephone Number
City	**State**	**Zip Code + 4**	**Number where you can be reached during the day**

3. MAILING ADDRESS *(IF DIFFERENT)*

Number Street	Apt. No.	Floor No.	Telephone Number

P.O. Box	City	State	Zip Code + 4

4. PREVIOUS ADDRESSES

Number Street	City	State	Zip Code + 4

When did you live there?	From	To	Did you own this home? ☐ YES ☐ NO

5. AUTHORIZED REPRESENTATIVE *(IF DESIRED)*

First Name	Middle Name	Last Name	Jr., III, etc.

Number Street	City	State	Zip Code + 4

Telephone Number	Relationship to you

Check what you want the representative to do:

☐ Complete interview for you ☐ Sign your application ☐ Cash your check ☐ Cash your Food Stamps ☐ Receive your notices ☐ Receive your Medical Assistance Card

FOR WORKER USE ONLY	LDSS Office	Programs Applied For / Receiving	Assistance Unit ID's
	Worker's Name		Client ID
	Application/Redetermination Date		

6. INDIVIUAL INFORMATION Complete the section below.

Last Name	First Name	Middle Name	Jr.,III etc.

Maiden/Other Name	Social Security Number	List Additional Social Security Number	Date of Birth

Sex ☐Male ☐Female	Race * (Optional)		

Resident of Maryland ☐YES ☐NO	Marital Status	Due date if pregnant	Number expected	Receiving Prenatal Care? ☐YES ☐NO

Receiving benefits in another state:
Public Assistance? ☐YES ☐NO Food Stamps? ☐YES ☐NO Medical Assistance? ☐YES ☐NO

U.S. Citizen? ☐YES ☐NO	Student? ☐YES ☐NO	On Strike? ☐YES ☐NO	Disabled or Incapacitated? ☐YES ☐NO	Medical Insurance? ☐YES ☐NO	Medicare Part A ☐YES ☐NO	Medicare#

7. MIGRANT WORKER

Are you a migrant worker?
☐YES ☐NO

8. BOARDER If you are a boarder, fill in this sections:

Number of Meals per Day	Cost of Meals per Month $

9. CITIZENSHIP if you are not a United States citizen, fill in this section

INS Status	Newly Legalized Status Date	Sponsored Alien ☐YES ☐NO	Country of Origin

US Entry Date	INS Number	

10. SCHOOL if you are in school, fill in this section:

Student Status ☐Full-time ☐Half-time ☐Less than half-time	Educational Level ☐Elementary ☐College ☐Secondary ☐Other, List:_____	Highest Grade Completed Expected Graduation Date (*If in high school*)

School Name	School Number

School Address City State Zip Code + 4

11. DISABILITY If you are disabled or incapacitated, what is the disability?

12. MEDICAL INSURANCE If you have medical insurance, fill in this section:

Policy Number	Group Number	Policy Holder Name

Relationship to Policy Holder

	Financial Responsibility Penalty Type Penalty Date Special Needs (NEED)

12. MEDICAL INSURANCE (continued)

POLICY HOLDER ADDRESS

Number Street			
City	State	Zip Code + 4	Telephone Number

INSURANCE COMPANY

Insurance Company Name			
Number Street			
City	State	Zip Code + 4	Telephone Number

UNION

Union Name	Union Local Number
Number Street	

City	State	Zip Code + 4	Telephone Number

13. VETERAN INFORMATION If you are a veteran or a disabled widow or widower, or a disabled child of a deceased veteran, fill in this section:

Veteran's Name	Relationship to Veteran	Veteran's Status	Military Service Number

14. MEDICAL EXPENSE

If you are 60 or older, blind or disabled and applying for or receiving Food Stamps, do you have medical bills that you must pay?

☐YES ☐NO *If Yes, bring in your bills.*

15. LIQUID ASSETS Complete for assets as of the 1st day of the month. Check Yes or No for each ASSET TYPE

ASSET TYPE	CHECK ONE	OWNER	AMOUNT Balance/value	ACCOUNT NUMBER	FDIC NUMBER	INSTITUTION
Cash on Hand	☐YES ☐NO		$	N/A	N/A	N/A
Checking Accounts	☐YES ☐NO		$			
Savings Accounts	☐YES ☐NO		$			
Credit Union Accounts	☐YES ☐NO		$			
Trust Funds	☐YES ☐NO		$			
IRA or Keogh Accounts	☐YES ☐NO		$			
Stocks, bonds, Certificates, Money Market Funds, treasury or Other Notes	☐YES ☐NO		$			
Annuities:	☐YES ☐NO		$			
Other, List:	☐YES ☐NO		$			
Other, List	☐YES ☐NO		$			
Other, List	☐YES ☐NO		$			
Other, List	☐YES ☐NO		$			
Other, List	☐YES ☐NO		$			

LIFE INSURANCE AND FUNERAL PLANS If you have any life insurance or pre-paid burial plans or funds, full in this section. List all policies and plans no matter who pays for them.

NAME OF PERSON WHO PAYS	ORIGINAL FACE VALUE OR VALUE OF PLAN	CURRENT CASH VALUE	POLICY NUMBER OR ACCOUNT NUMBER	LIFE INSURANCE OR BURIAL PLAN	COMPANY, FUNERAL HOME OR BANK NAME
	$	$			
	$	$			

17. REAL PROPERTY If you own property, fill in this section. Include burial plots.

Number Street	City	State	Zip Code + 4
How Used?	Current Fair Market	Amount Owed Now	Trying to Sell ☐YES ☐NO
Number Street	City	State	Zip Code + 4
How Used?	Current Fair Market	Amount Owed Now	Trying to Sell ☐YES ☐NO

18. OTHER ASSETS If you own other assets not listed, such as antiques, boat, recreational vehicle, coin collections, furs, jewelry, livestock, or stamp collections, fill in this sections:

ASSET TYPE	CURRENT FAIR MARKET VALUE	AMOUNT OWED
	$	$
	$	$

19. POTENTIAL ASSET OR INCOME If you are expecting to receive an accident settlement, trust fund, inheritance or other money or property, full in this section.

Type	Lawyer Name
Explanation	Lawyer Telephone

20. TRANSFER OF ASSETS if you sold, traded or gave any property, motor vehicles, stocks, bonds, cash or other assets in the past 3 years (5 years for a trust), fill in this sections:

Transfer Date	Who Received the Asset?	Type of Assets
Fair Market Value When Transferred	Amount Received	Reason for Transfer

21. INCOME FROM WORKING If you are working now, fill in this section. If not, list the last job held. Include full-time, part-time or temporary work or self-employment, such as owning a business, roomer or boarder income, babysitting, home demonstrations, cleaning houses, etc.

Employer Name						
Employer Address- Number Street City State Zip Code + 4					Telephone	Type of Job
Date Job Began	Date Job Ended	Reason for Leaving	Date Last Pay Received if Job Ended		Gross Wages before deductions per Pay Period (*include tips, commissions*) $	
Hours Per Pay Period	How Often Paid?	If Income from Boarders, How Many Boarders?		Self-employment or Handicapped work Expenses	Type	
					Amount	$ $

Employer Name						Federal ID
Employer Address Number Street City State Zip Code+4					Telephone	Type of Job
Date Job Began	Date Job Ended	Reason for Leaving	Date Last Pay Received If Job Ended		Gross Wages before deduction per Pay Period (include tips, commissions) $	
Hours per Pay Period	How Often Paid?	If Income from Boarders, How Many Boarders?		Self-employment or Handicapped Work Expenses	Type	
					Amount	$ $

22. OTHER INCOME AND BENEFITS Check if you are receiving, have applied for or have been denied any of the following:

TYPE OF BENEFIT	RECEIVING BENEFITS	AMOUNT	APPLICATION STATUS	APPLICATION OR DENIAL DATE
Alimony	☐YES ☐NO	$	☐Applied for ☐Denied	
Child Support	☐YES ☐NO	$	☐Applied for ☐Denied	
Social Security Claim #:	☐YES ☐NO	$	☐Applied for ☐Denied	
SSI Claim #:	☐YES ☐NO	$	☐Applied for ☐Denied	
Railroad Retirement Benefits Claim#:	☐YES ☐NO	$	☐Applied for ☐Denied	
Veteran's Pension/Benefits	☐YES ☐NO	$	☐Applied for ☐Denied	
Unemployement Benefits	☐YES ☐NO	$	☐Applied for ☐Denied	
Worker's Compensation	☐YES ☐NO	$	☐Applied for ☐Denied	
Pension or Retirement	☐YES ☐NO	$	☐Applied for ☐Denied	
Disablility/Sick/Maternity Benefits	☐YES ☐NO	$	☐Applied for ☐Denied	
Union Benefits	☐YES ☐NO	$	☐Applied for ☐Denied	
Military Allotment	☐YES ☐NO	$	☐Applied for ☐Denied	
HUD Section 8 Utility Benefits/Supplements	☐YES ☐NO	$	☐Applied for ☐Denied	
Money from Friends or Relatives (loans & other)	☐YES ☐NO	$	☐Applied for ☐Denied	
Money from Rental income	☐YES ☐NO	$	☐Applied for ☐Denied	
Black Lung Benefits	☐YES ☐NO	$	☐Applied for ☐Denied	
Lump Sum Amounts	☐YES ☐NO	$	☐Applied for ☐Denied	
Civil Service Annuity	☐YES ☐NO	$	☐Applied for ☐Denied	
Public Assistance/State Disability Benefits from Another State	☐YES ☐NO	$	☐Applied for ☐Denied	
Interest or Dividends from Stocks, Bonds, Savings, or Other Investments	☐YES ☐NO	$	☐Applied for ☐Denied	
Other Income (*not listed above*) Specify _____	☐YES ☐NO	$	☐Applied for ☐Denied	
Other Income (*not listed above*) Specify _____	☐YES ☐NO	$	☐Applied for ☐Denied	

23. WORK REGISTRATION/PARTICIPATION FOR FOOD STAMP AND REFUGEE ASSISTANCE ONLY Certain applicants over 16 must register and participate in a work program. The work programs are the Food Stamp Employment and Training Program and the Refugee work Registration Program. You may not have to participant if you have a good reason. You may volunteer if you do not have to participate. Fill in this section.

Wish to volunteer? ☐YES ☐NO	Reason **NOT** able to participate?

24. SHELTER COSTS Are you paying for any of the following? Complete only if you are applying for Food Stamps

Expenses	Check One	Amount	How Often Paid?	Who Pays?	Expenses	Check One	Amount	How Often Paid?	Who Pays?
Rent	☐YES☐NO	$			Sewer	☐YES☐NO	$		
Mortgage	☐YES☐NO	$			Garbage	☐YES☐NO	$		
Electric	☐YES☐NO	$			Coop/ Condo Fee	☐YES☐NO	$		
Oil	☐YES☐NO	$			Homeowner Insurance (if not included in mortgage)	☐YES☐NO	$		
Gas	☐YES☐NO	$				☐YES☐NO	$		
Property Taxes	☐YES☐NO	$			Other Utility Cost, list	☐YES☐NO	$		
Telephone	☐YES☐NO	$			Other Utility Cost, list	☐YES☐NO	$		
Water	☐YES☐NO	$			Other Utility Cost, list	☐YES☐NO	$		

Do you live in: ☐Public Housing ☐Section 8 Housing ☐FMHA 515 Housing ☐Private Housing

Do you receive a Utility Supplement? ☐YES ☐NO

Is heat included in the rent? ☐YES ☐NO

If heat is not included in the rent, Check the main source of heat:

☐Oil ☐Gas
☐Electric ☐Coal
☐Wood ☐Kerosene
☐Propane ☐Other, list:

Do you pay for lights or cooking? ☐YES ☐NO
Check any other source(s) of heat:

☐Oil ☐Gas
☐Electric ☐Coal
☐Wood ☐Kerosene
☐Propane ☐Other, list

If you are sharing any of the costs listed above, fill in this section:

TYPE OF EXPENSES SHARED	WITH WHOM	TOTAL AMOUNT OF SHARED EXPENSES	AMOUNT OF YOUR SHARE
		$	$
		$	$

25. ADDITIONAL INFORMATION

YOUR RIGHTS AND RESPONSIBILITIES

YOU HAVE THE FOLLOWING RIGHTS

RIGHT TO WRITTEN NOTICE – We must always give you a written notice explaining your benefits when we approve your case. We must always give you written notice when we change your benefits, deny or close your case. You have 90 days from the notice date to ask for a hearing. If you ask for a hearing **within 10 days**, you may be able to keep getting benefits while you wait for the hearing.

RIGHT TO APPEAL - Ask for a hearing if you disagree with the Department's decision. Your case manager can help you write your appeal. At the hearing, you can speak for yourself or bring a lawyer, friend or relative to speak for you. You may call the Department at 1-800-332-6347 for help to request a hearing.

EQUAL RIGHTS – Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy state we can not discriminate against you because of race, color, national origin, sex, age, or disability. Under the Food Stamp act and USDA policy, we also cannot discriminate against you because of religion or political beliefs.

If you think we have discriminated against you, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). USDA and HHS are equal opportunity providers and employers.

RIGHT TO PRIVACY – You are giving personal information in the application. We use the information to see if you are eligible for benefits. If you do not give information, we may deny your application. You have a right to review, change, or correct any information. We will not show your information or give it to others unless you give us permission or federal and state law allows us to do so.

RIGHT TO CLAIM GOOD CAUSE – If you want Temporary Cash Assistance (TCA), you must help the Department get child support. You may not have to help if it puts you or your family in danger.

RIGHT TO REFUSE HELP – You do not have to accept help from a religious organization if it is against your religious beliefs.

YOU HAVE THE FOLLOWING RESPONSIBILITIES

PROVIDE INFORMATION – You must give true and complete information. You must provide proof of this information. We will keep this information private.

Collecting application information, including the social security number of each household member, is authorized under the Food Stamp Act 1977 as amended, U.S.C. 2001-2036, Social Security Act 1137(F) and 42 U.S.C. 1320b –7 (d).. We use the information to find out if your household is eligible.

We also use the information to see if you meet program rules. We may contact your employer, bank or other party. We may also contact local, state or federal agencies to make sure the information is correct. We can give your information to other federal or state agencies for official use and to law enforcement officers who need it to find persons fleeing to avoid the law.

If you get too much in benefits, we may give the application information, including social security numbers, to federal or state agencies, as well as private claims collections agencies, for action.

Giving information is voluntary. If you do not give us information, including social security numbers, for everyone who wants help; we may deny benefits for each person who does not give a social security number. If you do not have a social security number, we will help you get one.

REPORT CHANGES – You must report all changes within 10 days unless you have a job and are part of the food stamp simplified reporting group and you are not receiving Cash Assistance or Medical Assistance. If you want to know if you are part of this group, ask your case manager. You may tell us about any changes in person, by telephone, or by mail to the Department.

