



APPLICATION FOR ADMISSION TO A PENNSYLVANIA VETERANS HOME

The application for admission to a Pennsylvania Veterans Home consists of six parts and requests information needed to determine eligibility for admission. **The application must be completed and submitted in its entirety. To ensure we keep all pages of your application together, please enter the first name and last name on each page where indicated.**

The applicant must complete Parts I, II, III, IV and VI. Part V must be completed and signed by a physician. Additionally, a copy of the applicant's honorable military discharge/separation document must be submitted with the application (example: DD214). *If required information is not furnished, the application will be returned for completion resulting in a delay to the admission process.* Also, failure to keep us informed of any address change or telephone contact number could delay or cancel your admission.

It is the policy of the Department of Military and Veterans Affairs to process all applications without regard to race, color, national origin, religious creed, age, sex, gender identity, ancestry or handicap. There is no distinction in eligibility for, or in the manner of, providing any applicant services provided by, or through, the Pennsylvania Veterans Homes. All Pennsylvania Veterans Homes are available without distinction to all residents and visitors, regardless of race, color, national origin, religious creed, age, sex, sexual orientation, gender identity, ancestry, or handicap. All persons and organizations that have occasion to refer residents for admission are to do so without regard to the resident's race, color, national origin, religious creed, age, sex, ancestry or handicap.

PLEASE NOTE: Only the original signed or e-signed application will be accepted. Mail to the following address:

**Department of Military and Veterans Affairs
Bureau of Veterans' Homes
Attn: Admission's Office
Edward Martin Hall, Bldg. S-0-47
Fort Indiantown Gap
Annville, Pennsylvania 17003-5002**

WWW.VETERANSHOMES.PA.GOV

Instruction Sheet for Completing the Application for Admission to a Pennsylvania Veterans Home

The instruction sheet is designed to provide the applicant with step-by-step instructions for filling out the Application for Admission to a Pennsylvania Veterans Home (BVH Form -101).

The following list will assist the applicant and ensure that the application is submitted with all required documentation. Once the application is received at the Department of Military and Veterans Affairs, it is date stamped, reviewed, and sent to the Home(s) that the applicant has chosen.

Part I - General Information

Question 1-13: Contains general information that pertains to the applicant. **Please note: If the applicant is a spouse of a veteran, a copy of the marriage certificate is required in order to process the application.**

Question 14 & 14a: If a Power of Attorney or Legal Guardian is in effect, please provide a copy of the order declaring Power of Attorney or the Legal Guardian documentation.

Question 15: Indicate individual we should contact regarding this application process.

Question 16: Indicate Veterans' Home preference.

Please note: If interested, you may choose up to two (2) Homes. Indicate this by marking 1 beside your first choice, and 2 beside your second choice.

Question 17: Felony charges.

Part II - Military Services Record

Complete all areas of Part II. Applications, as applicable, that do not contain a discharge/separation document will be returned. **Additionally, take note of the home of record at time of entry into the military.** If the applicant was born in a state other than Pennsylvania (PA) and had a home of record at time of entry into the military service other than PA, the applicant ***must*** submit proof of PA residency, such as income tax returns, rent receipts/mortgage closing statement as applicable, PA photo ID, bank statements, driver's license, etc.

If you cannot locate your military discharge/separation document, please contact your County Director of Veterans' Affairs, a Regional Veterans' Affairs Office, or the National Personnel Record's Center in St. Louis, Missouri at

1-866-272-6272 Option 4 or www.archives.gov/veterans/evetrecs/index.html

Part III - Financial Information

Please provide all applicable financial information. It is **not** necessary to send copies of bank statements when submitting the application.

Part IV - Residency Requirements

Request to confirm residency. **Note:** Veterans who live in PA have priority for admission. Non-residents of PA who entered the military when they were residents of PA will be added to the waiting list and offered admissions after Veterans who currently resides in PA. Applicant's who are not current PA residents or did not enter the military while a resident of PA are ineligible for admission to the Veteran's Homes.

Part V – Outreach Survey

Please complete to assist with improving outreach to our Veterans.

