OMB Approval No. 2900-0160
Estimated Burden: Avg. 30 min.

Department of Veterans Affairs

STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

PART I - ADMINISTRATIVE

STATE HOME FACILITY	DATE ADMITTED	GENDER ☐ M ☐ 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 ☐ NO ☐ 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	IS THERE A DIAGNOSIS OF MENTAL ILLNESS	HAS RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 YEARS	IS CLIENT A DANGER TO SELF OR OTHERS
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:

☐ SCHIZOPHRENIA ☐ PARANOIA ☐ OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY
☐ MOOD SWINGS ☐ SOMATOFORM DISORDER ☐ PANIC OR SEVERE ANXIETY DISORDER ☐ PERSONALITY DISORDER

OXYGEN						**FOLEY CATHETER**
☐ MASK	☐ PRN	☐ TUBE FEEDING		☐ DECUBITUS ULCERS		☐ TEMPORARY
☐ NASAL CANULAR	☐ CONTINUOUS	☐ OSTOMY		☐ DRAINING WOUND		☐ PERMANENT
		☐ TRACHOSTOMY		☐ WOUND CULTURED		

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

TREATMENT GOALS:
☐ ACTIVE ☐ COORDINATING ACTIVITIES ☐ FULL WEIGHT BEARING ☐ WHEELCHAIR INDEPENDENT
☐ STRETCHING ☐ ACTIVE ASSISTIVE ☐ NON-WEIGHT BEARING ☐ PROGRESS BED TO WHEELCHAIR ☐ COMPLETE AMBULATION
☐ PASSIVE ROM ☐ PROGRESSIVE RESISTIVE ☐ PARTIAL WEIGHT BEARING ☐ RECOVERY TO FUL FUNCTION

ADDITIONAL THERAPIES	SIGNATURE OF AND TITLE OF THERAPIST	DATE
☐ **O.T.** ☐ **SPEECH** ☐ **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
	☐ APPROVED ☐ DISAPPROVED	☐ NHC ☐ DOMICILIARY ☐ HOSPITAL ☐ ADHC

APPROVED FOR 70% SERVICE CONNECTED DISABILITY	APPROVED FOR ADMITANCE BECAUSE OF SERVICE CONNECTED ILLNESS (IF LESS THAN 70%) ILLNESS:
☐ **YES** ☐ **NO**	

SIGNATURE OF VA OFFICIAL	DATE	SIGNATURE OF VA PHYSICIAN	DATE

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