YOUR RIGHTS AND RESPONSIBILITIES

WARNING – WE MAY DENY, LOWER OR STOP YOUR BENEFITS IF YOU GIVE US WRONG INFORMATION OR DO NOT REPORT CHANGES. A JUDGE MAY FINE AND/OR IMPRISON YOU IF YOU DELIBERATELY GIVE WRONG INFORMATION OR DO NOT REPORT CHANGES.

FOOD STAMP PENALTY – Household members shall not

- Give false information or withhold information to get or continue to get Food Stamps
- Trade or sell Food Stamps, or electronic benefits cards.
- Use Food Stamps to buy items not allowed, such as alcohol and tobacco.
- Use someone else's Food Stamp benefits.
- Use someone else's Electronic Benefits Card without authorization

Your food stamps will not increase if your cash assistance case is reduced or closed because you did not follow the rules.

If a household member deliberately breaks the rules, we may bar the person from the Food Stamp Program.

- We may bar this person for one year after the first violation.

- We may bar this person for two years:
  *After the second violation, or
  *After the first time a court finds this person guilty of buying illegal drugs with Food Stamps, or
  *After the first time a court finds this person guilty of buying guns, bullets, or explosives, with Food Stamps.
  *After a court finds this person guilty of trafficking food stamp benefits of $500 or more.

A judge can also fine this person up to $250,000, imprison the person for up to 20 years, or both. A judge can also bar this person for an additional 18 months. The person may also have to face further prosecution under other federal laws.

TCA PENALTY – If an assistance unit members is convicted of an Intentional Program Violation (IPV), everyone in your family will lose their benefits.

- The first time, you will lose your benefits for 6 months or until you repay all of the money.
- The second time, you will lose your benefits for 12 months or until you repay all of the money.
- The third time, you cannot get TCA benefits again.

MEDICAL ASSISTANCE WARNING AND PENALTY – Only use Medical Assistance cards if you are eligible.

Every person convicted of "Medical Assistance Fraud" with a value of $500 or more in money, services, or goods is guilty of a felony, and shall:

1. Pay back money, services or goods; of the value of those services or goods unlawfully received;
2. Be subject to a fine of a no more than $10,000, imprisoned for no longer that five years, or both.

Every person convicted of "Medical Assistance Fraud" with a value of less than $500 in money, services or goods is guilty of a misdemeanor, and shall:

1. Pay back money, service or goods; of the value of those service or goods unlawfully received;
2. Be fined no more than $1,000 and imprisoned for no longer than three years, or both.

YOUR RIGHTS AND RESPONSIBITIES

READ BEFORE SIGNING:

I understand that I can be fined, imprisoned or have my benefits reduced for making false statements or for pretending to be another person.

I also know I can be punished for not reporting changes that may affect my eligibility or benefit amount.

I know the Department can use the application against me in a court or law for fraud prosecution.

I know that failing to report to verify shelter, medical, or dependent care expenses or child support payments is the same as saying I do not want a deduction for the expense I did not verify or report.

I understand that the Department may select my case for a spot check.

I agree to allow someone from the Department to visit me at home. I will help them get all needed proofs from any source.

I agree that Medicare Part B will make payments directly to doctors and medical suppliers.

I give the Department the right to seek payment from private or public health insurance and any liable third party. I understand that must cooperate with the Department in securing such payments. The Department may seek payment without legal action, as long as it does not keep more than amount Medical Assistance paid.

I give the Department the right to inspect, review and copy all medical records for service received through the Medical Assistance Program.

I understand that when a person is deceased who was at least 55 years old when receiving Medical Assistance the state may take money from the estate to repay payments made on behalf of that person. The program may take the money only if there is no surviving spouse, unmarried child younger than 21, or blind or disabled child (married or unmarried) of any age.

SIGNATURE SECTION

I have read or someone has read and explained the entire application to me, I swear or affirm under penalty of perjury that all the information I gave is true, correct, and complete to the best of my ability, behalf and knowledge. I received a copy of my rights and responsibilities. I authorize any person, partnership, corporation, association, or governmental agency that know the facts about my eligibility to give that information to the Department. I also authorize the Department to contact any person, partnership, corporation, association, or governmental agency that has given proof of my eligibility for benefits. I certify, under penalty of perjury, that by signing my name below, all persons for whom I am applying are U.S. citizens or lawfully admitted immigrants.

Signature of Applicant/Recipient	Date
Signature of Witness (If you signed an X)	Date
Signature of Spouse (If Applicable)	Date
Signature of Authorized Representative (If Applicable)	Date
Signature of Case Manager	Date

I withdraw my application for: ☐ Cash Assistance ☐ Food Stamps ☐ Medical Assistance

Signature of Applicant, Recipient or Authorized Representative	Date

YOUR RIGHTS AND RESPONSIBLITIES

ASSIGNMENT OF SUPPORT RIGHTS FOR TEMPORARY CASH ASSISTANCE

- I assign to the State of Maryland all rights, titles, and interest in support that I may have for myself or for any person receiving TCA.
- This includes any overdue support that has been collected.
- I agree to send to the State of Maryland any support I receive. If I do not turn over this support, I will have to repay this amount to the State of Maryland. I may also be prosecuted for fraud.

When I am eligible for Medical Assistance:

- I assign all rights, title, and interest in medical support and health insurance payments I may have for myself or any person receiving Medical Assistance. This includes overdue medical support or health insurance payments that have not been collected.
- I agree to have the child support agency collect medical support payments owed to me and to keep up to the amount of Medical Assistance payments that have been made to me.
- I agree give the State of Maryland any medical support or health insurance payments I receive.
- I will cooperate to the best of my ability and knowledge with the child support agency while I am receiving TCA and Medical Assistance
- If I do not cooperate with the child support agency to the best of my ability and knowledge, I may lose all of my benefits and my case may be closed.

I HAVE READ THESE STATEMENTS OR SOMEONE HAS READ THEM TO ME. I UNDERSTAND WHAT THEY MEAN. BY SIGNING MY NAME BELOW, I AGREE TO FOLLOW WHAT THEY SAY.

Signature	Date

MEDICAL ASSISTANCE PROGRAM
VOCATIONAL, EDUCATIONAL, AND SOCIAL DATA
Department of Social Services

To be completed by applicant and reviewed during interview, with assistance from case manager as necessary.

Name	Social Security #		Alien Residency Date
Customer ID#	Date of Birth	Sex: M___ F___	Alien Status

PART 1: WORK HISTORY

What is the date you last worked? _____/_____/_____
List all jobs held in the last fifteen years. Begin with your most recent job. To list more jobs, use Part 9: COMMENTS.

Job Title	What You Did	Date Started	Date Ended	Hours Per Week	Reason for Leaving

In your usual job did you:	YES	NO	
Use machines, tools, or equipment of any kind?	____	____	
Use technical knowledge and skills?	____	____	
Do any writing, complete reports, etc.?	____	____	
Supervise other people	____	____	If yes, how many people?_____

Check the number of **HOURS** you performed the following physical activities in your usual job:

Activity	0	1	2	3	4	5	6	7	8
Bend									
Squat									
Crawl									
Reach									
Climb									

Activity	0	1	2	3	4	5	6	7	8
Sit									
Stand									
Walk									
Lift									
Carry									

Check the **HEAVIEST** weight lifted in your usual job.
___ Less than 10 lbs. __ 10 lbs. __25 lbs. __ 50 lbs. __ 100 lbs. __ More than 100 lbs.

Check the weight **FREQUENTLY** lifted/carried in your usual job.
___ 10 lbs. ___ 25 lbs. ___ 50 lbs. ___ more than 50 lbs.

Part 2: EDUCATION/TRAINING

Can you Speak English? __YES __ NO Can you Read English? __ YES __ NO Can you Write English? __ YES __NO

Circle the highest grade completed 1 2 3 4 5 6 7 8 9 10 11 12

Were you in any special education classes during high school? ___ YES ___ NO

Please check and give date received if one applies:
___High School Diploma ___High School Certificate ___GED Date Received___/_____/_____

Attended College From Dates ____/_____/_____ to ____/_____/_____Degree:_____

Have you had Vocational, Military, or Job Training? ___ YES ____ NO

Please describe the training:_____

List type of license or certificate_____Date:_____

Part 3: SOCIAL SECURITY DISABILITY/SSI BENEFITS

Have you applied for Social Security Disability and/or SSI benefits __ YES __ NO

___ I applied for benefits on this date: ___/___/___
Month Day Year

___ My application for SSI/SSDI is still pending

___ My application for SSI/SSDI was denied: ___/___/___
Month Day Year

___ I intend to file an appeal

___ I have filed an appeal: *Please check all that apply and give date filed*

___Reconsideration Date: ___/___/___
Month Day Year

___Hearing before Administrative Law Judge Date: ___/___/___
Month Day Year

___Appeals Council Date: ___/___/___
Month Day Year

PART 4: MEDICAL

What medical conditions prevent you from working? Please list all conditions. Briefly explain how your conditions keep you from working.

When did your conditions first bother you? Date: ___/___/___
Month Day Year

PART 5: INFORMATION ABOUT YOUR MEDICAL TREATMENT AND RECORDS

Have you been seen by a doctor/hospital/clinic or anyone else for the illnesses, injuries or conditions that limit your ability to work?
___ YES ____ NO

Have you been seen by a doctor/hospital/clinic or anyone else for emotional or mental health problems that limit your ability to work?
___ YES ____ NO

Please list your treatment sources for your physical and/or mental conditions. To list more sources, use Part 9: COMMENTS

NAME OF DOCTOR/MCO	ADDRESS	TELEPHONE	DATES & REASON FOR VISIT
			Starting Date: _____ Last Seen: _____ Reason:_____
			Starting Date: _____ Last Seen: _____ Reason:_____
			Starting Date: _____ Last Seen: _____ Reason:_____

NAME OF THERAPIST/COUNSELOR	ADDRESS	TELEPHONE#	DATES & REASON FOR VISIT
			Starting Date:_____ Last Seen:_____ Reason:_____
			Starting Date:_____ Last Seen:_____ Reason:_____
			Starting Date:_____ Last Seen:_____ Reason:_____
NAME OF HOSPITAL/CLINIC	**ADDRESS**	**TELEPHONE#**	**DATES & REASON FOR VISIT**
			Admission:_____ Discharge:_____ Reason:_____
			Admission:_____ Discharge:_____ Reason:_____
			Admission:_____ Discharge:_____ Reason:_____

MEDICATIONS: List all prescription and nonprescription medications that you now take, and their side effects, which may keep you from working, e.g. drowsiness and dizziness, etc. To list additional medications, use **Part 9: COMMENTS**

NAME OF MEDICATION	REASON FOR MEDICATION	SIDE EFFECTS

PART 6: BEHAVIORAL HEALTH

Do you have any of the following thoughts or feelings?

Thought/Feeling	YES	NO
Feel sad a lot of the time		
Have problems sleeping (too much or too little)		
Loss of interest in activities I usually like		
Feel guilty or worthless		
Changes in appetite (eat too much or to little)		
Feel or think people are trying to hurt me		
Loss of energy		
Much more energy than usual		

Thought/Feeling	YES	NO
Have panic attacks		
Have problems concentrating or thinking		
Hear voices when no one is there		
See things that others don't see		
Feel nervous or worried all the time		
Think of hurting myself		
Think of hurting others		
Feel hopeless or desperate		

PART 7: INFORMATION ABOUT YOUR ACTIVITIES

How often do you have DIFFICULTY doing the following? (Check: always, often, seldom, or never after each activity.)
Please check, if pain is associated with or affects your ability to engage in an activity)

ACTIVITY	ALWAYS	OFTEN	SELDOM	NEVER	AFFECTED BY PAIN
Sitting					
Standing					
Walking					
Bending					
Lifting					

ACTIVITY	ALWAYS	OFTEN	SELDOM	NEVER	AFFECTED BY PAIN
Grasping					
Reaching					
Pushing					
Pulling					

Taking care of yourself

Do you have any problems bathing? __ YES __ NO If, yes, please explain:_____
Do you have any problems dressing? __ YES__ NO If yes, please explain:_____
Describe any changes in taking care of yourself since you became unable to work:_____

_____

_____

Taking care of where you live

Do you live in an apartment ___ or house ___? Who lives with you?_____
Do you clean house, do odd jobs/chores around the house/yard? ___ YES___ NO
If yes, what do you do?_____
How often do you do these things?_____
How long does it take you to do these things?_____Do you need help? __ YES __ NO If yes, please explain:

_____

Do you need to stop and rest? __ YES __NO If yes, explain why._____
Describe any changes in taking care of your household since you became unable to work:_____

_____

Cooking

Do you prepare your own meals? __ YES __ NO If yes, which meals? __Breakfast __ Lunch __ Dinner
What kind of food do you usually prepare?_____
How often do you cook your own meals?_____
Do you need help? __ YES __ NO If yes, please explain:_____
Do you need to stop and rest? __YES __ NO How often do you need to rest?_____
Describe any changes in your cooking habits since you became unable to work:_____

_____

Shopping

Do you go shopping? __ YES __ NO If yes, what kind of shopping do you do? (Groceries, clothing, etc):_____

_____

How often do you shop?_____Do you need help shopping? __YES ___ NO
If yes, please explain:_____
Do you handle your own money? __ YES __ NO If no, please explain:_____
Describe any changes in your shopping habits since you became unable to work:_____

_____

Going out in public

How do you get to places you need to go?_____
Can you drive? __ YES __NO If no, please explain:_____
How long can you drive without stopping and resting?_____
Do you need help when you go out? __ YES__ NO If yes, please explain:_____
Do you have problems walking or climbing stairs? __YES __NO If yes please explain:_____
Describe any changes in going out in public since you became unable to work:_____

_____

Hobbies/Activities/Pastimes

What do you do in your spare time? (For example: reading, writing, gardening, sewing, watching TV)

How often do you do these things?

Do you need to stop and rest? __ YES __ NO If yes, please explain:

How often do you need to stop and rest?

Describe any changes in your hobbies and pastimes since you became unable to work:

Social Relationships

Do you go and visit people? __ YES__ NO If yes, how often? How long?

If no, please explain why you do not go out and visit with people:

Do you talk on the phone with other people __ YES__ NO If yes, how often? How long?

Describe any changes in your social relationships since you became unable to work:

Other

Do you have any problems remembering? __ YES__ NO If yes, please explain:

Do you have any problems concentrating? __ YES__ NO If yes, please explain:

Do you have any problems understanding? __ YES__ NO If yes, please explain:

Do have problems listening? __ YES __ NO If yes, please explain:

Do have problems getting along with others? __ YES__ NO If yes, please explain:

(Only complete the next section if you experience pain)

Part 8: INFORMATION ABOUT YOUR PAIN. Use Part 9: COMMENTS if more space is needed.

Describe your pain – Please include where the pain is located and if it spreads to other areas of your body.

Describe the kind of pain (dull, burning, aching, sticking, sharp, shooting, etc) On a scale of 1-10 how severe is it. (10 is the worst)

Describe how pain affects your activities, including your ability to concentrate and remember.

How often do you experience pain? Is it constant or does it occur only with certain activities?

Is it worse in the morning, afternoon or evening?

How long does the pain last?

What makes your pain worse? (lifting, standing, cold weather, etc.)

Describe any treatments (medications, hot baths, therapy, exercise, etc.) used to relieve your pain. How well do they work? How often do you use them?

Describe the activities you have had to restrict or stop because of pain.

Part 9: COMMENTS

Use this space to provide additional information.

Applicant's Signature **Date** **Printed Name of Applicant**

FOR OFFICE USE ONLY

Comments by Case Manager: Please note any observations of the claimant's behavior, appearance, degree of limitations, etc.

Case Manager's Signature **Date** **Printed Name of Case Manager** **Case Manager's Phone #**

Supervisor's Signature **Date** **Printed Name of Supervisor** **Supervisor's Phone #**

_____Department of Social Services

MEDICAL REPORT FORM 402B

District: _____
Worker: _____
Phone#: _____
Date: _____
Client ID: _____

The information provided on this form may be used to determine eligibility for federal and state programs using Social Security disability criteria.

Please Print or Type

A. Patient Information:

Name of Patient: _____ Address: _____
Phone: _____ Date of Birth: _____ SSN# _____

Physician's Name: _____
Address: _____ Phone: _____

Specialty: _____
Dates of Examination _____ First Visit: _____ Last Visit: _____
Presenting Symptoms: _____

Height: _____ Weight: _____ BP: _____ Muscle Strength (1/5 to 5/5): UE _____ LE _____

B. Diagnosis: (You must attach progress notes or any other general records currently available)

_____ ICD-9-CM _____ Onset Date _____
_____ ICD-9-CM _____ Onset Date _____
_____ ICD-9-CM _____ Onset Date _____
_____ ICD-9-CM _____ Onset Date _____
_____ ICD-9-CM _____ Onset Date _____

HIV/AIDS INFECTION: Opportunistic and Indicator Disease (Please check all those that apply).

☐ Bacterial Infections ☐ HIV Wasting ☐ Viral Infections ☐ Diarrhea ☐ Protozoan or Helminthic Infections
☐ Neurological Abormalities ☐ Fungal Infections ☐ Other, specify _____
CD4 Count _____ Viral Load _____

Diagnostic Tests Performed: (To receive payment for laboratory tests or other diagnostic evaluations, including psychiatric and psychological evaluations, you must attach results or provide the date when results will be available.)

_____
_____
_____
_____

Treatment and Response: Include past treatment and response, if known, and current treatment and response. Please include therapy and recommendations:

_____
_____
_____
_____

C. MEDICATIONS: Include all prescription and nonprescription medications currently being taken, and side effects that may have implications for working, e.g. drowsiness and dizziness, etc.

Name of Medication	Reason For Medication	Side Effects

D. Referral to Specialist Recommended: Please explain reasons for referral_____

_____

_____

E. Physical Limitations:

In terms of the patient's ability to perform during an 8-hour workday with normal breaks, the patient can:

Activity	No Restrictions	Never	1 hr	2 hrs	3 hrs	4 hrs	5 hrs	6 hrs	7 hrs	8 hrs
Sit										
Stand										
Walk										
Climb										
Bend										
Squat										
Reach										
Crawl										

Check the **HEAVIEST** weight the patient can lift/carry.

□ Less than 10 lbs. □ 10 lbs. □ 20 lbs. □ 25 lbs. □ 50 lbs. □ 100 lbs. □ More than 100 lbs.

Check the weight the patient can lift/carry **FREQUENTLY**.

□ 10 lbs. □ 25 lbs. □ 50 lbs. □ More than 50 lbs.

The patient can be exposed to:

Environmental Conditions	Never	Occasionally	Frequently
Extreme Cold			
Extreme Heat			
Humidity			
Chemicals			
Dust			
Fumes/Odor			
Noise			
Height			

Describe how these environmental factors limit the patient's activities:_____

_____

_____

The patient can use hands for repetitive action such as:

Hand Action	Yes	No
Simple Grasping		
Pushing		
Fine Manipulation		

Visual Limitations: Visual Field: OD_____OS_____VA_____

(after corrections): OD_____OS_____VA_____

Hearing Limitations □ Yes □ No □ Minimal □ Moderate □ Extreme

Speaking Limitations □ Yes □ No □ Minimal □ Moderate □ Extreme

Is substance abuse present? □Yes □ No

Would the patient's current condition exist in the absence of substance abuse?
□ Yes □ No

F. Mental Status Information:

Does the patient suffer from mental illness? □ Yes □ No If yes, complete section F.
If no, go directly to section G.

Please provide all five axes of a DSM-IV diagnosis:

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V GAF score: current _____ Highest level in the past year _____

Cognitive testing (list tests performed with results) VIQ_____ PIQ_____ FSIQ_____

Please check the appropriate degree of limitation for the following:

Degree of Limitation is defined as "None," "Mild," "Moderate," "Marked" and "Extreme."

Moderate refers to an impairment or combination of impairments that produce symptoms that have an impact on one's ability to function independently, appropriately and effectively on a sustained basis.

Marked refers to an impairment or combination of impairments that produce symptoms that seriously interfere with one's ability to function independently, appropriately and effectively on a sustained basis. **Extreme** is defined as continuous and severe.

FUNCTIONAL LIMITATIONS	DEGREE OF LIMITATION				
Restriction of activities of daily living	None □	Mild □	Moderate □	Marked □	Extreme □
Difficulties in maintaining social functioning	None □	Mild □	Moderate □	Marked □	Extreme □
Difficulties in maintaining concentration, persistence or pace	None □	Seldom □	Often □	Frequent □	Constant □
Episodes of decompensation, each of extended duration	None □	Once □	Repeated or Twice(three or more) □		Continual □

DHR/FIA 402-B (Revised 3/07)

G. Evaluation of Medical Condition:

Based upon your evaluation is your patient's medical condition expected to last at least 12 months?

Yes ☐ No ☐

Please give date of onset and the length of time the patient's medical condition is expected to last or has lasted.

_____/_____/_____/ To _____/_____/_____/
month day year month day year

Is the patient's medical condition expected to result in death? Yes ☐ No ☐

Does the patient's medical condition prevent him or her from working in any employment?
Yes ☐ No ☐

If yes, please give the duration. _____/_____/_____/To____/_____/_____/
month day year month day year

H. Additional Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature:_____ Print Name:_____

Title:_____ Telephone: _____

License:_____

MA Provider#:_____

Date:_____

DHR/FIA 402-B (Revised 3-07)

ATTACHMENT V – LIQUIDATED DAMAGES TABLE

Attachment V DPSCS Inmate Medical Health Care and Utilization Services
Liquidated Damages

	Ref	Liquidated Damages Description	MIN Threshold % (if applicable)	Liquidated Damages Amount	Performance Standard
1	3.6.1.2 3.6.1.3	Provides clinical staffing, Specialist Staffing and any other positions identified in the Contractor's staffing plan in accordance with submitted staffing matrix @ rates for appropriate positions in Attachment R, CCC and proposal.	96%	Rate calculated on hourly rate per clinical positions.	An occurrence is total number of hours for each position that does not meet the 96% minimum fill rate per position per SDA.
2	3.8 3.9	Contractor maintains Credential Files	99%	$100 for each missing credentialing information item required for each employee past or present below minimum threshold	An occurrence is each missing credentialing information item required for each employee past or present not submitted to the agency.
3	3.10.1.2	Contractor shall develop and maintain a comprehensive competency based orientation program for new staff.		$250 for each employee that has not completed a documented orientation.	An occurence represents any staff that does not receive a pre-service orientation. The orientation shall include a review of the Policies and Procedures manual of the Agency, the Policies and Procedures manual of the Provider, how to access those manuals, EHR training basics of working in a prison setting and a review of the limits of the scope of responsibility based on competency.
4	3.17	Contractor provides Emergency Care		$500 per incident that emergency care is not adequately provided	An occurrence is each individual 911 event that does not follow the first aid and emergency procedures related to emergency triage to a community based hospital or infirmary as referenced in § 3.17, § 3.22.3 and § 3.32.2.
5	3.18	Contractor provides On-call Physician List		$100 per month that on call list is not updated or posted as required	An occurrence is each time an on call list is not updated or posted as required in the infirmary, dispensary and sick call areas.
6	3.21.5	Contractor provides Equipment Inventory Reporting as required		$100 per day annual inventory report is greater than 15 days past due date AND $25 for each equipment item not affixed with State tag number.	An occurrence is each day past the Annual Inventory Report due date + each equipment item without a State tag number as referenced in § 3.21.5.5(6). Liquidated damages will NOT be assessed against the Contractor for a missing piece of equipment that is the responsibility of one of the Other Healthcare Contractor. Liquidated damages will be assessed each day greater than 15 days past the due date.

Attachment V DPSCS Inmate Medical Health Care and Utilization Services
Liquidated Damages

	Ref	Liquidated Damages Description	MIN Threshold % (if applicable)	Liquidated Damages Amount	Performance Standard
7	3.21.5.4 3.21.5.5	Provide Equipment Maintenance Database and Report	98%	$25 for any element missing below 98% in the database and report	An occurrence is any element missing in the database and report.
8	3.24.3	Each inmate admitted to the infirmary, shall only be admitted upon physician order which may be performed telephonically.	100%	$100 for each admission without a documented order.	An occurrence is when any inmate assessment is not performed, thus no documentation in EHR.
9	3.24.3	Each Inmate in the infirmary shall receive an Assessment within 24 hours of Admission, which shall include a History, physical, and Treatment Plan documented in the EHR.		$100 for each history and physical on admission not documented in EHR.	An occurence is any admission history and physical not documented in EHR within 24 hours.
10	3.24.3	Infirmary and isolation unit rounds shall be made daily (1x/day) by the Clinician and documented in the EHR. Nursing rounds shall be performed per shift (3x/day) and evidence of such shall be documented in the EHR.		$50 for each round not made daily by Clinician and documented + $50 for Nursing round not made per shift and documented.	An occurrence is any time daily rounds are not conducted and documented and Nursing rounds not conducted per shift and documented.
11	3.25.8 3.25.10.1	An intake screening, to include a hearing test, of any newly admitted Inmate to any DPSCS institution conducted utilizing the IMMS form within two hours of entry into a facility.	within 10 minutes of 2-hr timeframe (i.e. 2 hours and 10	$50 for each occurance beyond 2-hr 10-min timeframe	An occurrence represents any timeframe beyond the 2-hr and 10-minute allowance.
12	3.25.8 3.25.10.1	An intake screening, to include a hearing test, of any newly admitted Inmate to any DPSCS institution conducted utilizing the IMMS form and the completion of all form questions within two hours of entry into a facility.		$50 per question for each question missed in IMMS.	A question represents any question with a missing component of the receiving process missed in IMMS.
13	3.26	Conduct a complete medical health examination on all inmates, including parole violators and escapees within 7-days of reception. Provide medical intake evaluations every day.	98%	$50 for each occurance of a medical health exam not completed below 98% threshold.	Any occurrence represents any failure to perform.
14	3.26.2.3	Offer either blood or oral testing (with blood confirmation) and provide counseling and education.	98%	$50 per occurrence below 98% threshold.	An occurrence is any detainee/inmate that does not have documentation of HIV testing being offered and counseling being completed within the required timeframe.

Attachment V DPSCS Inmate Medical Health Care and Utilization Services
Liquidated Damages

	Ref	Liquidated Damages Description	MIN Threshold % (if applicable)	Liquidated Damages Amount	Performance Standard
15	3.27	Each inmate with sufficient period of incarceration shall receive physical re-evaluations during his or her period of incarceration.	95%	$50 for each occurrence exam not completed within 10 days of schedule requirements below 95% threshold.	An occurrence is any physical re-exams not completed on inmates once every 4 years (under 50); or if over 50 years of age once per year. Liquidated damages will be assessed again each month that the requirement is not performed, provided the Department has notified the Contractor of the ommission or lack of performance.
16	3.27.1.3	An inmate shall be tested (screened) for TB annually whether or not scheduled for physical re-examination.	100%	$100 per annual PPD not provided to patient as required.	Annual PPDs must be completed on all inmates and detainees as required. Liquidated damages will be assessed again each month that the requirement is not performed, provided the Department has notified the Contractor of the ommission or lack of performance.
17	3.27.1.4	Inmates shall be re-informed of his or her opportunity for HIV testing at every physical re-examination.	95%	$50 for each occurrence re-education not completed within 10 days of schedule requirements below 95% threshold.	An occurrence is any re-educations not completed on inmates at every physical re-examination. Liquidated damages will be assessed again each month that the requirement is not performed, provided the Department has notified the Contractor of the ommission or lack of performance.
18	3.28.4.2	Each sick call clinic shall continue operation on that day until it is completed; i.e. no “backlogs”.	95%	$25 per patient scheduled but not seen in daily sick call below 95% threshold.	An occurence is when an inmate scheduled for a clinic session is not seen.
19	3.28.4.2	Each sick call clinic shall continue operation on that day until it is completed; i.e. no “backlogs”. Same day referrals from triage (emergent complaints) shall be seen during a clinic session on the same day that the Inmate appears for services.	100%	$50 per triage patient not seen in daily sick call.	An occurence is when same day referrals from triage (emergent complaints) not seen during a clinic session on the same day that the inmate appears for services.
20	3.29.2	Contractor maintains Medication Security	100% (narcotic) 95% (other than narcotic)	$100 for each occurrence of medication not secured appropriately.	An occurrence is any incidence of medication not secured appropriately.
21	3.29.2 (4)	Perform scanning of all medications ordered and shipped	100%	$100 for each order and shipment not scanned	An occurrence is each medical medication order (including STAT orders) and shipment not scanned.