Part VI - Medical Information

Medical information *must* be **completed and signed by a physician**. The first section of part VI is the **instruction page for Form MA51**. The second section of part VI is the **Medical Evaluation Form MA51**, and the third section of part VI is the **Activities of Daily Living Assessment Sheet (ADL)**.

Frequently Asked Questions

Question: How much does it cost to stay in a Pennsylvania Veterans Home?

Answer: Cost of care and income-related questions will be answered by the **Revenue Office** of the Home you have chosen.

Question: When can I expect to be admitted?

Answer: Each completed application is date stamped and forwarded to the Home of choice for further review and processing. Once the Home has made the determination of level of care, the applicant's name is placed on the appropriate waiting list by date of application. Each applicant is admitted in order of application date.

Question: Who can I contact if I have any questions?

Answer: If you need assistance completing the application, you may contact the **Admission Coordinator at the Home**, or you may contact the **Bureau of Veterans' Homes**, Fort Indiantown Gap.

Admission's Office - Fort Indiantown Gap	717-861-8906
Delaware Valley Veterans' Home	215-856-2718
Gino J. Merli Veterans' Center	570-961-4348
Hollidaysburg Veterans' Home	814-696-5352
Soldiers' and Sailors' Home	814-878-4939
Southeastern Veterans' Center	610-948-2406
Southwestern Veterans' Center	412-665-6782

Please re-enter your first and last name here:
This will assist in keeping your pages together.

Facility Phone Number

Email Address

- 11. If your current address is different from your mailing address, please indicate contact name and address of residency below.**

First and Last Name

(If different from number 1 above)

Number, Street, City, State, Zip

- 12. If you have been a previous resident of a Pennsylvania Veterans Home, please enter the name of the Veteran Home and dates of residency below.**

Veteran Home Name

Date entered residency

- 13. If you have applied to a Pennsylvania Veterans Home in the past, please enter the application date and name of Veteran Home below.**

Select previous application date below

Enter the name of the Veterans' Home you previously sent an application?

- 14. If you have a Power of Attorney (POA) in affect, please list your POA/Guardian's Contact Information below.**

First and Last Name

Relationship to Applicant

- 14a. If you have a Legal Guardian, please select if Medical and/or Financial below.**

Medical

Financial

Address: Number, Street, City, State, Zip Code

Home Phone Number Work Phone Number Cell Phone Number Email Address

(IMPORTANT: Please be sure to include a copy of your Power of Attorney.)

15. Please enter the contact information of whom we should contact regarding this application?

First and Last Name Relationship to Applicant

Address: Number, Street, City, State, Zip Code

Home Phone Number Work Phone Number Cell Phone Number Email Address

16. Indicate Veterans' Home Preference: You may choose 2 Homes. It is recommended to choose an alternative home by entering the number 2 next to your second choice.

Please choose the Home where the Veteran would like to reside by entering the number "1" next to your first choice. The application will be assigned to that Home once the application is deemed complete by Headquarters. That home will determine applicable level of care. Some Pennsylvania Homes may have shorter wait times than others. For quality control purposes, information will be made available to the second-choice home after the first choice reviews the application.

If you choose 2 Homes, enter a number 1 beside your first choice and a number 2 beside your second choice.

Hollidaysburg Veterans' Home, Hollidaysburg, PA 16648 (Blair County) - 814-696-5352

Pennsylvania Soldiers' and Sailors' Home, Erie, PA 16512 (Erie County) - 814-878-4939

Southeastern Veterans' Center, Spring City, PA 19475 (Chester County) - 610-948-2406

Gino J. Merli Veterans' Center, Scranton, PA 18503 (Lackawanna County) - 570-961-4348

Southwestern Veterans' Center, Pittsburgh, PA 15206 (Allegheny County) - 412-665-6782

Delaware Valley Veterans' Home, Philadelphia, PA 19154 (Philadelphia County) - 215-856-2718

17. Have you ever been convicted of a felony? Yes No

If yes, enter date of conviction:

PART II. MILITARY SERVICES RECORD

(IMPORTANT: Attach Copy of Release or Military Discharge for Latest Period of Service.)

