



**STATE HOME PROGRAM APPLICATION FOR VETERAN CARE
 MEDICAL CERTIFICATION**

PART I - ADMINISTRATIVE

| | | | |
|---|--|--|---|
| STATE HOME FACILITY | | DATE ADMITTED | GENDER <input type="checkbox"/> M <input type="checkbox"/> F |
| RESIDENT'S NAME (Last, First, Middle) (This is a mandatory field) | | SOCIAL SECURITY NUMBER. (Mandatory field) | |
| RESIDENT'S STREET ADDRESS | | AGE | DATE OF BIRTH (mm/dd/yyyy) |
| CITY, STATE AND ZIP CODE | | ADVANCED MEDICAL DIRECTIVE <input type="checkbox"/> NO <input type="checkbox"/> YES | |

PART II - HISTORY AND PHYSICAL (Use separate sheet if necessary)

HISTORY

| | | | | | |
|--------------|--------|------|--------------------------|----|-------------------------------|
| HEIGHT | WEIGHT | TEMP | PULSE | BP | HEAD/EYES/EAR/NOSE AND THROAT |
| NECK | | | CARDIOPULMONARY | | |
| ABDOMEN | | | GENITOURINARY | | |
| RECTAL | | | EXTREMITIES | | |
| NEUROLOGICAL | | | ALLERGY/DRUG SENSITIVITY | | |

| | | | | | | |
|---------------|-------------|-------------------|---------|-------|-------------------|---------|
| X-RAY/ LAB | CHEST X-RAY | DATE (mm/dd/yyyy) | RESULTS | CBC | DATE (mm/dd/yyyy) | RESULTS |
| | SEROLOGY | | | | | |
| | URINALYSIS | DATE (mm/dd/yyyy) | ALBUMEN | SUGAR | ACETONE | |

CHECK ALL BOXES THAT APPLY OR CHECK NA

| | | | |
|---|--|---|--|
| IS DEMENTIA THE PRIMARY DIAGNOSIS <input type="checkbox"/> YES <input type="checkbox"/> NO | IS THERE A DIAGNOSIS OF MENTAL ILLNESS <input type="checkbox"/> YES <input type="checkbox"/> NO | HAS RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 YEARS <input type="checkbox"/> YES <input type="checkbox"/> NO | IS CLIENT A DANGER TO SELF OR OTHERS <input type="checkbox"/> YES <input type="checkbox"/> NO |
|---|--|---|--|

IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:

| | | |
|--|--|--|
| <input type="checkbox"/> SCHIZOPHRENIA | <input type="checkbox"/> PARANOIA | <input type="checkbox"/> OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY |
| <input type="checkbox"/> MOOD SWINGS | <input type="checkbox"/> SOMATOFORM DISORDER | <input type="checkbox"/> PANIC OR SEVERE ANXIETY DISORDER |
| | | <input type="checkbox"/> PERSONALITY DISORDER |

| | | | | |
|---|--|--|---|---|
| OXYGEN <input type="checkbox"/> MASK <input type="checkbox"/> PRN <input type="checkbox"/> NASAL CANULAR <input type="checkbox"/> CONTINUOUS | | <input type="checkbox"/> TUBE FEEDING <input type="checkbox"/> OSTOMY <input type="checkbox"/> TRACHOSTOMY | <input type="checkbox"/> DECUBITUS ULCERS <input type="checkbox"/> DRAINING WOUND <input type="checkbox"/> WOUND CULTURED | FOLEY CATHETER <input type="checkbox"/> TEMPORARY <input type="checkbox"/> PERMANENT |
|---|--|--|---|---|

| | |
|---------------------|--------------------|
| REFERRING PHYSICIAN | PRIMARY DIAGNOSIS |
| SECONDARY DIAGNOSIS | TERTIARY DIAGNOSIS |

TYPE OF CARE RECOMMENDED: SKILLED NURSING HOME CARE DOMICILIARY CARE ADULT HEALTH CARE HOSPITAL

MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY

| | |
|---|---|
| PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN ASSIGNED | SIGNATURE OF PRIMARY PHYSICIAN ASSIGNED |
|---|---|

STATE HOME PROGRAM APPLICATION FOR VETERAN CARE - MEDICAL CERTIFICATION, CONTINUED

RESIDENT'S NAME (Last, First, Middle) _____

SOCIAL SECURITY NUMBER _____

EVALUATION (Select an appropriate number in each category)