Attachment V DPSCS Inmate Medical Health Care and Utilization Services
Liquidated Damages

	Ref	Liquidated Damages Description	MIN Threshold % (if applicable)	Liquidated Damages Amount	Performance Standard
22	3.29.3.1	Contractor maintains electronic Medication Administration Record (e-MAR)	95%	$200 for each e-MAR that is not completed below 95% threshold.	An occurrence is an individual dose not received within 2 hours after receipt; or an individual e-MAR not documented.
23	3.30.1.5	Shall follow national guidelines for disease/condition specific organizations in the development of treatment programs	95%	$250 for each deviation from established treatment programs below 95% threshold.	An occurrence is a deviation from established treatment programs.
24	3.30.3	Perform monthly chart review by a RN or Clinician for chronic care patients.	95%	$100 for each occurrence per audited patient record that was not provided in accordance with the OIHS Clinical Care Manuals below 95% threshold.	An occurrence is when a chronic care patient does not receive a chart review by a RN or Clinician every month.
25	3.30.3	Chronic care patients shall be seen by a Clinician every ninety days at a minimum.	95%	$250 for each occurrence per audited patient record that was not provided in accordance with the OIHS Clinical Care Manuals below 95% threshold.	An occurrence is where a chronic care patients are not seen by a Clinician every 90 days.
26	3.39.2.2	Make available appropriate prenatal care, specialized obstetrical services twice weekly and postpartum care for pregnant inmates.	100%	$250 per element not performed as required in the OIHS Pregnancy Management Manual	An element is non-performance as required in the OIHS Pregnancy Management Manual.
27	3.41.2.1	The transfer form designated by the Agency and contained within the EMR, shall be completed by the Clinician within twelve (12) hours of having been notified of transfer or release.	90%	$50 for each medical transfer assessment form not submitted below 90% threshold.	An occurrence represents an incomplete or absent transfer assessment form in EHR.
28	3.41.3	Utilize a Continuity of Care Form (hardcopy) consistent with Department Policy and Procedure in conjunction with Inmate release	95%	$250 for each occurrence a Continuity of Care Form is not complete in the discharge planning process below 95% threshold.	An occurrence represents a Continuity of Care Form not being complete in the discharge planning process.

Attachment V DPSCS Inmate Medical Health Care and Utilization Services
Liquidated Damages

	Ref	Liquidated Damages Description	MIN Threshold % (if applicable)	Liquidated Damages Amount	Performance Standard
29	3.49	Operate a comprehensive infection control program that ensures that communicable diseases are appropriately diagnosed, treated, and controlled to prevent and minimize infectious disease outbreaks.	100%	$150 for each occurrence of failure to document diagnosis/treatment of an infectious disease	An occurrence represents any failure to document the diagnosis of an Infectious Disease as well as providing the necessary treatment.
30	3.50	Contractor addresses Administrative Remedy Procedures (ARPs) & ARP Appeals timely & completely	99%	$50 for each ARP that is not completed by due date below 99% threshold. + $25 per day each ARP is past the due date below 99% threshold.	An occurrence is each ARP not submitted by the due date.
31	3.55.1	Implement the CQI program	100%	$100 per occurrence	An occurrence represents a failure to conduct required CQI meetings as outlined in § 3.55.2.
32	3.57.1	Performs Safety & Sanitation inspections	100%	$1,000 per each inspection not performed + $100 per each report not submitted within 30 days as required.	An occurrence is any inspection not performed and any report not submitted within 30 days as required.
33	3.59	Performs Morbidity and Mortality (M&M) reviews of adverse patient outcomes	100%	$125 for each M&M review not performed + $125 per each report not submitted	An occurrence when the Morbidity & Mortality (M&M) review is not completed within the 72 hours timeframe and the M&M report of Multi-disciplinary input is not submitted within 10 business days.
34	3.65	Provide Methadone maintenance according to Federal & State mandates.	100%	$1000 per incident that required Methadone licensure is not in place.	An occurrence is any incident whereby License is not maintained as current and available for inspection.

Attachment V DPSCS Inmate Medical Health Care and Utilization Services
Liquidated Damages

	Ref	Liquidated Damages Description	MIN Threshold % (if applicable)	Liquidated Damages Amount	Performance Standard
35	3.65.1.1	Maintain the methadone program currently in place at any approved DPSCS facility for: (1) Utilization in the detoxification / withdrawal of any Inmate experiencing withdrawal from opiates when prescribed by a physician; or (2) Maintenance on methadone of Inmates arrested at a time where the Inmate is enrolled and participating in a bona fide methadone program in the community.	100%	$250 for each occurrence of non-compliance with Methadone program.	An occurrence is any incident of non-compliance with Methadone program.
36	3.67	Maintain a complete EHR	95%	$50 per occurrence of non-completion of patient record in EHR below 95% threshold.	An occurrence is every instance of failure to document patient records properly in EHR.
37	3.70.1.1 3.70.1.2	Provides complete UM report	98%	$25 per each missing element below 98% threshold.	An element represents any item described in § 3.70.1.1 and § 3.70.1.2.
38	Attachment AA-1 (Reports)	Submission of all reports, excluding those itemized in this Attachment V.	99%	$25 for each day beyond the due date for each report below 99% threshold.	An occurrence represents any report not submitted as required.
39	Attachment AA-2 (Meetings)	Contractor Participation in Meetings as assigned	99%	$50 per meeting that required representation is not present below 99% threshold.	An occurrence is any instance where the required attendance of a contractor does not report as required.
40	Attacment Q	Submit State Stats Reports in accordance with Attachment Q.	100%	$100 each day past due date	An occurrence is each day past the due date.

ATTACHMENT W – IMMS POLICY

Attachment W IMMS Policy Part I

OFFICE OF PROGRAMS AND SERVICES: CLINICAL SERVICES

MEDICAL EVALUATIONS MANUAL

Chapter 1
MEDICAL INTAKE

Section 1A
Medical Intake Process Part I: The IMMS
(Incorporates Previous Accept Reject Policy)

I. Policy: All inmates newly admitted to DPSCS facilities shall receive a medical intake evaluation immediately upon an inmate's entrance from the community that will:

Identify and address any urgent medical/mental health/dental health needs of those arrestees/detainees/inmates admitted to any DPSCS facility and/or is transferred from a pretrial facility to Patuxent Institution or a Division of Correction facility.

Identify and triage arrestees/detainees/inmates with known or easily identifiable chronic health needs that require medical intervention.

Identify and isolate arrestees/detainees/inmates who appear potentially contagious or have communicable diseases.

Identify and facilitate intervention for arrestees/ detainees/inmates who may be at risk for suicide.

Identify and facilitate intervention for arrestees who have a history of acute or persistent and serious psychiatric illness.

Identify at an earlier time arrestees/detainees/ inmates who may be at risk for heat related health issues if placed in non-air conditioned environments

II. Procedures:

A. Initial Intake Processing:

1. Initial Intake screening shall be conducted by an RN or higher medical level staff in collaboration with correctional officers and

remaining medical and mental health staff. The processing shall include the following:

a. All arrestees shall have an initial observation screening by the RN before being accepted into Intake facilities.

i. The full screening as described below will not proceed unless the arrestee is deemed acceptable for continued detention secondary to an observed medical or mental health condition that would prohibit continuation of the process.

ii. Any inmate who presents to Intake sally port unconscious, semi-conscious, bleeding or otherwise obviously in need of immediate medical attention shall be identified prior to screening completion, rejected for admission, and referred to an Emergency Department for care.

2. This process shall be completed upon arrival to the facility, prior to custody exchange, while the patient is still in the custody of Police to ensure that the arrestee is medically and mentally stable to complete the booking process.

B. Completion of the Intake Screening Process

1. The Intake Screening Process shall be completed by an RN or higher level of staff once it is determined that the arrestee/detainee can be admitted, i.e., has no medical condition that would prohibit admission.

a. Medical personnel will screen all arrestees for medical/mental illness using a form approved by the Office of Programs and Services: Clinical Services. Information shall be entered into the Electronic Medical Record when possible and OPS approved paper form will be completed when EMR is not available

b. Intake Screening shall be conducted within 2 hours of admission for any inmate being admitted from the community or for any inmate being transferred from another facility who as not been so screened.

2. Intake Screening shall be conducted as an individual and confidential interview for both medical and mental health issues shall include the following:

a. Measurement and documentation of vital signs including:

i. A blood pressure measurement using a wrist cuff in the event that handcuffs cannot be removed,

ii. Temperature,

iii. Pulse,

iv. Respirations,

v. A finger-stick glucose reading on all known or suspected persons with diabetes,
vi. A pulse-ox measurement and a peak flow rate measurement when there is an indication or suspicious of respiratory problems,
vii. A pregnancy test on all females of child-bearing age (ages 12 through 65) entering the facility.

b. Nurse will question the arrestee/detainee/inmate regarding the presence of any known chronic or acute health conditions and will determine if any medications are currently being used.
    i. Nurse will document any report of disease, medical or mental health condition. Any accompanying records shall immediately be given to medical personnel conducting the intake processing and those records shall immediately be placed in the arrestee/detainee/inmate's medical record.
    ii. Arrestee/detainee/inmate reporting or determined to have active acute, chronic medical, mental health, substance abuse, or other conditions requiring immediate medical care shall be referred to an appropriate clinician for physical examination and treatment or referred to community emergency medical services as medically indicated within two hours of admission to the intake area.
    iii. Nurse will document any report of current medications whether prescriptive, over-the-counter, or street drugs.
    iv. Medications brought into a facility may be turned over to custody to be placed in Property. Any medications disposed of shall be done so in accordance with the Pharmacy Services Manual and applicable State laws and regulations.
    v. Arrestees may be told that medications may be administered to inmates once they are seen by a clinician and medications are ordered, and that only current physician prescribed drugs can be offered. No drugs from containers brought by the inmate or arresting officers to the facility.
    vi. Nurse will initiate the Continuity of Care form completing those sections regarding medical conditions and medications currently in use as well as any demographic information available.

3. Once the initial screening questionnaire is completed, the Intake team consisting of the Nurse, the Mid-Level Provider/ Physician's observations, visual inspection and/ or patient response findings

will be documented on appropriate forms electronically, if equipment is available, noting medical and mental health conditions, or on an OPS approved form if the equipment is not available.

a. Observations shall include, at a minimum:
    i. Behavior, which includes but is not limited to state of consciousness, mental status, appearance, conduct, tremors and sweating.
    ii. Body deformities, ease of movement, durable medical equipment needs, brace, prosthesis.
    iii. Condition of visible skin, including trauma markings, bruises, sores, ulcerations, jaundice, rashes and infestations, needle marks or other indications of drug abuse.

b. Individuals requiring immediate attention or referral for more focused attention will be referred immediately (within the hour of admission) to the appropriate clinician or special care provider. These include, but are not limited to, individuals who have evidence of:
    i. Potential withdrawal syndromes secondary to alcohol, substance abuse, use of barbiturates, or opiates,
    ii. Suicide risk,
    iii. Serious illness or injury previously un-noted that may require triage to community hospitals,
    iv. Acute or serious psychiatric conditions,
    v. Communicable diseases,
    vi. Urgent and emergent medical problems,
    vii. Age group issues that may indicate the need for special treatment (i.e. juveniles and aged individuals),
    viii. Education/DPSCS Student Information for Inmates must be completed for all inmates under the age of 22.
    ix. Mental or physical disabilities requiring special attention.

c. An opportunity for new arrestees, detainees and inmates to articulate their need for medical or mental health treatment will be provided.

d. Ectoparasite assessment shall be completed within the limits of discussion and visibility of hair and skin during this initial examination.
    i. Those inmates appropriate for empiric treatment for lice infestation shall receive such treatment within the first 24 hours of admission. (Pregnant inmates will receive alternative treatment as ordered by the clinician).

ii. Treatment supplies shall be obtained from the pharmacy vendor when treatment is ordered.

e. An examination of the mouth and teeth shall be done to determine if there any dental problems requiring immediate referral.

f. Individuals eligible for methadone detoxification or methadone continuation shall be referred to substance abuse specialists and enrolled in those enrolled in those programs in accordance with established procedures. Enrollment shall occur within twenty-four (24) hours of initial intake screening.

g. Individuals eligible for alcohol withdrawal shall be immediately referred for this treatment and appropriate placement.

h. PPD placement will be completed within 72 hours of acceptance into a facility, and will be read during the Comprehensive Physical Examination that shall occur within seven days of that acceptance.

i. A chest x ray for positive PPDs will be completed within five days of the positive reading and documented in the inmate health record.

ii. Persons with positive readings shall be isolated until a clearance for the disease is verified.

4. Initial mental health screening shall be completed as part of IMMS. The nurse or higher level provider completing the IMMS process provides a brief screening using the approved questionnaire. Arrestees/detainees/ inmates who present with symptoms of psychosis, unstable mood, suicidal thought or behaviors, severe agitation considered not to be related to substance abuse or who exhibit other symptoms suggestive of danger to themselves or others shall be referred immediately to a qualified mental health professional for further evaluation and initiation of a treatment plan.

a. Mental Health personnel will provide training for medical personnel to assure that a consistent approach to these issues prior to any attempt to make observations regarding symptoms of psychosis, unstable mood, suicidal thought or behavior, or non substance abuse related agitation.

b. All newly admitted detainees/inmates/retakes/parole violators entering intake facilities from the community shall receive a suicide risk assessment by a qualified Mental Health Professional within 24 hours of admission. (This is in addition to the brief screening done upon entry by the nurse.)

c. Individuals conducting mental health screening and suicide risk assessments shall follow the appropriate DPSCS protocol in doing so and in taking subsequent actions.

d. All individuals conducting mental health screenings shall receive training, at least annually, on the conduct of such screening by a qualified mental health professional. Training shall include didactic information and standardized instructions for completing the screening form and suicide assessment.

e. A complete mental health assessment will be completed for all arrestees/detainees/inmates within seven days of incarceration using OPS:CS approved Intake Mental Health Screening Form.

C. Medication Administration may be necessary to initiate or continue therapies begun prior to arrest.

1. Nursing staff will collect all known data regarding prescription or other medications during the screening process including a signed release of information that may be used to verify current medication, as well as other health information required for making decisions regarding patient care management including any recent hospitalizations or treatments in progress prior to arrest.
   a. The Release of Information signature may also be used to obtain pertinent medical records as necessary for continuity of care from the community into DPSCS.
   b. The Release shall be placed into the patient's hard copy record for use in the event that additional medical problems are revealed later in the admissions process.
   c. The Release of Information is valid for one year from the date it is signed.
   d. All efforts made to obtain information from external sources and the outcomes of those efforts will be recorded in the patient's medical record.
2. Arrestees with special medications related to special needs such as organ transplant, HCV, HIV, Chemotherapy, dialysis and other chronic or acute conditions will be allowed to continue those medications once verified by medical staff.
   a. Verification attempts shall be made by medical staff within forty-eight (48) hours of a detainees' arrival at the booking area.
   b. Documentation of all attempts to verify medications and the outcome of those attempts shall be documented in the patient's medical record.
   c. The medical/psychiatric provider, as appropriate, shall be notified of the outcome of the verification attempt within four (4) hours of the receipt of a response from the community.
3. Regardless of the outcome of verification attempts, arrestees will be maintained on pre-incarceration treatment regimens as reported by an arrestee or a pharmacologically equivalent

substitute for medical and mental health conditions whenever possible, i.e., the clinician can identify the need for those treatment regimens. Decisions to medicate or to withhold medication and rationale for the decision shall be documented in the patient medical record.

a. Persons requiring an evaluation for mental health medications will be referred immediately following initial intake screening to a Mental Health Specialist who will contact the psychiatrist assigned to the facility for bridge orders to enable immediate availability of mental health medications.
b. Once the psychiatrist has been apprised of the situation for persons with mental health conditions needing medication, the call shall be transferred to the mid-level or physician (not the nurse) working in the Sallyport Area who will accept the verbal order and initiate the first dose of medication.
c. Somatic medications needs will be referred to the mid-level or physician responsible for the area for orders to enable immediate availability of those medications.
d. Medical and psychiatric providers shall prescribe and initiate medication for chronic medical and mental health diseases (such as HIV+, Diabetes, Hypertension, Bi-Polar Disease, Depression, et al) using DPSCS formulary medications as appropriate for the disease and in keeping with community standards and safe medical practice in the event that the arrestee is unable to provide names or doses of medication, and the provider is able to determine a need for medication based on his or her examination, patient history, and signs/symptoms related.
e. Medications ordered shall be initiated within twenty-four (24) hours of initial intake screening.

