



**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)		SOCIAL SECURITY NUMBER	
RESIDENT'S STREET ADDRESS		AGE	DATE OF BIRTH
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	RESULTS	CBC	DATE	RESULTS
	SEROLOGY					
	URINALYSIS	DATE	ALBUMEN	SUGAR	ACETONE	

CHECK ALL BOXES THAT APPLY OR CIRCLE 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"/> 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
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REFERRING PHYSICIAN	PRIMARY DIAGNOSIS
SECONDARY DIAGNOSIS	TERTIARY DIAGNOSIS

TYPE OF CARE RECOMMENDED: SKILLED NURSING HOME CARE DOMICILIARY CARE ADULT DAY 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. Speaks 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. Limited hearing (e.g.- must speak loudly) <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 intermittent 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) Number _____ <input type="checkbox"/> 4. Open wound Stage _____ <input type="checkbox"/> 5. Decubitus	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) <input type="checkbox"/> NEW REFERRAL <input type="checkbox"/> CONTINUATION OF THERAPY			
SENSATION IMPAIRED <input type="checkbox"/> YES <input type="checkbox"/> NO	RESTRICT ACTIVITY <input type="checkbox"/> YES <input type="checkbox"/> NO	PRECAUTIONS <input type="checkbox"/> CARDIAC <input type="checkbox"/> OTHER (Specify)	FREQUENCY OF TREATMENT
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"/> COMPLETE AMBULATION <input type="checkbox"/> PASSIVE ROM <input type="checkbox"/> PROGRESSIVE RESISTIVE <input type="checkbox"/> PARTIAL WEIGHT BEARING <input type="checkbox"/> RECOVERY TO FULL FUNCTION			
ADDITIONAL THERAPIES <input type="checkbox"/> O. T. <input type="checkbox"/> SPEECH <input type="checkbox"/> DIETARY		SIGNATURE OF AND TITLE OF THERAPIST	DATE
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 <input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED	LEVEL OF CARE RECOMMENDED <input type="checkbox"/> NHC <input type="checkbox"/> DOMICILIARY <input type="checkbox"/> HOSPITAL <input type="checkbox"/> ADHC	
REASON FOR DISAPPROVAL		<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED	REASON FOR DISAPPROVAL
SIGNATURE OF VA OFFICIAL	DATE	SIGNATURE OF VA PHYSICIAN	DATE

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