| | | | |
|------------------------|---|-----------------------------------|--|
| COMMUNICATION | <input type="checkbox"/> 1. Transmits messages/receives information <input type="checkbox"/> 2. Limited ability <input type="checkbox"/> 3. Nearly or totally unable | SPEECH | <input type="checkbox"/> 1. Speak clearly with others of same language <input type="checkbox"/> 2. Limited ability <input type="checkbox"/> 3. Unable to speak clearly or not at all |
| HEARING | <input type="checkbox"/> 1. Good <input type="checkbox"/> 2. Hearing slightly impaired <input type="checkbox"/> 3. Nearly or totally unable <input type="checkbox"/> 4. Virtually/completely deaf | SIGHT | <input type="checkbox"/> 1. Good <input type="checkbox"/> 2. Vision adequate - Unable to read/see details <input type="checkbox"/> 3. Vision limited - Gross object differentiation <input type="checkbox"/> 4. Blind |
| TRANSFER | <input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Equipment only <input type="checkbox"/> 3. Supervision only <input type="checkbox"/> 4. Requires human transfer w/wo equipment <input type="checkbox"/> 5. Bedfast | AMBULATION | <input type="checkbox"/> 1. Independence w/wo assistive device <input type="checkbox"/> 2. Walks with supervision <input type="checkbox"/> 3. Walks with continuous human support <input type="checkbox"/> 4. Bed to chair (total help) <input type="checkbox"/> 5. Bedfast |
| ENDURANCE | <input type="checkbox"/> 1. Tolerates distances (250 feet sustained activity) <input type="checkbox"/> 2. Needs intermitten rest <input type="checkbox"/> 3. Rarely tolerates short activities <input type="checkbox"/> 4. No tolerance | MENTAL AND BEHAVIOR STATUS | <input type="checkbox"/> 1. Alert <input type="checkbox"/> 2. Confused <input type="checkbox"/> 3. Disoriented <input type="checkbox"/> 4. Comatose <input type="checkbox"/> 5. Agreeable <input type="checkbox"/> 6. Disruptive <input type="checkbox"/> 7. Apathetic <input type="checkbox"/> 8. Well motivated |
| TOILETING | <input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Assistance to and from and transfer <input type="checkbox"/> 3. Total assistance including personal hygiene, help with clothes <input type="checkbox"/> A. Bathroom <input type="checkbox"/> B. Bedside commode <input type="checkbox"/> C. Bedpan | BATHING | <input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Supervision Only <input type="checkbox"/> 3. Assistance <input type="checkbox"/> 4. Is bathed <input type="checkbox"/> A. Tub <input type="checkbox"/> B. Shower <input type="checkbox"/> C. Sponge bath |
| DRESSING | <input type="checkbox"/> 1. Dresses self <input type="checkbox"/> 2. Minor assistance <input type="checkbox"/> 3. Needs help to complete dressing <input type="checkbox"/> 4. Has to be dressed | FEEDING | <input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Minor assistance, needs tray set up only <input type="checkbox"/> 3. Help feeding/encouraging <input type="checkbox"/> 4. Is fed |
| BLADDER CONTROL | <input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Rarely incontinent <input type="checkbox"/> 3. Occasional - once/week or less <input type="checkbox"/> 4. Frequent - up to once a day <input type="checkbox"/> 5. Total incontinence <input type="checkbox"/> 6. Catheter, indwelling | BOWEL CONTROL | <input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Rarely incontinent <input type="checkbox"/> 3. Occasional - once/week or less <input type="checkbox"/> 4. Frequent - up to once a day <input type="checkbox"/> 5. Total incontinence <input type="checkbox"/> 6. Ostomy |
| SKIN CONDITION | <input type="checkbox"/> 1. Intact <input type="checkbox"/> 2. Dry/Fragile <input type="checkbox"/> 3. Irritations (Rash) <input type="checkbox"/> 4. Open wound <input type="checkbox"/> 5. Decubitus Number _____ Stage _____ | WHEEL CHAIR USE | <input type="checkbox"/> 1. Independence <input type="checkbox"/> 2. Assistance in difficult maneuvering <input type="checkbox"/> 3. Wheels a few feet <input type="checkbox"/> 4. Unable to use <input type="checkbox"/> NA |

SIGNATURE OF REGISTERED NURSE OR REFERRING PHYSICIAN _____

DATE _____

PHYSICAL THERAPY (To be completed by Physical Therapist or Referring Physician) NEW REFERRAL CONTINUATION OF THERAPY

| | | | |
|--|--|---|---|
| SENSATION IMPAIRED | RESTRICT ACTIVITY | PRECAUTIONS | FREQUENCY OF TREATMENT |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> CARDIAC <input type="checkbox"/> OTHER (Specify) _____ | |
| TREATMENT GOALS: | | | |
| <input type="checkbox"/> ACTIVE | <input type="checkbox"/> COORDINATING ACTIVITIES | <input type="checkbox"/> FULL WEIGHT BEARING | <input type="checkbox"/> WHEELCHAIR INDEPENDENT |
| <input type="checkbox"/> STRETCHING | <input type="checkbox"/> ACTIVE ASSISTIVE | <input type="checkbox"/> NON-WEIGHT BEARING | <input type="checkbox"/> PROGRESS BED TO WHEELCHAIR |
| <input type="checkbox"/> PASSIVE ROM | <input type="checkbox"/> PROGRESSIVE RESISTIVE | <input type="checkbox"/> PARTIAL WEIGHT BEARING | <input type="checkbox"/> RECOVERY TO FUL FUNCTION |
| <input type="checkbox"/> COMPLETE AMBULATION | | | |

| | | |
|--|---|------------|
| ADDITIONAL THERAPIES | SIGNATURE OF AND TITLE OF THERAPIST _____ | DATE _____ |
| <input type="checkbox"/> O.T. <input type="checkbox"/> SPEECH <input type="checkbox"/> DIETARY | | |

SOCIAL WORK ASSESSMENT (To be completed by Social Worker)

| | |
|-------------------------------------|----------------------------------|
| PRIOR LIVING ARRANGEMENTS | LONG RANGE PLAN |
| ADJUSTMENT TO ILLNESS OR DISABILITY | SIGNATURE OF SOCIAL WORKER _____ |
| | DATE _____ |

VA AUTHORIZATION FOR PAYMENT

| | | |
|--------------------------------|--|---|
| DATE RECEIVED BY VA | ELIGIBILITY FOR PER DIEM PAYMENT | LEVEL OF CARE RECOMMENDED |
| | <input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED | <input type="checkbox"/> NHC <input type="checkbox"/> DOMICILIARY <input type="checkbox"/> HOSPITAL <input type="checkbox"/> ADHC |
| REASON FOR DISAPPROVAL | <input type="checkbox"/> APPROVED | REASON FOR DISAPPROVAL |
| | <input type="checkbox"/> DISAPPROVED | |
| SIGNATURE OF VA OFFICIAL _____ | DATE _____ | SIGNATURE OF VA PHYSICIAN _____ |
| | | DATE _____ |

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