4. Stock medication will be used to initiate dosing on the same day the detainee is admitted.
   a. All medication administration, whether somatic, psychiatric, or single dose, from stock or non-stock shall be documented on the Medication Administration Record (MAR) following OPS policy and procedure.
   b. All stock medication shall also be documented on the stock card to assure the medication can be refilled when necessary.
5. Formulary substitution maybe necessary and only with the facility physician's or psychiatrist's order and only after approval from the respective clinicians' Medical or Psychiatric Director.
6. The mid-level clinician or physician initiating the medication shall order the medication using the accepted ordering process for patient specific medications that will last for seven full days from the

initial dose provided in the admission area. That medication shall be dispensed per dosing orders immediately upon receipt. (I.E., if the dose is to be at 10:a.m. and 10 p.m., the first ordered dose shall be given as close to the 12 hours following the initial dose as possible)

7. In the event that a medical or mental health provider is not on site at the time of the admission, the screening nurse shall contact the on-call clinician to receive orders regarding continuation of medication or other treatments deemed necessary as a result of the initial screening.

D. Special housing requirements may be necessary for certain arrestees. Urgent onsite referrals to medical/mental health triage team for items on screening questionnaire that require immediate intervention include:

1. An onsite referral to the mental health triage team for mental health items on initial screening questionnaire that require immediate intervention.
2. Isolation for arrestees with signs and symptoms of tuberculosis or any communicable disease suspected to prevent infection of others
3. Assurance that arrestees with alcohol withdrawal syndrome are housed in designated cells for monitoring and follow up.

E. Heat Stratification is required on all admissions to an Intake facility and periodically as conditions affecting any change in that status arises.

1. All arrestees, male and female will be assigned a heat risk category upon entry and at the Comprehensive Intake Physical Examination and housing assignment process, and throughout the year.
2. All male arrestees shall be designated for H1 housing by the receiving/screening nurse while at BCBIC (air conditioned housing) until they are reevaluated by a clinician and heat risk is reclassified based upon the initial chronic medical conditions or medications prescribed as per DPSCS heat stratification policy.
3. Clinical findings and medications prescribed at the intake examination will determine the final heat risk stratification.
4. Any detainee who is prematurely moved prior to receiving a Comprehensive intake Physical or is placed into a non air-conditioned facility as part of the transfer screening process, prior to receipt of a final heat stratification assignment will receive an his or her Intake Comprehensive Intake Physical and a final heat stratification.

    a. The H-1 assignment will remain until the intake physical is completed and an alternative risk is assigned.

    b. Female arrestees will receive heat stratification upon entry to BCBIC and upon their Comprehensive Intake Physical at WDC per protocol.

c. Final heat stratification shall be by medical doctor and shall be documented on the Electronic Medical Record (EMR) Patient Problem list as “Heat Risk Stratification” category H-1 H-2 or H-3 and in the Electronic Medical Record (EMR) classification template located on the home page.

d. A weekly data report of H-1 and H-2 detainees will be maintained and submitted to classification and to the OPS as an electronic file from May 1 through September 30th each calendar year from both medical and mental health contractors. Included in that file shall be, at a minimum:

i. The inmate’s name ,

ii. Date of birth,

iii. DOC number,

iv. Heat stratification code

v. Facility and

vi. Any code changes.

e. There shall be a notification on the individual problem lists for patients requiring a heat stratification code change, specifically, the original heat stratification on the problem list will be recorded as resolved and the new Heat Stratification will be entered as the current “problem” on that list. This process will be repeated every time there is a Heat Stratification change.

5. If the clinician recommends housing other than general population related to heat such as infirmary or air-conditioned dormitory, staff will be responsible for coordinating the transfer of information regarding that order notifying custody of special housing needs or special needs and only by using the designated classification and housing form.

F. Arrestee’s at Pre-Trial with positive response(s) to the Initial Medical/Mental Screening Questionnaire will have an orange wristband placed on the right wrist by the Triage team and a disposition made.

1. Arrestees /detainees identified as alcohol withdrawal problems will have a yellow wrist band placed on the left wrist by the triage team.

2. Arrestee’s who require immediate intervention will be directed/escorted to see the Medical Treatment Team and/ or Mental Health Team as soon as the IMMS disposition is completed.

3. The Medical/Mental treatment team will perform a targeted patient evaluation focusing on the immediate medical/mental issue(s) and provide intervention(s) accordingly.

   a. Arrestees with an Orange wristband and identified to have a medical condition and/or mental health problem, but are determined to be stable while being triaged, will be evaluated sequentially along with the booking process.

   b. Arrestees with an orange wristband will be given priority during the booking process.

   c. Arrestees with a yellow wristband will be monitored and evaluated for signs and symptoms of withdrawal and maybe given priority during the booking process

   d. A daily log will be created and maintained to schedule medical evaluation of arrestees. The patient log created for the day will be communicated among the team leaders (Physician, Psychiatrists, Psychologist, PA, CRNP) of each shift to plan the follow-up and provision of services. A log of arrestee's not seen/shift will be reconciled every 12 hours to reflect completed screenings and submitted for review to the ACOM daily.

G. Inmate Transfers/Releases require additional attention by medical/nursing staff.

1. Within 12 hours of being notified by custody that an inmate is to be released or transferred, the inmate's medical records shall be reviewed by nursing staff at the intake facility and a Transfer Screening Form shall be completed.
2. Inmates with risk stratification of M-1 and M-2 shall have their medical records envelopes labeled M-1 and M-2 as appropriate.
3. All persons admitted through facilities other than Pre-Trial shall follow transfer screening policies as patients are moved from facility to facility.
   i. The initial Intake is done only once per admission.
   ii. Once completed, the transfer screening shall accompany the patient to his or her next facility and the polices for transfer shall be followed.
   iv. Concurrently, the continuation of the Intake Process (Medical Evaluations Manual Chapter 1, Section 2 shall be continued.

III. Rescission: DCD 130-100, Section 110 Medical Intake Evaluation, dated March 1, 1996.
OPS Manual or Medical Evaluations Chapter Three (Accept/Reject)

IV. Date Issued: July 15, 2007/ Revised July 2008 / Revised April 2009
Edited and revised September 28, 2009
Reviewed/ Revised October, 2010

Attachment W IMMS Policy Part II

OFFICE OF PROGRAMS AND SERVICES: CLINICAL SERVICES

MEDICAL EVALUATIONS MANUAL

Chapter 1
MEDICAL INTAKE

Section 1B
Medical Intake Process: Part II

I. Policy:

All inmates newly admitted to DPSCS facilities shall receive a medical intake evaluation immediately upon an inmate's entrance from the community that will:

Identify and address any urgent medical/mental health/dental health needs of those arrestees/detainees/inmates admitted to any DPSCS facility and/or are transferred from a pretrial facility to Patuxent Institution or a Division of Correction facility.

Identify and triage arrestees/detainees/inmates with known or easily identifiable chronic health needs that require medical intervention.

Identify and isolate arrestees/detainees/inmates who appear potentially contagious or have communicable diseases.

Identify and facilitate intervention for arrestees/ detainees/inmates who may be at risk for suicide.

Identify and facilitate intervention for arrestees who have a history of acute or persistent and serious psychiatric illness.

Identify at an earlier time arrestees/detainees/ inmates who may be at risk for heat related health issues if placed in non-air conditioned environments

II. Procedure: PART TWO

A. Physical Examinations

1. All intake physical examinations shall be conducted by a clinician utilizing the DPSCS Intake History and Physical Examination Form found in the Electronic Medical Record (EMR).
2. All newly admitted inmates entering DPSCS facilities from the community shall receive a physical examination within seven (7) days of intake.
3. New Inmates or those called “Retakes” (such as parole violators) who have not received physical examinations within the past 12 months shall receive physical examinations.
    a. Clinician will at a minimum, however review the physical examination that was completed within the last 12 months and comment upon any changes or updates and record that information in the EMR.
    b. Clinician will ask the Inmate whether or not there have been changes in his or her medical/mental health since the time of that physical as each section is reviewed.
    c. Clinician will follow the steps below (4) and do a new physical if the stated criteria above are unmet.
    d. Regardless of whether a new physical is completed or the less than 12 month old physical is used, the clinician will enter a statement into the medical record regarding any changes and sign that entry.
4. Inmates who have a documented physical examination within the last 12 months need not have a new physical examination unless:
    a. Abnormal vital signs are apparent
    b. An acute medical problem or chronic medical condition by history is present, including but not limited to:
        i. Hypertension (HTN)
        ii. Coronary Artery Disease (CAD)
        iii. Congestive Heart Failure (CHF)
        iv. Chronic Obstructive Lung Disease (COPD)

v. Asthma
vi. Diabetes Types 1 and 2
vii. Seizures
viii. HIV infection
ix. Tuberculosis infection or disease (TBC)
x. CC (Chronic Care Needs)
xi. Cancer
xii. Recent surgery (past 12 months)
xiii. Recent physical trauma (past 12 months)
xiv. Other medical conditions requiring emergent or chronic care.
xv. Prescription medications he inmate is receiving.
xvi. Physical disability
xvii. Special needs
xviii. Medical screening identifies a new medical problem that requires evaluation.

c. The date of the last physical examination and the absence of active medical problems by history shall be documented on the Intake History and Physical Evaluation Form for all inmates who have had a physical examination within the past 12 months and for whom the physical examination has been deferred.

5. All inmates receiving a history and physical examination shall be evaluated by a provider using the Intake History and Physical Examination Form documenting the following:

a. Medical history including but not limited to:
i. Allergies,
ii. Current medications,
iii. Chronic medical conditions,
iv. Hospitalizations,
v. Family history,

vi. Review of symptoms and

vii. Identification of disabilities.

viii. Last menstrual period

ix. Head Injuries

x. Vaccination history for juveniles

b. Physical examination to include evaluation of the:

i. Head,

ii. Ears,

iii. Eyes,

iv. Nose,

v. Oropharynx,

vi. Neck,

vii. Lymphatics,

viii. Skin,

ix. Extremities,

x. Breasts,

xi. Lungs,

xii. Heart,

xiii. Abdomen,

xiv. Genitalia,

xv. Pelvic (females)

xvi. Digital rectal/prostate exam and inspection (as stated below in diagnostics), includes stool guaiac for inmates 40 years of age and older.

xvii. Neurological functioning cranial nerves 2-12 and reflexes and deficits

xviii. Mouth and teeth to determine if there are any apparent dental issues requiring referral and make referrals as appropriate

x.ix. Clinician will document any refusals and the reason for the refusal.

6. Time frames for conducting physical examinations for detainees and inmates entering DPSCS facilities may be expedited at the discretion of the DPSCS OIHS.

7. Diagnostic and age appropriate preventive health screening tests consistent with the recommendations of the American Academy of Family Practice Physicians will be conducted and documented on the DPSCS Intake History and Physical Examination Form, as follows:

   a. STD Screening and syphilis serologies (RPR with automatic FTA if RPR is positive). Blood will be drawn for the purpose of the necessary lab work at the time the PPD is planted enabling the results to be available at the time of the complete physical examination.

      i. If PPD is contraindicated the RPR will be drawn prior to the intake PE by the 5th day.

      ii. STD screening including gonorrhea, Chlamydia, Trichomonas will be done for females as part of their pelvic exam.

      iii. Symptomatic males who complain of urethral discomfort or discharge will receive screening if antibiotic treatment fails to resolve the complaint.

   b. Education and voluntary HIV testing for all sentenced and pretrial detainees/inmates in accordance with DPSCS protocol.

   c. Pap smear for all female inmates unless performed and documented within the last 12 months as normal.

   d. A review of the pregnancy test results and necessary referrals to obstetrical care following the OIHS Care of the Pregnant Inmate Manual if pregnant. If for any reason, the pregnancy test result cannot be located a repeat test shall

be completed at this time and the clinician will proceed as already stated here.

e. Clinically indicated mammograms shall be performed for detainees and inmates in a time frame consonant with American Academy of Family Physicians. (AAFP)

f. Snellen Vision Test unless performed and documented within the past 12 months and testing for near vision .

g. Audiometric screening in accordance with the following:

   i. Audiometric testing for all inmates less than 21 years of age.

   ii. Audiometric testing including tuning fork assessments for all inmates 21 years of age and older unless performed and documented within the past 12 months

h. Electrocardiogram (ECG),

i. Blood chemistries, and urinalysis with microscopic exam

j. PPD or chest x-ray if past positive for TB

k. Sickle cell screen and other diagnostic studies shall be ordered when medically indicated so that appropriate treatment may be provided.

l. A digital prostate examination will be performed on all males beginning at age 40 or earlier if symptoms indicate a need.

   i. All males age 40 and above will be evaluated for the need to perform a PSA (Prostate Specific Antigen) test and the test will be done if deemed appropriate by the examining physician.

   ii. All males age 50 and above will have a PSA at the time of their periodic physical examination

8. All intake diagnostic lab tests shall be completed and documented in the patient health record within 48 hours of the order with the exception of RPR tests which must be reviewed and the review

documented in the patient health record within 4 hours of receipt by the provider

9. All inmates identified with disabilities at the time of physical examination shall have documentation of the disabilities included in the medical record utilizing the DPSCS Disabilities Assessment Form.
    a. Disabilities shall be described in functional terms only, without disclosure of related medical problems such as hypertension, diabetes, cancer or HIVC infection.
    b. A copy of the form shall be forwarded to the case management manager or supervisor of the intake facility.
10. The evaluating clinician shall determine the level of medically permissible activity and medically necessary housing assignments.
    a. The clinician's recommendation shall be documented using the Medical Clearance: Program and Work Assignment Form
    b. A copy of the form shall be forwarded to the case management manager or supervisor.