18. Please Select branch of service (Select all that apply)

Army Navy Air Force Marine Corps Reserve

Coast Guard PA National Guard Merchant Marine

Service Number (If Known) Date Entered Service Date of Separation

Character of Discharge:

Honorable General Rank at Discharge

Dishonorable Medical

19. If you are registered in the U.S. Veteran's Administration System, please enter your Veteran's Administration number. (This number is located on your VA-ID Card)

VA - ID Number

20. If you have a service-connected disability please enter % of disability as 10, or 70, or 100 as applicable.

Percent of Disability:

PART III. FINANCIAL INFORMATION

21. By completing the required financial information below, will assist in the determination of the appropriate cost-of-care for your stay in our Veteran Homes.

A. Provide monthly income from the Federal Government:

Veteran

Spouse

1. VA Compensation:
2. VA Pension:
3. Military Retirement Pay:

TOTAL FEDERAL FUNDS

B. Other Income: Provide veteran and spouse's monthly income in dollar amounts.

Veteran

Spouse

1. Social Security
2. Retirement/Pension
3. Employment
4. Supplemental Security Income (SSI)
5. Interest/Dividends
6. Rent/Royalties

GRAND TOTAL - OTHER INCOME:

C. Investments

Veteran

Spouse

1. Bank Accounts
(Savings /Checking)

2. Stocks/Bonds

3. Annuities

4. Trust Funds

5. Certificates of Deposit

TOTAL OF INVESTMENTS:

**GRAND TOTAL FEDERAL FUNDS, OTHER INCOME
& INVESTMENTS:**

6. Burial Fund? Yes No 7. Real Estate? Yes No

If you replied “yes” above, please enter first and last name on Deed.

First Name/Last Name:

Deed Property Location (Enter address If different from the address in number 1 above)

Address: Number, Street, City, State, Zip Code

D. If you have transferred or assigned title to assets or income to anyone in the past three (3) years, please explain why and to whom below.

E. Financial Verification Information

For verification purposes, please list contact information of all financial institutions.

Name of institution(s) and Address(s) (City, State)

If additional space is needed, please continue on a separate sheet of paper and attach with your application.

PART IV. RESIDENCY REQUIREMENTS

22. Were you a resident of Pennsylvania when you entered the military? Yes No

a. Are you currently a resident of Pennsylvania? Yes No

Part V – Outreach Survey

We are constantly looking for better ways to reach our veterans and their spouses. Your responses to the questions below will help us improve our outreach to all Pennsylvania's veterans.

Your Name:

1st Veterans' Home Preference:

How did you hear about our services? (Chose from the options below)

- | | | |
|-----------------|--------------------------------|------------------------|
| Internet | Pamphlet/Publication | Radio/Television Ad |
| Friends/Family | Veterans' Home Resident | Veteran Service Office |
| Exhibit/Display | Veterans' Service Organization | County Director |
| Facility/Agency | Other (please specify) | |

SIGNATURE AND CERTIFICATION

READ CAREFULLY BEFORE SIGNING

I have read, or have heard, the questions contained in Parts I, II, III, and IV of this application for admission to a Pennsylvania Veterans Home. I hereby certify under penalty of law that the foregoing information is true and correct to the best of my knowledge and belief. I understand that if I do not provide accurate information, I will be subject to discharge from the Home and prosecuted for violation of 18 Pa. C.S. paragraph 4904 (relating to unsworn falsification to authorities).

By signing or entering my typed name in this application, I hereby give my expressed written consent to the Commonwealth of Pennsylvania, Department of Military and Veterans' Affairs, through its Bureau of Veterans' Homes, to obtain information to verify this application from any source. I specifically direct the U.S. Veterans' Administration, the Department of Defense, the Armed Forces, and any banks, financial institutions or others with information about my military service, financial, and medical condition including drug/ alcohol and mental health related conditions to release any and all information from my records to any authorized agent of the Bureau of Veterans' Homes for purpose of processing this application. I hereby specifically authorize the Bureau of Veterans' Homes to review and discuss my medical records.

I understand that, if I am admitted to a Pennsylvania Veterans Home, my estate and I will be legally obligated to pay for the full cost of my care and maintenance while a resident of the Home. I further understand that the Commonwealth is authorized to recover the costs of maintaining persons in Pennsylvania Veterans Homes in accordance with Pennsylvania law.

