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.


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.


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:

<table>
<thead>
<tr>
<th>Nursing Facility Clinically Eligible (NFCE)</th>
<th>Personal Care Home</th>
<th>ICF/ID Care</th>
<th>ICF/ORC Care</th>
<th>Inpatient Psychiatric Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>Provides Personal Care services such as meals, housekeeping, &amp; ADL assistance as needed to residents who live on their own in a residential facility.</td>
<td>Provides health-related care to ID individuals. More care than custodial care but less than in a NF.</td>
<td>Provides health-related care to ORC individuals. More care than custodial care but less than in a NF.</td>
<td>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.</td>
</tr>
</tbody>
</table>

20B. Complete only if Consumer is NFCE and will be served in a Nursing Facility. Check whether the patient will be eventually 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 are completed by Aging Well or the appropriate Department of Human Services program office. These questions are used by the Department to certify the Individual’s medical eligibility for services.
**MEDICAL EVALUATION**

<table>
<thead>
<tr>
<th>1. MA RECIPIENT NUMBER</th>
<th>2. NAME OF APPLICANT (Last, first, middle initial)</th>
<th>3. SOCIAL SECURITY NO.</th>
<th>4. BIRTHDATE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>5. AGE</th>
<th>6. SEX</th>
<th>7. ATTENDING PHYSICIAN</th>
<th>8. PHYSICIAN LICENSE NUMBER</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>9. EVALUATION AT (Description and code)</th>
</tr>
</thead>
</table>

- 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**

<table>
<thead>
<tr>
<th>11. HEIGHT</th>
<th>WEIGHT</th>
<th>BLOOD PRESSURE</th>
<th>TEMPERATURE</th>
<th>PULSE RATE</th>
<th>CARDIAC RHYTHM</th>
</tr>
</thead>
</table>

**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**

<table>
<thead>
<tr>
<th>PRIMARY (Principal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SECONDARY</td>
</tr>
<tr>
<td>TERTIARY</td>
</tr>
</tbody>
</table>

**16. PROFESSIONAL AND TECHNICAL CARE NEEDED**

- 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**

<table>
<thead>
<tr>
<th>Nursing Facility Clinically Eligible</th>
</tr>
</thead>
</table>
| Personal Care Home  
| Services to be provided at home or in a nursing facility  
| ICF/ID Care  
| Services to be provided at home or in an Intermediate care facility for the intellectually disabled  
| 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.**

- YES
- NO  

If Yes, Check ✓ Only One

- 1. Within 180 days
- 2. