## 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-9-CM 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.		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.

MEDICA	'T EAVI	LUATIO		NEW		UPD	DATED						
1. MA RECIPIEN	IT NUMBER	2. NAM	ME OF APPLICA	NT (Last, firs	t, middle initial)	)	3. SOCIA	AL 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)					Based S medical Welfare	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, State Department of Public Welfare or its agents.    SIGNATURE - APPLICANT OR PERSON ACTING FOR APPLICANT DATE							
11. HEIGHT	WEIGHT		BLOOD PRES	SSURE	TEMPERATI	URE		PULSE RATE	CARDI	IAC RHYTHM			
12. MEDICAL SU	<u>I</u> JMMARY												
13. IN EVENT OF AN EMERGENCY THE PATIENT CAN VACATE THE BUILDING  14. PATIENT IS CAPABLE OF ADMINISTERING HIS/HER OWN MEDICATIONS  15. ICD-9-CM DIAGNOSTIC CODES													
	□. □		PRIMARY (Principa	al)									
	一.	+	SECONDARY										
	$\dashv$ . $\vdash$	+	TERTIARY										
	7.	$\top$											
	┦.[												
16. PROFESSIO	NAL AND TE	ECHNICAL	CARE NEEDE	D - CHECK ▼	EACH CATE	GORY	THAT IS A	APPLICABLE					
Physical The Special Skin	n Care	= '	ech Therapy enteral Fluids	=	cupational Ther	гару	=	Inhalation Therapy Other (Specify)	y [	Special Dressings	i Irri	igations	
17. PHYSICIAN (													
Medications													
Treatment													
	and Restora	ative Servic	ces										
Therapies													
Diet Activities													
Social Service	es												
Special Proce	edures for He	ealth and S	Safety or to Meet	t Objectives_									
18. PROGNOSIS	_	_	_			19			_	CHECK ✓ ONLY ONE	- 5		
1. Stabl	e	2. Impro	oving _	3. Deterio	rating		<u> </u>	. Good	2. Lin	nited	3. Poor		
PHYSICIAN'S RECOMMENDATION  Nursing Facility Clinically Eligible Services to be provided at home or in a nursing facility  Personal Care Home Nursing facility Personal Care Home Services to be provided at home or in an Intermediate care facility for consumers with ORCs  Personal Care Home Personal Care Home Personal Care Home Nursing facility Personal Care Home Personal Care Home Nursing facility Personal Care Home Personal Care Home Nursing facility Nursing Facility Personal Care Home Nursing facility Nursing Facility Clinically Eligible Services to be provided at home or in an Intermediate care facility for consumers with ORCs													
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	1'S SIGNATI	JRE											
	PHYSICIAN (PRI	INTED NAME)		TE	ELEPHONE			PHYSICIAN	N SIGNATUF	RE	DAT	Ē	
FOR DEPARTM	VIENT USE	Medical and		versonnel of the Me	edicaid agency or its	designee	MUST evaluat	te each applicant's or recip	pient's need	for admission by reviewing and	d assessing the evalua	ations required	
21A. MEDICALL	Y ELIGIBLE			No	Medically App for Waiver Ser	oropriat ervices	te	21B. Length of	f Stay	Within 180 days	Over 1	180 days	
22 Comments. Attach a separate sheet if additional comments are necessary.													
	REV	IEWER'S SIGN	NATURE AND TITLE			_		DATE	—				