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. 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

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

PATIENT'S NAME

PATIENT'S SOCIAL SECURITY NUMBER	PATIENT'S DATE OF BIRTH

PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)

1. Date you last examined the patient _____

2. Do you believe the patient is capable of managing or directing the management of benefits in his or her own best interest? By capable we mean the patient:

- Is able to understand and act on the ordinary affairs of life, such as providing for own adequate food, housing, clothing, etc., and
- Is able, in spite of physical impairments, to manage funds or direct others how to manage them.

☐ Yes
If "Yes", please omit question 3, but be sure to sign and date the form.

☐ No
If "No", please provide a brief summary of the findings that led to this conclusion. Also, complete question 3.

☐ Unsure
If "Unsure", please explain.

3. Do you expect the patient to be able to manage funds in the future (for example, the patient is temporarily unconscious)?

☐ Yes ☐ No

If yes, please explain.

NAME OF PHYSICIAN/MEDICAL OFFICER (Please print.)	TITLE
ADDRESS (Number and street, City, State, and ZIP Code)	TELEPHONE NUMBER (*Include Area Code*)

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

SIGNATURE OF PHYSICIAN/MEDICAL OFFICER	DATE

Social Security Administration

Form Approved
OMB No. 0960-0024

PHYSICIAN'S/MEDICAL OFFICER'S STATEMENT OF PATIENT'S CAPABILITY TO MANAGE BENEFITS

In replying, use this address: SOCIAL SECURITY ADMINISTRATION	TELEPHONE NUMBER (Including Area Code) DATE

SSA CONTACT

IDENTIFYING INFORMATION (SSA Only)
If different from patient

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON	SOCIAL SECURITY NUMBER

PATIENT'S NAME

PATIENT'S SOCIAL SECURITY NUMBER	PATIENT'S DATE OF BIRTH

PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)

YOUR HELP IS NEEDED

The patient shown above has filed for or is receiving Social Security or Supplemental Security Income payments. We need you to complete the back of this form and return it to us in the enclosed envelope to help us decide if we should pay this person directly or if he or she needs a representative payee to handle the funds. Please Note: This determination affects how benefits are paid and has no bearing on disability determinations; SSA will NOT pay for this information. Thank you for your help.

WHO IS A REPRESENTATIVE PAYEE

A representative payee is someone who manages the patient's money to make sure the patient's needs are met. The payee has a strong and continuing interest in the patient's well-being and is usually a family member or close friend.

WHO NEEDS A REPRESENTATIVE PAYEE

Some individuals age 18 and older who have mental or physical impairments are not capable of handling their funds or directing others how to handle them to meet their basic needs, so we select a representative payee to receive their payments. Examples of impairments which may cause incapability are senility, severe brain damage or chronic schizophrenia. However, even though a person may need some assistance with such things as bill paying, etc., does not necessarily mean he/she cannot make decisions concerning basic needs and is incapable of managing his/her own money.

PLEASE COMPLETE THE INFORMATION ON THE REVERSE OF THIS FORM

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a) and 205(j) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to make a determination regarding the beneficiary's need for a representative payee.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than to make a determination regarding management of benefits. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information form our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,

2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices 60-0089, entitled Claims Folders Systems; and, 60-0222, entitled Master Representative Payee File. Additional information about these and other system of records notices and our programs is available online at www.socialsecurity.gov or at your local Social Security office.

We may also use the information you provide in our computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

Bureau of Human Services Licensing - Documentation of Medical Evaluation (DME)

INSTRUCTIONS FOR USE

Personal Care Home

Applicable Regulations

§ 2600.141

It's important to remember that the primary focus of these requirements is the need for residents to be evaluated by a physician, physician's assistant or certified registered nurse practitioner – **NOT that a form be completed**. The Department specifies a form simply to ensure that all of the required elements of the evaluation are performed during the evaluation.

Homes are PERMITTED to:

- Complete all or a portion of the DME prior to the in-person evaluation, except for the "Medical Professional Information" section, and present the DME to the physician, physician's assistant or certified registered nurse practitioner for signature and certification of accuracy at the time of the examination.
- Complete all or a portion of the DME after an in-person evaluation that was performed within the timeframes specified by this regulation, except for the "Medical Professional Information" section, and present the completed form to the physician, physician's assistant or certified registered nurse practitioner for signature in person, by facsimile, or via electronic mail.
- Correct a DME upon discovering that the physician, physician's assistant or certified registered nurse practitioner has recorded inaccurate information or omitted information, IF a registered nurse (RN) or licensed practical nurse (LPN) contacts the person who performed the evaluation, AND receives permission from that person to correct the DME, AND documents the date, time, and person spoken to on the DME next to the correction.

Homes are PROHIBITED from:

- Completing the "Medical Professional Information" section, unless the home employs a physician, physician's assistant or certified registered nurse practitioner.
- Completing all or a portion of the DME without an in-person evaluation by a medical professional.
- Completing all or a portion of the DME after an in-person evaluation that was performed outside of the timeframes specified by this regulation.
- Changing the content of a DME without the consent of the person who performed the evaluation. After obtaining consent, the DME must be changed by a registered nurse (RN) or licensed practical nurse (LPN).

It is strongly recommended that homes carefully review DME forms completed by a physician, physician's assistant or certified registered nurse practitioner to verify that all of the required information was recorded. Although the evaluations must be completed by medical professionals, homes are responsible for ensuring that the evaluations were complete and that the DMEs were filled out in their entirety.