No person will be denied admission to a Veterans' Home on grounds of inability to pay maintenance fees. I agree to pay the maintenance charges and to inform the Home, at once, of any changes in my financial circumstances that may affect my ability to pay. I understand that, although my estate and I remain obligated to pay the full charge, the amount of periodic payments may be reduced depending on the amount of my income. If I am admitted to the Home, I agree to abide by all rules and regulations governing the Home. The applicant also acknowledges, the medical forms (MA-51 & ADL) will be submitted to the Veterans' Home upon completion.

(Applicant/Responsible Party Signature or enter first & last name for e-signature if completed on-line)

Date

INSTRUCTIONS FOR COMPLETING MA-51 MEDICAL EVALUATION



NOTE: THE MA-51 IS VALID AS LONG AS IT REFLECTS THE CURRENT CONDITIONS FOR THE APPLICANT

At the top of the page, mark if this is a new or updated MA-51.

Questions 1-7 are self-explanatory.

8. **Physician License Number.** Enter the physician license number, not the Medical Assistance number.
9. **Evaluation At.** Enter 1-5 to describe where evaluation took place. If 5 is used, specify where evaluation was completed.
10. **Signature.** Applicant should sign if able. If unable, legal guardian or responsible party may sign.
11. **Essential Vital Signs.** Self-explanatory.
12. **Medical Summary.** Include any medical information you feel is important for determination of level of care. **Please list patient's known allergies in this section.**
13. **Vacating of building.** How much assistance does the patient require to vacate the building?
14. **Medication Administration.** Is the patient capable of being trained to self-administer medications?
15. **Diagnostic Codes and Diagnoses.** ICD diagnostic codes should be put in the blocks, then written by name in the space next to the block. List diagnoses starting with primary, then secondary, and finally tertiary.
16. **Professional and Technical Care Needs.** Indicate care needed. Examples of "other" include mental health and case management.
17. **Physician Orders.** Orders should meet needs indicated in box 16. Medications should have diagnoses to support their use.
18. **Prognosis.** Indicate patient's prognosis based on current medical condition.
19. **Rehabilitation Potential.** Indicate based on current condition. Should be consistent with box 18.
- 20A. **Physician's Recommendation.** Physician must recommend patient's level of care. If the box for "other" is checked, write in level of care. In order to provide assistance to a physician in the level of care recommendation, the following definitional guidelines should be considered:

Nursing Facility Clinically Eligible (NFCE)	Personal Care Home	ICF/ID Care	ICF/ORC Care	Inpatient Psychiatric Care
Requires health-related care and services because the physical condition necessitates care and services that can be provided in the community with Home and Community Based Services or in a Nursing Facility.	Provides Personal Care services such as meals, housekeeping, & ADL assistance as needed to residents who live on their own in a residential facility.	Provides health-related care to ID individuals. More care than custodial care but less than in a NF.	Provides health-related care to ORC individuals. More care than custodial care but less than in a NF.	Provides inpatient psychiatric services for the diagnoses and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

20B. **Complete only if Consumer is NFCE and will be served in a Nursing Facility.** Check whether the patient will be eventually discharged from facility based on current prognosis. If yes, check expected length of stay.

20C. The physician must sign and date the MA-51. A licensed physician must sign the MA-51. It may not be signed by a "physician in training" (a Medical Doctor in Training [MT] or an Osteopathic Doctor in Training [OT]).

Questions 21 and 22 are completed by Aging Well, the appropriate Department of Human Services program office, or the Department's designee. These questions are used by the Department to certify the individual's medical eligibility for services.



