**ADMISSION APPLICATION**
**FOR BERKS HEIM NURSING AND REHABILITATION**

**SECTION ONE – Personal information**

1. **Name** _____
   **(First) (Middle) (Last)**
2. **Address** _____

   _____
   **(City) (County) (State) (Zip)**
3. **Telephone** _____

4. **Applicant is currently at** ☐ **Home** ☐ **Personal Care/Assisted Living**_____
   ☐ **Other Nursing Facility** _____ ☐ **Hospital** _____
5. **Current Age** _____ **Date of Birth**_____ **Sex** ☐ **Male** ☐ **Female**
6. **Social Security Number** _____ - _____ - _____
7. **Religious Affiliation** _____ **Church/Temple Name** _____
   **City** _____ **State** _____ **Zip** _____ **Phone** _____
8. **Place of Birth** _____
9. **Maiden Name** _____
10. **Marital Status** _____
11. **Education** _____
12. **Occupation** _____
13. **Contact Persons(s)**

| Name | Address | Relationship | Phone |
|---|---|---|---|
| **1.** | | | **Home** |
| | | | **Work** |
| | | | **Cell** |
| | | | **Email** |
| **2.** | | | **Home** |
| | | | **Work** |
| | | | **Cell** |
| | | | **Email** |

9. **Funeral Home** _____
   **Address** _____ **Phone** _____
   ☐ **Prepaid Arrangement** ☐ **Irrevocable Burial Fund** **Amount $**_____

**10. Please list power of attorney or legal guardian appointed to manage your affairs and check the type.**
****Note – At time of admission, please submit copy of the legal document****

| | Name | Address | Phone |
|---|---|---|---|
| ☐ Financial & Medical | | | |
| | | | |
| ☐ Financial Only | | | |
| | | | |
| ☐ Medical Only | | | |
| | | | |
| ☐ Court Appointed | | | |
| Legal Guardian | | | |

**Does Applicant have a Living Will? ☐ Yes ☐ No**

**SECTION TWO – Health Insurance & Prescription Drug Coverage**

**11. Complete all that apply:**

| Coverage | Name | Policy Number |
|---|---|---|
| Medicare | | |
| HMO/PPO/POS (Managed Care Plan) or Medicare Supplement | | |
| Long-Term Care Insurance | | |
| Prescription Drug Plan | | |

****Please submit copies of all insurance cards and long-term care policies as soon as possible****

**SECTION THREE – Financial Information**

**12. Please list monthly income from all sources**

**Social Security $ _____**
**Pension $ _____ Source _____**
**Annuity $ _____ Source _____**
**Interest $ _____**
**Dividends $ _____**
**Veterans Benefit $ _____**
**SSI Benefit $ _____**
**Other $ _____ Source _____**

**13. Please list cash assets from savings accounts, checking accounts, certificates of deposit (CD's), money market funds, etc. Please also indicate single or joint ownership (use additional paper if necessary)**

| Institution | Type of account | Amount | Ownership |
|---|---|---|---|
| | | $ | ☐ Single ☐ Joint |
| | | $ | ☐ Single ☐ Joint |
| | | $ | ☐ Single ☐ Joint |
| | | $ | ☐ Single ☐ Joint |

| Life Insurance Company | Face Value | Cash/Surrender Value |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**14. Please list any Stocks, Bonds, and Mutual Funds held**

| Institution | Type of account | Current Value | Ownership |
|---|---|---|---|
| | | $ | ☐ Single ☐ Joint |
| | | $ | ☐ Single ☐ Joint |
| | | $ | ☐ Single ☐ Joint |
| | | $ | ☐ Single ☐ Joint |

**15. Real Estate Owned**
**Primary Home:**

| Address | Assessed Value | Estimated Value |
|---|---|---|
| | $ | $ |
| | | |
| | Ownership | ☐ Single ☐ Joint |

**Are there any liens against this property?** ☐ **Yes** ☐ **No**

**If yes, is it a:**
☐ **First Mortgage** **Amount $**_____
☐ **Home Equity** **Amount $**_____
☐ **Reverse Mortgage** **Amount $**_____

**Does anyone currently live in your Primary Home?** ☐ **Yes** ☐ **No** **If yes, please list:**

| Name | Relationship to you |
|---|---|
| | |
| | |
| | |
| | |

**Other Real Estate Owned:**

| Address | Assessed Value | Estimated Value |
|---|---|---|
| | $ | $ |
| | Ownership | ☐ Single ☐ Joint |

**Are there any liens against this property?** ☐ **Yes** ☐ **No**

**If yes, please list: Name**_____ **Amount $**_____

**16. Have you given away, or transferred any money, stocks, bonds, personal property, real estate, mortgages or anything else of value during the last five years?** ☐ **Yes** ☐ **No**

**If yes, please specify:**

| Transferred to Whom | Date of Transfer | Amount or Value |
|---|---|---|
| | | $ |
| | | $ |
| | | $ |

**17. Other assets (vehicles, etc.)**

| Asset | Estimated Value |
|---|---|
| | $ |
| | $ |
| | $ |

**I attest that all information is truthful, and understand that any misrepresentation or omission of information on this application will disqualify me from admission to the facility indicated and will be cause for discharge if discovered after my admission.**

_____ _____

**Signature of Applicant** **Date**

_____ _____

**Signature of person completing application if other than applicant** **Date**

NAME:_____

# DAILY PERSONAL HABITS

SIDE ONE

| ACTIVITY | ASSISTANCE REQUIRED | BEHAVIOR ASSOCIATED WITH ACTIVITY | WHAT ACTION HELPS BEHAVIOR IMPROVE? | WHAT ACTION MAKES BEHAVIOR WORSE? |
|---|---|---|---|---|
| **BATHING**<br>**(PREFERS A.M. OR P.M.?)** | | | | |
| **DRESSING** | | | | |
| **TOILETING** | | | | |
| **AMBULATION**<br>**PLEASE NOTE IF HISTORY OF LEAVING HOME AND/OR FACILITY UNATTENDED** | | | | |
| **BEDTIME ROUTINE** | | | | |
| **A.M. ROUTINE** | | | | |

**CONTINUED ON OTHER SIDE**

# DAILY PERSONAL HABITS

**SIDE TWO**

| HOW DOES RESIDENT EXHIBIT: ASSOCIATED BEHAVIOR | WHAT ACTION HELPS IMPROVE BEHAVIOR? | WHAT ACTION MAKES BEHAVIOR WORSE? |
|---|---|---|
| PAIN OR DISCOMFORT | | |
| STRESS | | |
| FRUSTRATION | | |
| ANXIETY | | |
| HUNGER | | |
| FATIGUE | | |

**IS RESIDENT CAPABLE OF FEEDING SELF? _____**

**COMPLETED BY:_____**

**RELATIONSHIP:_____**

# 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**



Clear All Pages | Save | Print