B. Treatment Plan/Risk Stratification

1. A physician shall review all inmates receiving physical examinations and shall develop an approved individual treatment plan that is documented on the Intake History and Physical Examination Form. The treatment plan shall include, but not be limited to the following:
    a. An assessment of active medical problems
    b. An enumeration of all medically indicated diagnostic studies and treatments.
    c. Recommendations for specialty referrals.

d. Chronic Care Clinic assignment as per DPSCS protocol including the placement of the clinic flow record sheet in the medical

e. Special housing assignment.

f. Risk stratification for chronic illnesses, as follows:

i. 0 – Healthy

ii. M-1 – Chronically ill – stable (hospitalization not anticipated during the next year)

iii. M-2 – Chronically ill – unstable (hospitalization anticipated during the next year. To include moderate to severe asthmatic individuals.

g. Final Heat Risk assignment which shall also be communicated to Custody Staff per procedure

h. Immunization assessment (see section II. C of this document)

j. Medical Alert Assessment (see Section II. D of this document)

k. Education/Special Needs Assessment and order referrals as appropriate.

2. The reviewing physician shall ensure that all identified medical, dental and mental health problems are documented on the DPSCS problem list.

C. Immunizations

1. All inmates shall receive immunization with tetanus/diphtheria toxoid when medically indicated. Immunization shall be documented in the inmate's medical record.

2. Inmates under the age of 18 will be assessed regarding immunization needs and the contractor will provide age appropriate vaccinations updates.

3. Authorization to update vaccinations by appropriate guardian will be documented in the medical record. An excel spread sheet tracking juvenile vaccination status will be maintained.

D. Medical Alert

1. All inmates shall be assigned medical alert badges if one of the following conditions applies:
   a. Heart Disease (including pacemaker and internal defibrillators)
   b. Diabetes (insulin dependent)
   c. Seizure disorder (under treatment)
   d. Asthma (moderate to severe)
   e. Renal Disease (dialysis dependent)
   f. Disabilities (blindness, deafness)
   g. Allergies (life threatening only)
   h. External medical devices (e.g. catheters, colostomy, etc.)
2. Inmates with psychiatric illnesses or infectious disease conditions shall be identified by a medical alert badge.
3. A physician shall secure a medical alert badge for an inmate by completing the Medical Alert Identification Request Form and submitting the form to the institution's Identification Unit unless otherwise specified by the Warden.
4. The same criteria and form shall be utilized for issuing alert badges in maintaining institutions for inmates newly identified with medical conditions requiring alert badges.

E. Education/Special Needs Referral.

II. References:

A. Standards for Health Services in Prisons, National Commission on Correctional Health Care

B. American Correctional Association: 3rd Edition with 2002 Supplements ALDF, 3-ALDF-4E-19 and 4-E-21

C. Clinical Practice In Correctional Medicine, Michael Puisis, D. O. 1999

D. American Public Health Association APHA Standards for Health Services In Correctional Institutions – 2003

E. Public Health Behind Bars from Prison to communities , Robert B.Greifigner ,2007

F. Department of Justice MOU

G. PDSD 185-4 Heat Stratification

H. DPSCS Receiving Screening

I. DPSCS Intake Mental Health Screening

J. DPSCS Intake History and Physical Evaluation Form

K. DPSCS Tuberculosis Testing Form

L. DPSCS Disabilities Assessment (DCD Form 130-100nR)

M. DPSCS Medical Clearance: Program and Work Assignment

N. Maryland State Department of Education/Correctional Education/DPSCS Student Information for Inmates Under 21 years of age.

O. OIHS Manual on Care of the Pregnant Inmate

III. Rescission: DCD 130-100, Section 110 Medical Intake Evaluation, dated March 1, 1996.

IV. Date Issued: July 15, 2007

Revised July 2008

Revised April 2009

Revised October 2009

Reviewed/Revised December 2010

ATTACHMENT X – PROPOSED PHARMACY DELIVERY SCHEDULE

Attachment X
Proposed Pharmacy Delivery Schedule

Service Area / Institution	Day of Week	Cut-Off Time	Arrives Onsite
Eastern			
ECI, ECI-A, PHPRU	Mon-Fri	3:00 PM (4:00 PM cut-off for ECI-Infirmary)	Night Shift
	Sat	12:00 PM	Evening Shift
	Sun	12:00 PM	Evening Shift
Jessup			
BCF, HTCBC, JPRU, MCIJ, MCIW, JCI, JRI, PATX, CMCF	Mon-Fri	12:00 PM	Evening Shift
	Sat	12:00 PM	Evening Shift
	Sun	10:00 AM	Evening Shift
EPRU, SMPRU	Mon-Fri	4:00 PM	Day Shift
	Sat	12:00 PM	Day Shift
Western			
Hagerstown-MCIH, RCI, MCTC	Mon-Fri	2:00 PM (3:00 PM MCIH Infirmary)	Night Shift
	Sat	12:00 PM	Evening Shift
	Sun	12:00 PM	Evening Shift
Cumberland-WCI, NBCI	Mon-Fri	2:00 PM (3:00 PM WCI Infirmary)	Night Shift
	Sat	12:00 PM	Evening Shift
	Sun	12:00 PM	Evening Shift
Baltimore			
BPRU, BCCC, BCBIC,BCDC, BCBIC, MCAC, MRDCC, MTC,	Mon-Fri	10:00 AM	Evening Shift
BCDC, BCBIC, MRDCC, MTC, CHDU	Mon-Fri	4:00 PM	Evening Shift
ALL	Sat	12:00 PM	Evening Shift
ALL	Sun	10:00 AM	Evening Shift

ATTACHMENT Y – SUICIDE PREVENTION PROGRAM MANUAL

OFFICE OF PROGRAMS AND SERVICES:
CLINICAL SERVICES

MENTAL HEALTH SERVICES MANUAL

Chapter 4
SUICIDE PREVENTION
New Policy for 2011
Section A
Definitions

I. Policy DPSCS will remain proactive in the prevention of suicide.

II. Procedure:

A. Because mental health services require special use of terms, the following definitions used in Mental Health policies and procedures are employed:

1. "Administrative Review" means a case analysis of a suicide or attempted suicide developed by the Director for Mental Health/designee and a multi-disciplinary panel.
2. "Agency" means the Department of Public Safety and Corrections.
3. "Close Observation" means a process by which a detainee/inmate is paced in an area where he or she can be observed for behaviors that may be dangerous to him/herself or others.
4. "Continuous Observation" means a process by which assigned staff maintain an "at-risk" inmate in constant view.
5. "Correctional Mental Health Center (CMHC)" means an inpatient mental health unit located in Baltimore, Patuxent, and Jessup.
6. "Critical Incident Stress Management" means a program of debriefing services providing emotional first aid to individuals

who have witnessed a traumatic event. Referrals for further counseling can be made through this program.

7. “Electronic Health Record (EHR)” means the electronic file on all detainees/inmates that, when combined with certain hard copy materials are inclusive of all health aspects of the patient.
8. “First Responder” means in suicide precaution process that person who witnesses by audio or vision a potential suicide event.
9. “Intent” means there is motivation and/or desire to kill oneself.
10. “Lethality” means there is a likelihood that an action may lead to death.
11. “Licensed Health Care Professional” means an individual that is licensed to practice his or her skills in the area in which he or she is licensed and may do so only within the scope of that licensure.
12. “Licensed Mental Health Professional” means an individual who is licensed by a Maryland Board of Examiners for one of the following disciplines: Psychology, Licensed Clinical Professional Counselor, Psychiatrist, Nurse Practitioner, Psychiatric Nurse.
13. “Suicide attempt” means an act that is self-harming and has a likelihood of resulting in death.
14. Suicide Cell means a cell that has been approved by the Director of Mental Health and meets the criteria developed by Lindsay Hayes to remove all aspects of the cell that could be used for self harm.
15. “Suicide event” means an act of ideation, gesture , or attempted suicide or the completed act of suicide.

16. “Suicide gesture” means an act that may be self-harming but has a low likelihood of resulting in death.
17. “Suicide ideation” means a verbal statement indicating thoughts of self-harm or the desire to be dead.
18. “Suicide precautions” means a process in which all items that a detainee/inmate could use for self-harm are removed from his or her person for safe confinement and monitoring. In addition the detainee/inmate is placed in a cell that has been approved by the Director of Mental Health as a “Suicide Cell”
19. “Suicide Smock” means a gown that is made specifically to make it difficult to use for self-harm

III. References: Suicide Prevention Activities Manual 7/2007

IV. Rescissions: Suicide Prevention Activities Manual 7/2007

V. Date Issued: April . 2011

OFFICE OF PROGRAMS AND SERVICES:
CLINICAL SERVICES

MENTAL HEALTH SERVICES MANUAL

Chapter 4
SUICIDE PREVENTION
New Policy for 2011
Section B
Suicide Prevention Committees

I. Policy — DPSCS will remain proactive in the prevention of suicide. This will be done through active committees composed of mental health professionals and (as needed) medical, dental and social work professionals. The committees will study suicide events and make recommendations for prevention of such events, reporting on a monthly basis to the Department's Clinical Services directors for mental health, medicine, and nursing.

II. Procedure:

A. The mental health vendor contracted for services to DPSCS detainees and inmates shall establish a Suicide prevention Committee in each service delivery area (SDA) across the State.

1. At a minimum, there will be committees for the Eastern Correctional facilities, Baltimore, Jessup, Hagerstown, and Cumberland.

2. Committees shall be facilitated by the Quality Assurance director for the DPSCS Mental Health Contractor.

2. Composition of the committees shall include at a minimum:

a. The vendor's quality assurance coordinator

b. The Mental Health Medical Director for the SDA,

c. The Medical Vendor's Regional Manager

d. Directors of nursing from each of the medical and mental health vendors for the SDA,
e. The Regional State Psychologist for the SDA, and
f. The local ACOM (Area Contract Operations Manager)

3. The Committees will:
   a. Evaluate each suicide event in its SDA on no less than a monthly basis.
   b. Trend activities seen in those evaluations.
   c. Prepare an action plan that will address the seen trends and attempt to avoid situations identified that occurred at the time of the ideations, attempts or suicide completions.
      i. The action plan shall be available for presentation at the video meetings held with DPSCS.
      ii. Updates to the plan shall be recorded on the plan at the time of the monthly meeting of the committee.
      ii. The updated action plan shall be forwarded electronically no less than monthly to the Directors of Medical, Psychology, and Nursing for the Department.

III. References:

IV. Rescissions:

V. Date Issued: April. 2011

OFFICE OF PROGRAMS AND SERVICES:
CLINICAL SERVICES

MENTAL HEALTH SERVICES MANUAL

Chapter 4
SUICIDE PREVENTION
New Policy for 2011
Section C
SUICIDE PREVENTION TRAINING

I. Policy: Correctional and healthcare personnel working in corrections shall be provided information and strategies necessary to decrease the occurrence of suicide events including but not limited to:

- Identification of potentially suicidal patients
- Effective assessment of suicide risk factors, and
- Appropriate interventions for patients experiencing a suicide event.

II. Procedure:

A. Training shall be provided to all correctional and medical/mental health staff who have inmate/detainee contact on an annual basis by the DPSCS Mental Health Vendor. Additional training may be required by individual facilities according to specific accreditation requirements. These facilities will arrange trainings and notify personnel of the requirement.

B. There are three levels of suicide prevention training.

1. Entry level training is provided to all employees of corrections and health either by the Mental Health Vendor or as a part of the routine training offered to all correctional staff as part of the pre-service Academy program. This training shall include at a minimum:

a. Basic issues about the nature and prevalence of suicide in the prison system versus non-incarceration communities.
b. Factors that represent a high risk of self-harm.
c. Indicators that signal the potential for suicide.
d. Management strategies for suicide prevention.
e. Departmental policy and procedure related to suicide prevention.

2. Orientation shall build upon the entry level training and re-enforce Departmental policy and procedure/directives on suicide prevention and provide additional information on specific facility procedures.

3. Annual in-service modules shall be provided by the DPSCS Mental Health Vendor and within 60 days of the previous annual in-service, and shall include at a minimum:
   a. Signs and symptoms of predisposing factors in potentially suicidal detainees/inmates.
   b. Risk factors associated with suicide potential.
   c. Management of suicidal detainees/inmates and who will take what role in that management.
   d. A review of DPSCS policies and procedures regarding suicide prevention.

C. All training modules/curricula shall be developed in collaboration with the DPSCS Director of Mental Health.

D. All levels of training shall be performed by a licensed mental health professional, an Licensed Clinical Professional Counselor (LCPC) or higher, and who has been assigned to this responsibility by the Director of Mental Health/designee..

III.	References:	DPSCS Suicide Prevention Activities Manual 2007 ACA Standards for Health Services in Correctional Institutions, Chapter Five (Mental health Services) E. Suicide Prevention. NCCHC Standards on Correctional Health Care (Prisons): P-G-05 Suicide Prevention Program NCCHC Standards on Correctional Health Care (Jails): J-G-05 Suicide Prevention Program
IV.	Rescissions:	DPSCS Suicide Prevention Activities Manual 2007
V.	Date Issued:	April. 2011

OFFICE OF PROGRAMS AND SERVICES:
CLINICAL SERVICES

MENTAL HEALTH SERVICES MANUAL

Chapter 4
SUICIDE PREVENTION
New Policy for 2011
Section D
SUICIDE ASSESSMENT

I. Policy: Correctional and healthcare personnel working in corrections shall assume that detainees/inmates found to have certain risk factors revealed during initial screening are at risk for suicide and shall respond with complete assessments of the individual.

II. Procedure:

A. Initial triage which includes the completion of a suicide risk assessment of persons with suicidal risk factors shall occur within two hours of a referral (form 124-400-1) for suicidal risk factors, and shall be accomplished by the following personnel:

1. During regular State business hours, i.e., Monday through Friday 8:30 a.m. -5:00 p.m., State Psychology or Vendor Psychiatry shall provide the first responder triage.
2. During other hours, medical vendor staff shall contact the on-call vendor psychiatrist who will assume the role of first responder for triage purposes.
3. All information pertinent to the referral and assessment with the initial treatment plan shall be recorded in the EHR immediately upon completion of the assessment.

B. The initial triage consists of a structured interview, information gathering form others that may have contributing information, assignment of a risk level, and initiation of a treatment plan specific to the problems revealed during the assessment.

1. The structured interview includes but may not be limited to:
    a. Past suicidal ideation and/or attempts
    b. Current suicidal ideation, threats, or plans
    c. Homicidal ideation or threats
    d. Prior mental health treatment including hospitalizations
    e. Recent significant losses such as change in a loved one's health, death of a loved one, major change in one's own health status, change in marital or significant other status, additional sentence time, termination from a special program, etc.
    f. History of suicidal behaviors by family members or significant others
    g. Suicide risk recorded during a previous incarceration or at the most recent sending facility including facilities outside DPSCS.
    h. Current health status in the detainee/inmate's own description.
2. Information gathering form others may include but not be limited to:
    a. Observations made by transporting correctional or police officers, or by other staff in or around the facility that may have been in contact with the patient.
    b. Observations made first hand by the mental health professional conducting the interview.
    c. Medical status from the medical (EHR) record.
    d. The institutional adjustment record.