MEDICAL EVALUATION

 NEW UPDATED

1. MA RECIPIENT NUMBER		2. NAME OF APPLICANT (Last, first, middle initial)		3. SOCIAL SECURITY NO.		4. BIRTHDATE	
5. AGE	6. SEX	7. ATTENDING PHYSICIAN			8. PHYSICIAN LICENSE NUMBER		
9. EVALUATION AT (Description and code)				10. For the purpose of determining my need for TITLE XIX INPATIENT CARE, Home and Community Based Services, and if applicable, my need for a shelter deduction, I authorize the release of any medical information by the physician to the county assistance office, Pennsylvania Department of Human Services or its agents.			
01 Hospital 02 NF 03 Personal Care/Dom Care 04 Own House/Apartment 05 Other (Specify) _____				SIGNATURE - APPLICANT OR PERSON ACTING FOR APPLICANT _____			
				DATE _____			

11. HEIGHT	WEIGHT	BLOOD PRESSURE	TEMPERATURE	PULSE RATE	CARDIAC RHYTHM
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12. MEDICAL SUMMARY

13. IN EVENT OF AN EMERGENCY THE PATIENT CAN VACATE THE BUILDING	14. PATIENT IS CAPABLE OF ADMINISTERING HIS/HER OWN MEDICATIONS
<input type="checkbox"/> 1. Independently <input type="checkbox"/> 2. With Minimal Assistance <input type="checkbox"/> 3. With Total Assistance	<input type="checkbox"/> 1. Self <input type="checkbox"/> 2. Under Supervision <input type="checkbox"/> 3. No

15. ICD DIAGNOSTIC CODES

	PRIMARY (Principal)
	SECONDARY
	TERTIARY

16. PROFESSIONAL AND TECHNICAL CARE NEEDED - CHECK EACH CATEGORY THAT IS APPLICABLE

<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Inhalation Therapy	<input type="checkbox"/> Special Dressings	<input type="checkbox"/> Irrigations
<input type="checkbox"/> Special Skin Care	<input type="checkbox"/> Parenteral Fluids	<input type="checkbox"/> Suctioning	<input type="checkbox"/> Other (Specify) _____		

17. PHYSICIAN ORDERS

Medications _____

Treatment _____

Rehabilitative and Restorative Services _____

Therapies _____

Diet _____

Activities _____

Social Services _____

Special Procedures for Health and Safety or to Meet Objectives _____

18. PROGNOSIS - CHECK <input checked="" type="checkbox"/> ONLY ONE	19. REHABILITATION POTENTIAL - CHECK <input checked="" type="checkbox"/> ONLY ONE
<input type="checkbox"/> 1. Stable <input type="checkbox"/> 2. Improving <input type="checkbox"/> 3. Deteriorating	<input type="checkbox"/> 1. Good <input type="checkbox"/> 2. Limited <input type="checkbox"/> 3. Poor

20A. **PHYSICIAN'S RECOMMENDATION**

To the best of my knowledge, the patient's medical condition and related needs are essentially as indicated above. I recommend that the services and care to meet these needs can be provided at the level of care indicated - check only one

<input type="checkbox"/> Nursing Facility Clinically Eligible Services to be provided at home or in a nursing facility	<input type="checkbox"/> Personal Care Home Services provided in a Personal Care Home	<input type="checkbox"/> ICF/ID Care Services to be provided at home or in an Intermediate care facility for the intellectually disabled	<input type="checkbox"/> ICF/ORC Care Services to be provided at home or in an Intermediate care facility for consumers with ORCs	<input type="checkbox"/> Inpatient Psychiatric Care	<input type="checkbox"/> Other (Please Specify) _____
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20B. **COMPLETE ONLY IF CONSUMER IS NURSING FACILITY CLINICALLY ELIGIBLE AND WILL BE SERVED IN A NURSING FACILITY.**

ON THE BASIS OF PRESENT MEDICAL FINDINGS THE PATIENT MAY EVENTUALLY RETURN HOME OR BE DISCHARGED. YES NO If Yes, Check Only One 1. Within 180 days 2. Over 180 days

20C. **PHYSICIAN'S SIGNATURE**

PHYSICIAN (PRINTED NAME) _____ TELEPHONE _____ PHYSICIAN SIGNATURE _____ DATE

FOR DEPARTMENT USE Medical and other professional personnel of the Medicaid agency or its designee MUST evaluate each applicant's or recipient's need for admission by reviewing and assessing the evaluations required by regulations.

