# INSTRUCTIONS FOR COMPLETING MA-51 MEDICAL EVALUATION

1st Section of Part VI

You can also print these forms by selecting the print button on the last page.

**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. There is room for any other pertinent diagnoses.
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/MR 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 MR 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 be 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 completed by the OPTIONS Unit in the Area Agency on Aging.**

# MEDICAL EVALUATION

☐ NEW ☐ UPDATED **2nd Section of Part VI**

| 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) ☐

01 Hospital
02 NF
03 Personal Care/Dom Care
04 Own House/Apartment
05 Other (Specify) ______

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.

SIGNATURE - APPLICANT OR PERSON ACTING FOR APPLICANT ______ DATE ______

| 11. HEIGHT | WEIGHT | BLOOD PRESSURE | TEMPERATURE | PULSE RATE | CARDIAC RHYTHM |
|---|---|---|---|---|---|
| | | | | | |

12. MEDICAL SUMMARY

13. IN EVENT OF AN EMERGENCY THE PATIENT CAN VACATE THE BUILDING

☐ 1. Independently ☐ 2. With Minimal Assistance ☐ 3. With Total Assistance

14. PATIENT IS CAPABLE OF ADMINISTERING HIS/HER OWN MEDICATIONS

☐ 1. Self ☐ 2. Under Supervision ☐ 3. No

15. ICD DIAGNOSTIC CODES

| | |
|---|---|
| | PRIMARY (Principal) |
| | SECONDARY |
| | TERTIARY |
| | |
| | |

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

☐ Physical Therapy ☐ Speech Therapy ☐ Occupational Therapy ☐ Inhalation Therapy ☐ Special Dressings ☐ Irrigations
☐ Special Skin Care ☐ Parenteral Fluids ☐ Suctioning ☐ 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 ✓ ONLY ONE

☐ 1. Stable ☐ 2. Improving ☐ 3. Deteriorating

19. REHABILITATION POTENTIAL - CHECK ✓ ONLY ONE

☐ 1. Good ☐ 2. Limited ☐ 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

☐ Nursing Facility Clinically Eligible Services to be provided at home or in a nursing facility
☐ Personal Care Home Services provided in a Personal Care Home
☐ ICF/MR Care Services to be provided at home or in an Intermediate care facility for the mentally retarded
☐ ICF/ORC Care Services to be provided at home or in an Intermediate care facility for consumers with ORCs
☐ Inpatient Psychiatric Care
☐ Other (Please Specify) ______

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.

21A. **MEDICALLY ELIGIBLE** ☐ Yes ☐ No ☐ Medically Appropriate for Waiver Services

21B. **Length of Stay** ☐ Within 180 days ☐ Over 180 days

22 **Comments. Attach a separate sheet if additional comments are necessary.**

REVIEWER'S SIGNATURE AND TITLE ______ DATE ______

**ORIGINAL TO CAO - RETAIN PHOTOCOPY FOR YOUR FILE**

## 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 (3rd section of part VI)**

**Additional Medical:**

**Please enter applicant's first & last name to help keep documents together.**

- 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 MA51and / the "Activities OF Daily Living Sheet (ADL)".

**EVALUATION - PLEASE ENTER A CHECK (√) FOR ALL THAT APPLY IN EACH CATEGORY**

| Category | No. | Item | Category | No. | Item |
|---|---|---|---|---|---|
| **COMMUNICATION** (Can Convey Thoughts & Feelings) | 1. | VERBALLY | **SPEECH** | 1. | ABLE TO ARTICULATE WORDS CLEARLY |
| | 2. | WRITING (PRINTED OR CURSIVE) | | 2. | ABLE TO UNDERST 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. | SLIGHLY 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 (3rd section of part VI)

If printed enter applicant's first & last name: Enter

| Category | No. | Description | Category | No. | Description |
|---|---|---|---|---|---|
| **AMBULATION** | 4. | USES MECHANICAL LIFT FOR TRANSFER | | 4. | TAKES NOURISHMENT BY TUBE FEED |
| | 5. | BEDFAST/BED BATH ONLY | **MENTAL STATUS** | 1. | ATTENTIVE/INDEPENDENTLY MAKES DECISIONS |
| **ENDURANCE** | 1. | WALKS INDEPENDENTLY 250 FEET OR MORE | | 2. | INATTENTIVE/DISTRACTED/MONITORING OR GUIDANCE NEEDED |
| | 2. | USES ASSISTIVE DEVISE TO WALK 250 FEET OR MORE | | 3. | DISORGANIZED THINKING/CUEING AND SUPERVISION NEEDED |
| | 3. | NEEDS INTERMITTENT REST PERIODS | | 4. | SEVERELY IMPAIRED/RARELY MAKES DECICIONS/DOZES OFF DURING CONVERSATION |
| | 4. | WHEELCHAIR/CHAIR/BEDBOUND | **BEHAVIOR STATUS** | 1. | EVEN TEMPERED/GENERALLY HAPPY/CONVERSATIONAL |
| **TOILETING** | 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 PERSONASSIST 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 | **EQUIPMENT / DEVICE NEEDS** | 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 | | 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)

