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

RESIDENT'S NAME (*Last, First, Middle*)	SOCIAL SECURITY NUMBER

EVALUATION (Circle appropriate number in each category)

COMMUNICATION	1. Transmits messages/receives information 2. Limited ability 3. Nearly or totally unable	**SPEECH**	1. Speaks 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. Limited hearing (e.g.- must speak loudly) 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 intermittent rest 3. Rarely tolerates short activities 4. No tolerance	**MENTAL AND BEHAVIOR STATUS**	1. Alert 2. Confused 3. Disoriented 4. Comatose 5. Agreeable 6. Disruptive 7. Apathetic 8. Well motivated
TIOLETING	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 2. Supervision only 3. Assistance 4. Is bathed A. Tub B. Shower C. Sponge bath
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:

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

REASON FOR DISAPPROVAL		REASON FOR DISAPPROVAL
	☐ APPROVED ☐ DISAPPROVED	

SIGNATURE OF VA OFFICIAL	DATE	SIGNATURE OF VA PHYSICIAN	DATE