pennsylvania
DEPARTMENT OF MILITARY
AND VETERANS' AFFAIRS

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, Ill, **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

BVH Form-101 (Revised May 1, 2023)

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

PART 1. GENERAL INFORMATION

1. **Name of Applicant:** *(First Name, Middle Name, Last Name)*

Check Military Status: Veteran ◯ Spouse ◯

2. **Current Marital Status**

Married ◯ Never Married ◯ Separated ◯ Widowed ◯ Divorced ◯

3. **Birth Sex**

Male ◯
Female ◯
Intersex ◯

SELF-IDENTIFIED GENDER IDENTITY

Male ◯ Female ◯
Trans-male/Transman/Female/Female - To -Male ◯
Trans-female/Transwoman/Male - To - Female ◯
Prefer Not to Disclose ◯

4. **Mailing Address**
(Number, Street, City, State, Zip Code)

5. **County**

6. **Telephone Number**

7. **Date of Birth**

8. **Place of Birth** (City & State)

9. **Social Security Number**

10. **If you are currently residing in a nursing home or another type of facility such as Alternative Living, Personal Care Home, Rehabilitation Facility, etc., please enter the facility name and address below.**

Facility Name

Number, Street, City, State, Zip

First/Last Name

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	$ 0.00	

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: $ 0.00

C. Investments

	Veteran	Spouse
1. Bank Accounts (Savings /Checking)		
2. Stocks/Bonds		
3. Annuities		
4. Trust Funds		
5. Certificates of Deposit		

TOTAL OF INVESTMENTS: $ 0.00

GRAND TOTAL FEDERAL FUNDS, OTHER INCOME & INVESTMENTS: $ 0.00

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

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

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)". **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 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)							
				Enter applicant's first & last name:			
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)

Enter applicant's first & last name:

Describe Shoe/ Brace Type Here:

	☐	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		
	☐	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	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)

Enter applicant's first & last name:

		NEVER/RARELY MAKES DECISIONS			
	☐ 4.	SEVERELY IMPAIRED - NEVER/RARELY MAKES DECISIONS	**DIET**	☐ 1.	REGULAR
FALLS	☐ 1.	DID NOT HAVE ANY FALLS YES ○ NO ○		☐ 2.	SPECIA L/ SPECIFY BELOW
	☐ 2.	HAS HAD 1 OR MORE FALLS IN THE PAST THREE MONTHS		☐ 3.	ETHNIC / SPECIFY BELOW
	☐ 3.	WAS HOSPITALIZED DUE TO A FALL - Enter Mo./Yr. Hosp below:		☐ 4.	OTHER / SPECIFY 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.	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)

☐	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
☐	CONCENTRATOR		
☐	MASK		
☐	CANNULA		

ADDITIONAL COMMENTS:

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