21 **MEDICALLY ELIGIBLE** Yes No 22 **Comments. Attach a separate sheet if additional comments are necessary.**

REVIEWER'S SIGNATURE AND TITLE _____ DATE



Part VI - Medical Information

Medical information *must* be **completed and signed by a physician**. The first section of part VI is the **instruction page for Form MA51**; the second section of part VI is the **Medical Evaluation Form MA51**; and the third section of part VI is the **Activities of Daily Living Assessment Sheet (ADL)**.

PART V. ACTIVITIES OF DAILY LIVING ASSESSMENT SHEET (3 rd section of part VI)					
Additional Medical:			Please enter applicant's first & last name to help keep documents together.		
<ul style="list-style-type: none"> Please attach a copy of Veteran's or Spouse's current medication list Please attach a copy of any pertinent medical progress note to suffice any related information to anything noted on the MA51 and / the "Activities of Daily Living Sheet (ADL)". If applicant is seeing medical specialist, please list in additional comments below. 					
EVALUATION - PLEASE ENTER A CHECK (✓) FOR ALL THAT APPLY IN EACH CATEGORY					
COMMUNICATION (Can Convey Thoughts & Feelings)	1.	VERBALLY	SPEECH	1.	ABLE TO ARTICULATE WORDS CLEARLY
	2.	WRITING (PRINTED OR CURSIVE)		2.	ABLE TO UNDERSTAND AND INTERPRET WHAT IS SAID
	3.	SMALL PHONE, EMAIL, TEXTING		3.	MUTE
	4.	ILLUSTRATION, ELECTRONICALLY, DRAWING		4.	USES SIGN LANGUAGE
	5.	SPEECH-GENERATING DEVICE (SGD)	SIGHT	1.	20/20 VISION
	6.	SIGN LANGUAGE		2.	LESS THAN 20/20 FOR READING & CLOSE WORK
	7.	IS ENGLISH THE FIRST LANGUAGE? Check box below		3.	LESS THAN 20/20 FOR DISTANCE
		Yes	4.	LEGALLY BLIND	
		No	5.	WEARS GLASSES/CONTACTS	
HEARING	1.	GOOD	BATHING	1.	INDEPENDENT IN TUB/SHOWER
	2.	SLIGHTLY IMPAIRED; DOES NOT USE HEARING DEVICE		2.	SUPERVISION ONLY
	3.	LEGALLY DEAF; USES SIGN LANGUAGE OR HEARING AID		3.	ASSISTANCE OF 1 - 2 PERSONS
	4.	SUFFERS WITH TINNITUS (RINGING IN THE EARS)		4.	USES MECHANICAL LIFT FOR TRANSFER
	5.	EXPOSED TO LOUD NOISES THROUGH WORK OR ACTIVITIES		5.	BEDFAST/SPONGE BATH ONLY
AMBULATION Continues Below	1.	AMBULATES & TRANSFERS INDEPENDENTLY	FEEDING Continues Below	1.	INDEPENDENTLY FEEDS SELF
	2.	NEEDS SUPERVISION ONLY		2.	NEEDS ASSISTANCE TO SET UP MEAL
	3.	HELP OF 1 - 2 PERSON FOR TRANSFER		3.	TOTAL ASSISTANCE AT MEAL-TIME