Bureau of Human Services Licensing - Documentation of Medical Evaluation (DME)

Licensed Setting:
Personal Care Home

Resident Information			**Evaluation Information**		
Name:			Type (Check one) ☐ INITIAL ☐ ANNUAL ☐ STATUS CHANGE	Date of In Person Evaluation:	Date Form Completed:
Date of Birth:					
(1) - General Physical Examination					
Height:	Weight:	Pulse Rate:	Blood Pressure:		Temperature:

(2) - Medical Diagnoses, Physical / Mental	**(3) - Medical Information Pertinent to Diagnoses and Treatment, if applicable**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

For additional diagnoses, see **Diagnoses Addendum** on page 4.

(4) Poisonous Materials	**(5) - Advanced Directives**
☐ This resident CAN safely use or avoid poisonous materials ☐ This resident CAN NOT safely use or avoid poisonous materials	☐ Yes ☐ No Check One: ☐ Full Code ☐ DNR (Do Not Resuscitate)
(6) - Special Health or Dietary Needs	**(7) - Allergies**
☐ None ☐ Special Diet - Check all that apply ☐No Added Sodium ☐Low Cholesterol ☐Heart Healthy ☐Mechanical Soft Foods ☐Pureed Foods ☐No Concentrated Sweets ☐ Respiratory Care Describe: _____ ☐ Wound Care ☐ Other - See **Needs Addendum** on page 4	☐None ☐Unknown ☐Listed Below:

(8) - Medications	(9) - Immunization History	
☐ None **OR** See **Medication Addendum** on page 4	Are immunizations current? ☐Yes ☐No ☐Unknown	
Ability to Self-Administer Medications - Check all that apply: ☐ Can self-administer - no assistance from others. ☐ Can self-administer -assistance to store medication in a secure place ☐ Can self-administer - assistance in remembering schedule. ☐ Can self-administer - assistance in offering medication at prescribed times. ☐ Can self-administer some medications but not others - See **Medication Addendum** on page 4 **OR** ☐ Cannot self-administer medications.	Td/Tdap Date: Type:	Influenza Date:
	Pneumonia Date:	Covid Date:
	TB Test Date:_____ Type: ☐Skin ☐Blood Chest X-Ray Date:_____	
	Other Immunization - (List Date and Type):	

(10) - Body Positioning / Movement - Level of Assistance for Ambulation or Transfers	(11) - Health Status	(12) - Cognitive Functioning (Check All That Apply)
☐ None ☐ Assistive devices and/or wheelchair: Listed: _____ ☐ Supervision ☐ Cueing ☐ One person assist ☐ Two person assist ☐ Assist with repositioning ☐ Assist with turning ☐ Assist with transfers	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Actively Dying	☐ No impairment/Independent ☐ Short term memory deficits ☐ Long term memory deficits ☐ Needs assist with high level decision making ☐ Needs assist with all decision making ☐ Dementia diagnosis ☐ Brain injury

(13) Mobility Needs Assessment (For Ability To Evacuate In An Emergency)	☐ **Independent (Mobile)** Resident has **no** mobility needs and can evacuate independently in an emergency	☐ **Minimal (Mobile)** Resident requires **limited** physical or oral assistance to evacuate in an emergency	☐ **Moderate (Immobile)** Resident requires **moderate** physical or oral assistance to evacuate in an emergency	☐ **Total (Immobile)** Resident requires **total** physical or oral assistance to evacuate in an emergency from one or more staff persons

(14) Special Care Needs (For Secure Dementia Care Unit Admissions Only)

Dementia

Does resident require dementia - related care in a secured area?

☐ YES

☐ NO

Documentation of Medical Evaluation (DME) - Addendum Sheet

This sheet may be copied as needed if additional space is required

Resident Information	Evaluation Information	
Name:	Date of In Person Evaluation:	Date Form Completed:

Diagnoses Addendum

(2) - Medical Diagnoses, Physical / Mental	(3) - Medical Information Pertinent to Diagnoses and Treatment, if applicable
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

(6) Needs Addendum

Other (describe):

(8) Medication Addendum

Medication Name	Strength (Example: 100 mg.)	Dose (Example: 2 Tablets)	Frequency (Example: 2x / Day)	Purpose (Example: COPD)	Self-Administration* (Check One)
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No

*** Residents may be able to self-administer some medications, but not others. The resident's ability to self-administer each medication should be assessed. If the resident can self-administer a medication, check "Yes." If a resident cannot self-administer a medication, check "No." If nothing is checked, the Department will assume that the resident cannot self-administer the medication.**

Medical Professional Information

By Signing Below, I certify that:

- ☐ I am a physician, physician assistant, or certified registered nurse practitioner whose license to practice is in good standing.
- ☐ The information on this form, the addendum sheet, and any attached list of medications was generated based on my evaluation.
- ☐ The above-named resident requires assistance or supervision with Activities of Daily Living, Instrumental Activities of Daily Living, or both, as defined by 55 Pa. Code Chapter 2600.

Check One Of The Options Below:

- ☐ The resident's needs can be met safely at the Personal Care Home.
- ☐ The resident is Nursing Facility Clinically Eligible (NFCE). Services to be provided at home or in a nursing facility. The resident's needs CAN NOT be met safely at the Personal Care Home.

Medical Professional Name:	**Medical Professional License #:**
Medical Professional Signature:	**Date Signed:**