3. The assignment of risk level follows the following guidelines:
    a. High = high intent and high lethality
    b. Medium = high intent and low lethality or low intent and high lethality
    c. Low = low intent and low lethality
4. The initiation of a treatment plan for this problem/diagnosis should include the findings of the assessment and shall be recorded into the patient's EHR immediately upon completion of the assessment.
5. A treatment plan should include at a minimum such factors as:
    a. Medications
    b. Suggested housing
    c. Suggested group or individual counseling
    d. Any treatment modalities that are considered to be conducive to assisting this patient in recovery or deterrence from suicidal ideation.

C. In the event that a detainee/inmate is presumed to have suicidal risk factors, the licensed mental health professional shall begin and follow through on the following:
1. Assume the detainee/inmate to be at maximum risk until he or she has completed an evaluation.
2. Notify Custody that the detainee/inmate needs continuous observation from a security standpoint until a full suicide assessment can be completed by a Mental Health professional. This request shall include an acknowledgement that specific persons will be assigned to assume this responsibility with a time that it will begin.
3. Initiate and complete a full suicide assessment on the patient.

a. Determine if the patient is safe to return to his original housing setting, or

b. Determine that the patient is in need of placement in an area for suicide precautions.

i. Initiate paperwork that will document the need for suicide precautions (Attachment A) and authorizes the need for and frequency of observation.

ii. Notify the facility shift commander, and medical of the need for suicide observation.

iii. Notify the Mental Health vendor of this placement and the need for follow up of this patient if the event occurs on a holiday, evening, or weekend.

4. Request from custody an Observation Aide to be assigned to the individual, understanding that the Observation Aide is an adjunct to persons responsible for the observation (Custody Staff)

i. Observations shall be made and recorded at least every fifteen (15) minutes by Custody staff assigned to the patient per DOC Directive.

ii. A time limit of twenty-four hours maximum shall be set at the time of placement on observation before a repeat evaluation is completed by the licensed professional initiating the observation or by a licensed professional from the Mental Health vendor if the maximal observation period (24 hours) expires on “off” hours and the State licensed mental health professional is not available.

iii. If the re-assessment determines there is a need for continued observation or additional treatment, the

licensed mental health professional shall initiate next steps which may include additional observation with re-assessment in no more than twenty-four hours, placement in an inpatient setting (see Infirmary Manual policies on transfer to medical and for mental health units), a specialized facility unit, hospitalization, or other setting as appropriate per the assessment.

iv. Repeat process described above every twenty-four hours for up to seven days. At the end of no more than seven days, the licensed mental health professional shall release the observation or refer for specific treatment to a medical/mental health setting.

III. References:

DPSCS Suicide Prevention Activities Manual 2007

ACA Standards for Health Services in Correctional Institutions, Chapter Five (Mental health Services) E. Suicide Prevention.

NCCHC Standards on Correctional Health Care (Prisons): P-G-05 Suicide Prevention Program

NCCHC Standards on Correctional Health Care (Jails): J-G-05 Suicide Prevention Program

IV. Rescissions: DPSCS Suicide Prevention Activities Manual 2007

V. Date Issued: May, 2011

Attachment A

CLOSE OBSERVATION
Initiation Form

Name			Number:	Institution:
Last	First	MI		
Date of Placement:	Time: _____AM/PM		Official Authorizing Placement:	
Frequency of Observation:		Authorizing Mental Health Professional:		
Property? ☐ Y ☐ N If yes, what:				
Clothing? ☐ Y ☐ N If yes, what:				
Bedding? ☐ Y ☐ N If yes, what:				
Meals? ☐ Bag ☐ Regular		Specific Behaviors to Look For:		

RATIONALE FOR INITIATION OF CLOSE OBSERVATION

☐ Bizarre Behavior ☐ Severe Agitation ☐ Recently received bad news
☐ Significant change in hygiene ☐ Significant change in attitude ☐ Threatening others
☐ Appears depressed ☐ Bizarre verbalizations ☐ Serious Hygiene problem
☐ Inmate isolating self ☐ Significant change in behavior ☐ Other: _____

Events which led to current situation:_____

Unusual Circumstances:

_____

Check if Known:

History:
☐ History of Mental Health issues ☐ History of Aggressive / Hostile Behavior
☐ History of suicidal behavior ☐ History of psychiatric admissions
☐ Recent transfer to institution ☐ History of Psychotropic medication

Symptoms:
☐ Incoherent speech ☐ Tearful ☐ Poor Hygiene
☐ Bizarre appearance ☐ Withdrawn ☐ Disoriented
☐ Agitated ☐ Oppositional ☐ Angry / hostile
☐ Restless ☐ Scared ☐ Looks or acts in an irrational fashion
☐ Yelling / Screaming ☐ Pacing ☐ Does not relate to Staff
☐ Refusing medication ☐ Restless ☐ Banging Door
☐ Other : _____

Termination Form

Rationale for termination of Close Observation: _____

_____

Name of authorizing Licensed Mental Health Professional _____

Title:_____Date: _____ Time: _____

OFFICE OF PROGRAMS AND SERVICES:
CLINICAL SERVICES

MENTAL HEALTH SERVICES MANUAL

Chapter 4
SUICIDE PREVENTION
New Policy for 2011
Section E
MANAGEMENT OF DETAINEES/INMATES AT RISK FOR SELF-HARM OR SUICIDE

I. Policy: DPSCS will provide a guideline for the management of persons in their care that have been found to be at risk for self-harm or suicide.

II. Procedure:

A. Upon completion of the assessment (Section D of this Chapter), by the licensed mental health care professional will consider all of the following in the plan of care for the detainee/inmate:

1. Is there a need for placement on suicide precautions?
2. What are the safest housing recommendations that should be made for this patient?
3. Should this patient be under observation and if so, at what frequency, for how long, and who will provide the observation?
4. Should there be property restriction in what the patient may possess while under care for the issues at hand?
5. What follow up care should be provided immediately? (emergency room, psychiatric appointment, somatic physician appointment, etc.)

B. The licensed mental health professional that completes the assessment shall record all recommendations into the Electronic Health Record (EHR) immediately upon completion of the evaluation and shall make the referral to the immediate follow up care and assure that the patient is seen within time frames appropriate to the recommendation:

1. An emergency room referral shall be made within fifteen minutes of the evaluation after contacting the appropriate somatic or psychiatric clinician licensed to order such a transfer.
2. A psychiatric appointment shall be scheduled to occur no more than twenty-four (24) hours of the findings if there is an acute problem and no more than forty-eight (48) hours if the evaluator can document that the situation is not acute.
3. A somatic appointment shall be scheduled to occur no more than eight (8) hours of the findings if there is an acute problem and no more than twenty-four (24) hours if the evaluator can document that the situation is not acute.
4. Somatic issues may employ the aid of mid-level practitioners instead of physicians.
5. All referrals shall be completed immediately and the individual referring shall follow up to assure that the referral was carried through and record same in the EHR.
6. Custody staff shall be notified immediately upon completion of the evaluation and recommendations regarding patients considered to be acutely ill about the recommendations made and the referrals for clinical orders to enable them to ready for any transportation that may be needed either internally or outside of the facility.

7. The DPSCS Director of Mental Health/designee shall be notified of events within (24) twenty-four hours with a copy to the Regional Assistant Mental health Director.

C. The intensity of intervention is based on the levels of risk determined during the assessment (Section D of this Chapter) and shall be provided as follows, with the appropriate order from a licensed clinician to assure that the order is followed:

1. High Risk requires that the patient be:
    a. Placed on suicide precautions
    b. Placed in a safe/suicide cell by custody upon the recommendation of the assessing licensed mental health professional.
    c. Provided with a suicide smock.
    d. Continually observed by an inmate watcher following the Department's guidelines for these watchers with oversight by Custody.
    e. Observed and observations documented at a frequency of every fifteen minutes by Custody.
    f. Evaluated for transfer to an inpatient mental health setting. (See Chapter 4, Section B Transfers to Mental Health Infirmary).
2. Medium Risk requires that a patient be:
    a. Placed on Suicide precaution status.
    b. Placed in a safe/observation cell.
    c. Provided with a suicide smock.
    d. Continually observed by an inmate watcher following the Department's guidelines for these watchers with oversight by Custody.
    e. Observed and observations documented at a frequency of every fifteen minutes by Custody.
3. Low Risk requires that a patient be:

a. Placed in a close observation cell.

i. Upon placement in close observation cell by custody upon the recommendation of the assessing licensed mental health professional.

ii. Patient shall be provided a suicide smock by Custody.

ii. If placed in a close observation cell, patient shall be observed and observation documented by custody at fifteen minute intervals throughout stay in close observation.

4. See Mental Health Manual, Chapter 4 Section D: Suicide Assessment for more information on precautionary measures.

D. Self harm or Injury by a patient requires special attention that shall include but not be limited to:

1. Immediate attention at the scene by First Responder who shall take all necessary steps to protect the patient from further harm or injury. Such steps may include (but not be limited to:

a. Cutting the materials used in hanging,

b. Applying appropriate First-Aid,

c. Call for assistance,

d. Removing the patient to a clean, safe environment.

2. Obtaining appropriate emergency services as needed including, if appropriate after initial evaluation by a clinician, to a local emergency room.

3. Communication with all appropriate persons of the event including at a minimum the Security Chief for the facility, the Psychiatrist and Physician/Mid-Level on site or on call, the Directors of DPSCS Mental Health, Vendor Mental Health,

and the Utilization Management Vendor designee. Such communication shall be made in writing using the DAILY LOG OF SUICIDE BEHAVIOR (Appendix A).

E. The mental health professional and any person who observed the initial behaviors that began the assessment process the patient shall notify the DPSCS Director of Mental Health/designee, the Medical Director of the Mental Health Vendor, and the Utilization Management Vendor designee of all suicide events in writing using the DPSCS Daily Log of Suicide Behavior Form (Appendix A)

III. References:

DPSCS Suicide Prevention Activities Manual 2007

ACA Standards for Health Services in Correctional Institutions, Chapter Five (Mental health Services) E. Suicide Prevention.

NCCHC Standards on Correctional Health Care (Prisons): P-G-05 Suicide Prevention Program

NCCHC Standards on Correctional Health Care (Jails): J-G-05 Suicide Prevention Program

IV. Rescissions: DPSCS Suicide Prevention Activities Manual 2007

V. Date Issued: May, 2011

Appendix A

This log is to be completed by each staff (State or contractor) who observes the behavior shall be submitted to the Assistant Director of Mental Health on a daily basis (fax: (410) 764-5150).

Name/In. #	Type of Event: (circle and describe)	Description of event/circumstances
	Suicide/Suicide Attempt/Suicide Gesture/Suicide Ideation	
	Suicide/Suicide Attempt/Suicide Gesture/Suicide Ideation	
	Suicide/Suicide Attempt/Suicide Gesture/Suicide Ideation	
	Suicide/Suicide Attempt/Suicide Gesture/Suicide Ideation	

Suicide: When an inmate has died as a result of suicide a complete post mortem report shall accompany this notification form within 24 hours. This report should summarize the situation and all contact with mental health professionals.
Suicide attempt: When an attempt has been made, a summary of the situation and assessment by the Chief Psychologist/Lead staff of the facility must accompany this form.
Suicide gesture: A suicidal gesture is an action which has very little chance of lethality. In these cases a brief summary is sufficient.
Suicidal ideation: In these situations the inmate has discussed with someone that there are thoughts of suicide but there has been no action taken. A brief summary of the situation is sufficient.

Completed by: _____Institution: _____Date: _____

OFFICE OF PROGRAMS AND SERVICES:
CLINICAL SERVICES

MENTAL HEALTH SERVICES MANUAL

Chapter 4
SUICIDE PREVENTION
New Policy for 2011
Section F
POST EVENT CARE INCLUDING CARE FOR EVENT WITNESSES

I. Policy: DPSCS will provide a guideline for the management of persons in their care that have been found to be at risk for self-harm or suicide following a suicide event thoughout the process and into after-care.

II. Procedure:

A. For patients who have experienced a suicide event or has been at risk for en event, the following steps shall be taken:

1. A Licensed Mental Health Professional will evaluate the patient to determine:
    a. Appropriate housing recommendations.
    b. Completion of the termination portion of the Close Observation Form (Appendix A).
    c. Document patient evaluate outcome in EHR, including the rationale for terminating Close Observation and/or Suicide Precautions.
2. A State Mental Health Professional will complete the close Observation paperwork authorizing removal of Close Observation and/or Suicide Precautions.
3. The State Mental Health department will follow the patient and:

a. Assure that the patient is scheduled to be seen for additional evaluation by the most appropriate mental health professional, and treatment as necessary within twenty-four (24) hours of removal form Close Observation/Suicide Precautions.
b. Assure there is repeat follow up in on (1) week from the first post evaluation.
c. Assure additional follow up interval is determined and added to the patient treatment plan in the EHR.
d. Document all encounters in the patient's medical record.

B. Inmates who may have been witness to suicide events shall have critical incident stress management and debriefing services, by a Licensed Mental Health Professional, made available to them.
1. Requests for these services shall be obtained by the inmate by submitting a sick call request.
2. Persons requesting sick call shall be seen within forty-eight (48) hours of the request. (See Sick Call Manual Chapter 1)

C. The Chief Psychologist /Lead Mental Health of the facility housing the patient that has had an event shall ensure that inmates/detainees in surrounding areas of the incident location are surveyed for any emotional needs they may have and schedule appointments for them to be seen as needed.

D. The Chief Psychologist /Lead Mental Health of the facility housing the patient that has had an event shall ensure that staff is surveyed for any critical stress debriefing needs and follow up with any measures found to be needed.

E. The Director of Mental Health or the Regional Assistant Mental Health Director for the area where the patient suffering the event is housed shall survey mental health staff to determine any need for critical stress debriefing needs and follow up with any measures found to be needed.