PART V. ACTIVITIES OF DAILY LIVING ASSESSMENT SHEET (3 rd section of part VI)				Enter	
AMBULATION	4.	USES MECHANICAL LIFT FOR TRANSFER		Enter applicant's first & last name: <input type="text"/>	
				4.	TAKES NOURISHMENT BY TUBE FEED
ENDURANCE	5.	BEDFAST/BED BATH ONLY	MENTAL STATUS	1.	ATTENTIVE/INDEPENDENTLY MAKES DECISIONS
	1.	WALKS INDEPENDENTLY 250 FEET OR MORE		2.	INATTENTIVE/DISTRACTED/MONITORING OR GUIDANCE NEEDED
	2.	USES ASSISTIVE DEVICE TO WALK 250 FEET OR MORE		3.	DISORGANIZED THINKING/CUEING AND SUPERVISION NEEDED
	3.	NEEDS INTERMITTENT REST PERIODS		4.	SEVERELY IMPAIRED/RARELY MAKES DECISIONS/DOZES OFF DURING CONVERSATION
TOILETING	4.	WHEELCHAIR/CHAIR/BEDBOUND	BEHAVIOR STATUS	1.	EVEN TEMPERED/GENERALLY HAPPY/CONVERSATIONAL
	1.	TOILETS INDEPENDENTLY/NO ASSISTANCE NEEDED		2.	DEPRESSED/HAVING LITTLE ENERGY/LITTLE INTEREST IN ACTIVITIES
	2.	ONE PERSON ASSIST TO/FROM TOILET		3.	SHORT-TEMPERED/EASILY ANNOYED/THREATENING OR COMBATIVE
	3.	TWO PERSON ASSIST TO/FROM TOILET		4.	EXHIBITS HALLUCINATIONS/DELUSIONS
	4.	TOTAL DEPENDENCE FOR WEIGHT-BEARING/OR MECHANICAL LIFT NEEDED		5.	WANDERS/WALKS AIMLESSLY INSIDE OR OUTSIDE BUILDING
PERSONAL HYGIENE (combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands):	1.	PERFORMS INDEPENDENTLY/NO ASSISTANCE NEEDED		6.	HISTORY OF OR SPEAKS ABOUT ELOPEMENT
	2.	NEEDS SET-UP ONLY		1.	NONE/NO SPECIAL EQUIPMENT NEEDED
	3.	OVERSIGHT NEEDED/CUEING TO COMPLETE THE TASKS		2.	CANE FOR AMBULATION
	4.	TOTAL DEPENDENCE/NEEDS FULL SUPPORT TO COMPLETE TASKS		3.	WALKER FOR AMBULATION
DRESSING Continues Below	1.	DRESSES INDEPENDENTLY/NO ASSISTANCE NEEDED	EQUIPMENT / DEVICE NEEDS	4.	MANUAL/SELF-PROPELLED WHEELCHAIR
	2.	NEEDS SET-UP ONLY		5.	ELECTRIC/MOTORIZED WHEELCHAIR
	3.	CAN PERFORM UPPER BODY DRESSING ONLY		6.	UPPER EXTREMITY PROTHESIS
	4.	CAN PERFORM LOWER BODY DRESSING ONLY		7.	LOWER EXTREMITY PROTHESIS
	5.	CAN PUT ON/TAKE OFF FOOTWEAR INDEPENDENTLY		8.	SPECIALIZED SHOE(S)/BRACE/STOCKINGS Describe Below:

PART V. ACTIVITIES OF DAILY LIVING ASSESSMENT SHEET (3rd section of part VI)

	6.	NEEDS CUEING/SUPERVISION TO COMPLETE THE TASK	
	7.	TOTAL DEPENDENCE FOR ALL PARTS OF THE TASK	Enter applicant's first & last name: <input style="width: 100px; height: 20px;" type="text"/> Describe Shoe/ Brace Type Here:
SKIN CONDITION	1.	INTACT/NO SKIN PROBLEMS	9.
	2.	DRY/APPLIES LOTION OR OIL DAILY	10.
	3.	RASH/REDDENED OR SCABBED/FRAGILE SKIN Enter Location(s) Below	11.
	4.	OPEN WOUND / CUT RASION/SKIN TEAR/ SURGICAL SITE Enter Location(s)Below	1.
	5.	PRESSURE INJURY Enter Location(s) Below	2.
	6.	SPECIALIZED SKIN TREATMENT OR DRESSINGS Describe Below:	3.
COGNITIVE FUNCTION	1.	INDEPENDENT - DECISION CONSISTENT/ REASONABLE	4.
	2.	MODIFIED INDEPENDENCE-SOME DIFFICULTY IN NEW SITUATIONS ONLY	5.
	3.	MODERATELY IMPAIRED	1.
			2.