| Category | No. | Item |
|---|---|---|
| | 6. | NEEDS CUEING/SUPERVISION TO COMPLETE THE TASK |
| | 7. | TOTAL DEPENDENCE FOR ALL PARTS OF THE TASK |
| SKIN CONDITION | 1. | INTACT/NO SKIN PROBLEMS |
| | 2. | DRY/APPLIES LOTION OR OIL DAILY |
| | 3. | RASH/REDDENED OR SCABBED/FRAGILE SKIN Enter Location(s) Below |
| | 4. | OPEN WOUND / CUT RASION/SKIN TEAR/ SURGICAL SITE Enter Location(s)Below |
| | 5. | PRESSURE INJURY Enter Location(s) Below |
| | 6. | SPECIALIZED SKIN TREATMENT OR DRESSINGS Describe Below: |
| COGNITIVE FUNCTION | 1. | INDEPENDENT - DECISION CONSISTENT/ REASONA BLE |
| | 2. | MODIFIED INDEPENDENCE-SOME DIFFICULTY IN NEW SITUATIONS ONLY |
| | 3. | MODERATELY IMPAIRED |

If printed enter applicant's first & last name:

Describe Shoe/ Brace Type Here:

| Category | No. | Item | BOWEL | BLADDER |
|---|---|---|---|---|
| | 9. | BEDRAIL/OVERBED TRIANGLE FOR MANEUVERING | | |
| | 10. | MOTION SENSOR ALARM | | |
| | 11. | SPECIALIZED MATTRESS FOR BED/CUSHION FOR CHAIR-Describe Mattress/Cushion Below: | | |
| BOWEL & BLADDER CONTROL | 1. | ALWAYS CONTINENT | | |
| | 2. | OCCASIONALLY INCONTINENT (ONCE/WEEK OR LESS) SELECT TYPE | | |
| | 3. | FREQUENTLY INCONTINENT (2 OR MORE EPISODES OR INCONTINENCE): SELECT TYPE | | |
| | 4. | ALWAYS INCONTINENT (NO EPISODES OF CONTINENCE): SELECT TYPE BELOW | | |
| | 5. | OSTOMY: SELECT TYPE | | |

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

If printed, enter first & last name to help keep documents together.

| | | |
|---|---|---|
| | | NEVER/RARELY MAKES DECISIONS |
| | 4. | SEVERELY IMPAIRED - NEVER/RARELY MAKES DECISIONS |
| **FALLS** | 1. | DID NOT HAVE ANY FALLS (YES / NO) |
| | 2. | HAS HAD 1 OR MORE FALLS IN THE PAST THREE MONTHS |
| | 3. | WAS HOSPITALIZED DUE TO A FALL - Enter Mo./Yr. Hosp below: |
| **HOSPICE** | 1. | DOES NOT NEED HOSPICE CARE |
| | 2. | DESIRE OR REQUEST HOSPICE CARE |
| | 3. | ALREADY RECEIVING HOSPICE CARE<br>Enter Number of Months Receiving Hospice Care Below: |
| **SLEEP HABITS** | 1. | NORMAL NUMBER OF HOURS ASLEEP:<br>Please Enter Number Below: |
| | 2. | DIFFICULTY FALLING ASLEEP |
| | 3. | AWAKE FREQUENTLY AT NIGHT |
| | 4. | NAPS DURING THE DAY |

| | | |
|---|---|---|
| **DIET** | 1. | REGULAR |
| | 2. | SPECIA L/ SPECIFY BELOW |
| | 3. | ETHNIC / SPECIFY BELOW |
| | 4. | OTHER / SPECIFY BELOW |
| **MOUTH** | 1. | NATURAL TEETH |
| | 2. | SOME TEETH MISSING |
| | 3. | EDENTULOUS/NO TEETH PRESENT |
| | 4. | GUM DISEASE |
| | 5. | DENTURES / PARTIAL- Please Check Appropriate Box (UPPER / LOWER) |
| | 6. | SWALLOWING DIFFICULTY |

**ADDITIONAL COMMENTS:**

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

If printed, enter first & last name to help keep documents together.

**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)**

| | | | | | |
|---|---|---|---|---|---|
| | WOUND VAC | | TRACHEOSTOMY | | FOLEY CATHETER |
| | WOUND CARE | | GASTRIC TUBE | | IMPLANTABLE CARDIOVERTER DEFIBERLATOR (ICD) |
| | UROSTOMY | | OTHER: | | |
| | OXYGEN (TANK) OR (SEE BELOW) | | SPECIALIZED EATING UTENSILS – Describe Below | | ADDITIONAL COMMENTS: |
| | CONCENTRATOR | | | | |
| | MASK | | | | |
| | CANNULA | | | | |

**LIST RECENT SURGERIES/FRACTURES:**

| PHYSICIAN NAME (PLEASE PRINT IF MANUALLY SIGNED) | PHYSICIAN SIGNATURE<br>Before signing on-line, ensure all fields are complete, document will lock after signing. | 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:**

**If you do not want to submit electronically using the button below, you can 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