III. References: DPSCS Suicide Prevention Activities Manual 2007
ACA Standards for Health Services in Correctional Institutions, Chapter Five (Mental health Services) E. Suicide Prevention.
NCCHC Standards on Correctional Health Care (Prisons): P-G-05 Suicide Prevention Program
NCCHC Standards on Correctional Health Care (Jails): J-G-05 Suicide Prevention Program

IV. Rescissions: DPSCS Suicide Prevention Activities Manual 2007

V. Date Issued: May, 2011

Appendix A

CLOSE OBSERVATION
Initiation Form

Name		Number:	Institution:
Last First MI			
Date of Placement:	Time: _____AM/PM	Official Authorizing Placement:	
Frequency of Observation:	Authorizing Mental Health Professional:		
Property? ☐ Y ☐ N If yes, what:			
Clothing? ☐ Y ☐ N If yes, what:			
Bedding? ☐ Y ☐ N If yes, what:			

Meals? ☐ Bag ☐ Regular	Specific Behaviors to Look For:

RATIONALE FOR INITIATION OF CLOSE OBSERVATION

☐ Bizarre Behavior	☐ Severe Agitation	☐ Recently received bad news
☐ Significant change in hygiene	☐ Significant change in attitude	☐ Threatening others
☐ Appears depressed	☐ Bizarre verbalizations	☐ Serious Hygiene problem
☐ Inmate isolating self	☐ Significant change in behavior	☐ Other: _____

Events which led to current situation:_____

Unusual Circumstances:

_____

Check if Known:

History:

- ☐ History of Mental Health issues
- ☐ History of Aggressive / Hostile Behavior
- ☐ History of suicidal behavior
- ☐ History of psychiatric admissions
- ☐ Recent transfer to institution
- ☐ History of Psychotropic medication

Symptoms:

☐ Incoherent speech	☐ Tearful	☐ Poor Hygiene
☐ Bizarre appearance	☐ Withdrawn	☐ Disoriented
☐ Agitated	☐ Oppositional	☐ Angry / hostile
☐ Restless	☐ Scared	☐ Looks or acts in an irrational fashion
☐ Yelling / Screaming	☐ Pacing	☐ Does not relate to Staff
☐ Refusing medication	☐ Restless	☐ Banging Door

☐ Other : _____

Termination Form

Rationale for termination of Close Observation:

_____

_____

Name of authorizing Mental Health Professional _____

Title:_____Date: _____ Time: _____

To whom information was given:_____

ATTACHMENT Z – TELEMEDICINE / TELEPSYCHIATRY LOCATIONS

Attachment Z DPSCS Telemed Locations

FACILITY	DEVICE LOCATION	ADDRESS
NBCI	SSBWest	14100 McMullen Hwy, SW Cumberland 21502
BCDC (Female)	Scribner Hall (W307)	401 East Eager Street Baltimore 21202
BCDC (Men)	Med Conf. Room on 2nd Floor	401 East Eager Street Baltimore 21202
Correct RX	Conference Room	806 G Barkwood Ct, Linthicum, MD 21090
ECI	East Med. Exam 2 (M.99.6)	30420 Revells Neck Road Westover 21890
JCI-MHC	Male Medical Infirmary	768 Ahn 1 House of Correction Road Jessup 20794
JCI	Conference Room	768 Ahn 1 House of Correction Road Jessup 20794
MCIH	2nd Floor, Rm. 215	18601 Roxbury Road Hagerstown 21746
MCIJ	Physical Therapy Rm.	Post Office Box 549, Jessup 20794
MCIW (Medical Unit)	Support Service Bldg	7943 Brock Bridge Road Jessup 20794
MCIW (MH Unit)	Support Service Bldg	7943 Brock Bridge Road Jessup 20794
MD Regional Office	Conference Room	6990 Columbia Gateway Dr., Columbia, MD 21046
MHM	Conference Room	3104 lord baltimore pike suite 105
MTC	3rd Floor Medical Office	954 Forrest Street Baltimore 21202
Office of Inmate Health	Conference Room	6776 reisterstown rd suite 315 (equipment is in maintenace closet 3rd floor)
Patuxent	Male Inpatient MH Unit	7550 Waterloo Road Jessup 20794
University of Maryland	Mobile Device	725 West Lombard St., Baltimore, MD 21201
WCI	WCI Conf. Rm or Rm. 6-50A	13800 McMullen Highway SW Cumberland 21502

ATTACHMENT AA – SUMMARY OF REPORTS AND MEETINGS

As part the Department's review for Contract Performance, the following is a summary of Meetings the Contractor is required to attend and Reports the Contractor is required to provide at the specified timeframe(s).

Attachment AA-1: Reports

** Submit all Monthly / Quarterly reports by the 10th of the following month or quarter (as appropriate) if that day is a weekday; if not the next available business day.*

RFP Section	Report	Submission Timeframe	Evidence Received/Approved By DPSCS Personnel:
3.20.2	Meeting Agenda	at least 10 days prior to each meeting	Contract Manager
3.20 3.55.2(3)(v)	Meeting Minutes	within five (5) days of the meeting	Contract Manager
3.21.5.6.1	Initial Physical Inventory Report	within 20 days after current contract's expiration date	Contract Manager
3.69.3.1	Initial Utilization Report	within 60 days after contract commencement	Contract Manager
3.69.2.1	Utilization Management Report	Weekly [non pre-certified admissions only]	Management Associate Contract Manager
3.23.2	MonthlyDispensary Services Schedule	Monthly	Contract Manager
3.26.2.1.4 3.26.2.3.4	Infectious Disease Report	Monthly	Medical Director Director of Nursing
3.27.2	Periodic Physical Exam Report	by the 3rd Monday of the following month for the exams due the previous month	Contract Manager Medical Director Director of Nursing
3.26.1.1	Seven (7) Day Exam Report	Monthly	Contract Manager
3.28.5	Sick Call Log	Monthly	Director of Nursing ACOM
3.59.5 3.63.2	Continuous Quality Improvement (CQI) Report ~ Mortality Review Report ~ Serious Incident Report	Monthly	Director of Nursing SDA Multidisciplinary CQI Committee
3.30.1.2	Chronic Care Clinic Attendance Report	Monthly	Contract Manager
3.30.1.3	Glaucoma and Diabetic Retinopathy Conditions Monitoring Report	Monthly	Director of Nursing
3.30.3 3.73.1.4.3.1	Chronic Care Report	Monthly	Medical Director Director of Nursing
3.49.3.1 3.57.1.2	Safety and Sanitation Report	Monthly	Director of Nursing
3.49.3.4 3.49.3.8	Infectious Disease Report	Monthly	Medical Director Director of Nursing
3.69.1.2.3.2	Medicaid Assistance Eligibility Collection Status Report	Monthly	Contract Manager
3.73.1.6(5)	Administrative Remedy Procedure (ARP) Report	Monthly	Medical Director

*** Submit all Bi-Annual / Annual reports by the 15th of the month following the end of year if that day is a weekday; if not the next available business day.*

Attachment AA-1: Reports

** Submit all Monthly / Quarterly reports by the 10th of the following month or quarter (as appropriate) if that day is a weekday; if not the next available business day.*

RFP Section	Report	Submission Timeframe	Evidence Received/Approved By DPSCS Personnel:
3.21.3 3.69.2.1 3.69.4.2 3.70.1 3.70.1.1 3.70.1.2	Utilization Management Report	Monthly	Contract Manager Medical Director
3.49.3.1.2	Infectious Disease Surveillance Report	Monthly	Director of Nursing
3.65.1.6.1	Inmate Count in Methadone Program (upon Admission)	Monthly	Medical Director Director of Nursing
3.73.1.2	State Stat Report	Monthly	Contract Manager or designee
3.73.1.2	Prime Contractor Paid/Unpaid MBE Invoice Report	Monthly	Contract Manager
3.72.3.1 3.59.5 3.63.2	Continuous Quality Improvement (CQI) Report ~ Mortality Review Report ~ Serious Incident Report	Quarterly	Management Associate for the Department Medical Director Director of Nursing SDA Multidisciplinary CQI Committee
3.58.2	Risk Management Report	Quarterly	Director of Nursing
3.32.2.5	Security Incident Report	Quarterly	ACOM
3.49.2	Infectious Disease Report	Quarterly	Medical Director Director of Nursing
3.21.3	Semi-Annual Durable Medical Equipment Report	Bi-Annually by the 15th of January every other year	Contract Manager
3.73.1.5	Peer Review Report	Bi-Annually by the 10th of January every other year	Medical Director
3.21.5.6.2	Annual Physical Inventory Report	Annually within last thirty (30) days of each contract year; due no later than June 1st of each year	Contract Manager
3.23.2	Dispensary Services Schedule	Annually by the 10th of January every year	Contract Manager
3.70.1.3	Annual Utilization Management Report	by July 30th for each contract year, including the final year of the contract	Medical Director

*** Submit all Bi-Annual / Annual reports by the 15th of the month following the end of year if that day is a weekday; if not the next available business day.*

Attachment AA-1: Reports

** Submit all Monthly / Quarterly reports by the 10th of the following month or quarter (as appropriate) if that day is a weekday; if not the next available business day.*

RFP Section	Report	Submission Timeframe	Evidence Received/Approved By DPSCS Personnel:
3.49.4.2	Annual In-Service Training Calendar	within thirty (30) days after the commencement of the contract **and** each subsequent contract year	Director of Nursing
3.51.4	"Man Down" Drill Report [Per Facility Per Year]	within thirty (30) days of the activity each contract year	Contract Manager
3.21.5.6.3	Final Physical Inventory Report	within 20 days of the end of the Contract	Contract Manager
3.77.2.1.1	Outstanding Third Party Reimbursement RequestsReport	5 days prior to end of the Contract	Contract Manager

*** Submit all Bi-Annual / Annual reports by the 15th of the month following the end of year if that day is a weekday; if not the next available business day.*

Attachment AA-2
Meetings

**Proposed meeting agendas shall be submitted to the DPSCS Contract Manager and all applicable Department staff at least 10 days prior to each meeting.*

RFP Section	Meeting	Timeframe	Attendees: [along w/Contractor's Statewide Medical Director]
3.19.1	Weekly Start Up Meetings	Weekly	DPSCS Contract Manager Contractor's Contract Manager Contractor's Statewide Medical Director
3.6.3.4	Administrative and Clinical Management Meeting	Monthly	Internal Contractor Employees
3.49.2.1	Multi-Disciplinary Regional Infection Control Meeting [within each Service Delivery Area]	Monthly	Contractor's Regional Medical Director Contractor's Regional Director of Nursing Contractor's Regional Infection Control staff appropriate DPSCS personnel
3.49.2.1 3.49.2.4	Multi-Disciplinary Statewide Infection Control Meeting [within each Service Delivery Area]	Monthly	Contractor's Director of Infection Control Contractor's Regional Medical Directors Contractor's Statewide DON Contractor's Regional Directors of Nursing Pharmacy Contractor's Statewide Director DPSCS Director of Infection Control ACOMs DPSCS Contract Manager DPSCS Medical Director ~ as appropriate and necessary ~ representatives from the Dental and Mental Health Contractors, local health departments, the Department of Health and
3.55.2(3)	Monthly Statewide Multi-Disciplinary Continuous Quality Improvement (CQI) Meeting [in each Service Delivery Area]	Monthly	chaired by the Contractor's Service Delivery Area's Medical Director. Membership shall include, but not be limited to: (a). The Assistant Commissioner of Correction/designee for the SDA, (b). The Department's Area Contract Operations Monitor (ACOM), (c). The Contractor's Area DON, (d). A Dental Contractor representative, (e). The Mental Health Contractor's Area Psychiatrist, (f). The Contractor's Area Infection

Attachment AA-2
Meetings

**Proposed meeting agendas shall be submitted to the DPSCS Contract Manager and all applicable Department staff at least 10 days prior to each meeting.*

RFP Section	Meeting	Timeframe	Attendees: [along w/Contractor's Statewide Medical Director]
3.55.2(1)	Quarterly Statewide Multi-Disciplinary Continuous Quality Improvement (CQI) Meeting	Quarterly	chaired by the Contractor's UM Medical Director: Department's Medical Director, Director of Mental Health and Director of Social Work; (b). The Department's Director of Nursing, (c). The Contractor's Infection Control Staff, (d). Directors of Nursing and Regional Medical Directors of the Contractor and the Medical Professionals of other health delivery modules.
3.49.2.4	Service Delivery Area (SDA) Meeting ~ Department Advisory Council Meeting	Monthly	Assistant Commissioner of Correction/designee for the SDA, (b). The Department's Area Contract Operations Monitor (ACOM), (c). The Contractor's Area Director of Nursing, (d). The Contractor's Area Dentist, (e). The Contractor's Area Psychiatrist, (f). The Contractor's Area Infection Control Coordinator/designee, (g). The Department Chief Psychologist(s) within the SDA, (h). Representatives from other departments as appropriate
3.2.4 3.49.2.1	Monthly Multi-Disciplinary Regional Infection Control Meeting [within each Service Delivery Area]	Monthly	Contractor's Regional Medical Director Contractor's Regional Director of Nursing Contractor's Regional Infection Control staff appropriate DPSCS personnel
3.60.1.1	Monthly Regional Pharmacy and Therapeutics (P & T) Meeting	Monthly	Contractor's Regional Medical Director Regional Director of Nursing, Regional Operations Manager, Regional Health Services Administrators, Regional Psychiatrists, Regional Psychologists and Dental Representatives

Attachment AA-2
Meetings

****Proposed meeting agendas shall be submitted to the DPSCS Contract Manager and all applicable Department staff at least 10 days prior to each meeting.***

RFP Section	**Meeting**	**Timeframe**	**Attendees: [along w/Contractor's Statewide Medical Director]**
3.60.1.2	Quarterly Statewide Pharmacy and Therapeutics (P & T) Meeting	Quarterly	Director of Clinical Services Statewide Medical Director, Statewide Director of Nursing, Utilization Director, Regional Medical Directors, Psychiatric Directors, Dental Representatives, the DPSCS Medical Director, the DPSCS Director of Nurses, the DPSCS Director for Mental Health, Regional Pharmacists
3.69.4.3	Quarterly Bon Secours Meeting	Quarterly	Contractor's Medical Director for Utilization Management
3.4.3	Quarterly Regional Multi-Disciplinary Trends/Cost Effective Practices Meeting	Quarterly	• Contractor's Contract Manager • Contractor's Regional Medical Director • other DPSCS Health Care Contractors (as requested)
3.19.1	Weekly Start Up Meetings	up to sixty (60) days following contract commencement	DPSCS Contract Manager Contractor's Contract Manager
3.19.2	Initial Kick-Off Meeting	to be determined by DPSCS Contract Manager in cooperation w/Contractor's Contract Manager	DPSCS Contract Manager Contractor's Contract Manager

ATTACHMENT BB - NBCI CLIA (TROPONIN) CERTIFICATION

Attachment BB NBCI CLIA (Troponin) Certification

MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY

SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MD 21228-4663

MEDICAL LABORATORY PERMIT

NUMBER: 990123 EFFECTIVE PERIOD: 09/01/2010 - 08/31/2012

Pursuant to the provisions of TITLE 17, subtitle 2, Health-General Article § 17-201 et seq., Annotated Code of Maryland, this permit is issued to:

WESTERN CORRECTIONAL INSTITUTION/MEDICAL SERVICES
13800 MCMULLEN HIGHWAY SW
CUMBERLAND, MD 21502

Director: Dr ISAIAS TESSEMA
Owner: CORRECTIONAL MEDICAL SERVICES

For the performance of Medical Laboratory Tests in the following disciplines:

Microbiology:
Occult Blood

Chemistry:
Dipstick Urinalysis, Glucose (FDA Home Device), Troponin I

Hematology:
INR

Nancy B. Grimm

CONTROL: **43573**

Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the impostition of civil fines.