BOWEL & BLADDER CONTROL

	BEDRAIL/OVERBED TRIANGLE FOR MANEUVERING		
	MOTION SENSOR ALARM		
	SPECIALIZED MATTRESS FOR BED/CUSHION FOR CHAIR-Describe Mattress/Cushion Below:		
1.	ALWAYS CONTINENT		
2.	OCCASIONALLY INCONTINENT (ONCE/WEEK OR LESS) SELECT TYPE	BOWEL	BLADDER
3.	FREQUENTLY INCONTINENT (2 OR MORE EPISODES OR INCONTINENCE): SELECT TYPE	BOWEL	BLADDER
4.	ALWAYS INCONTINENT (NO EPISODES OF CONTINENCE): SELECT TYPE BELOW	BOWEL	BLADDER
5.	OSTOMY: SELECT TYPE	BOWEL	BLADDER

PART V. ACTIVITIES OF DAILY LIVING ASSESSMENT SHEET (3rd section of part VI)

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		NEVER/RARELY MAKES DECISIONS		Enter applicant's first & last name:			
	4.	SEVERELY IMPAIRED - NEVER/RARELY MAKES DECISIONS	DIET	1.	REGULAR		
FALLS	1.	DID NOT HAVE ANY FALLS		2.	SPECIAL / SPECIFY BELOW		
		YES NO		3.	ETHNIC / SPECIFY BELOW		
	2.	HAS HAD 1 OR MORE FALLS IN THE PAST THREE MONTHS		4.	OTHER / SPECIFY BELOW		
	3.	WAS HOSPITALIZED DUE TO A FALL - Enter Mo./Yr. Hosp below:					
HOSPICE	1.	DOES NOT NEED HOSPICE CARE	MOUTH	1.	NATURAL TEETH		
	2.	DESIRE OR REQUEST HOSPICE CARE		2.	SOME TEETH MISSING		
	3.	ALREADY RECEIVING HOSPICE CARE Enter Number of Months Receiving Hospice Care Below:		3.	EDENTULOUS/NO TEETH PRESENT		
4.		4.		GUM DISEASE			
SLEEP HABITS	1.	NORMAL NUMBER OF HOURS ASLEEP: Please Enter Number Below:		5.	DENTURES / PARTIAL- Please Check Appropriate Box	UPPER	LOWER
	2.	DIFFICULTY FALLING ASLEEP		6.	SWALLOWING DIFFICULTY		
	3.	AWAKE FREQUENTLY AT NIGHT	ADDITIONAL COMMENTS:				
	4.	NAPS DURING THE DAY					

PART V. ACTIVITIES OF DAILY LIVING ASSESSMENT SHEET (3rd section of part VI)

Enter applicant's first & last name:

SPECIAL NEEDS EQUIPMENT -PLEASE ENTER A CHECK (✓) ALL THAT APPLY IF NOT ABOVE BUT - AND ON THE MA - 51 AND/OR OBSERVED - (3rd section of part V)

<input type="checkbox"/>	WOUND VAC	<input type="checkbox"/>	TRACHEOSTOMY	<input type="checkbox"/>	FOLEY CATHETER
<input type="checkbox"/>	WOUND CARE	<input type="checkbox"/>	GASTRIC TUBE	<input type="checkbox"/>	IMPLANTABLE CARDIOVERTER DEFIBERLATOR (ICD)
<input type="checkbox"/>	UROSTOMY	OTHER:			
<input type="checkbox"/>	OXYGEN (TANK) OR (SEE BELOW)	SPECIALIZED EATING UTENSILS – Describe Below			ADDITIONAL COMMENTS:
<input type="checkbox"/>	CONCENTRATOR				
<input type="checkbox"/>	MASK				
<input type="checkbox"/>	CANNULA				

LIST RECENT SURGERIES/FRACTURES:

PHYSICIAN NAME (PLEASE PRINT IF MANUALLY SIGNED)

PHYSICIAN SIGNATURE

DATE

PHYSICIAN: PLEASE CONFIRM THE ABOVE ASSESSMENT IS ON BEHALF OF: (ENTER APPLICANT'S FIRST AND LAST NAME BELOW)

ADDRESS: STREET NAME & NUMBER) CITY, STATE, ZIP CODE

PHONE NUMBER:

Mail to:
 Department of Military and Veterans Affairs Bureau of Veterans' Homes
 Attn: Admission's Office
 Edward Martin Hall, Bldg. S-0-47 Fort Indiantown Gap
 Annville, Pennsylvania 17003-5002