



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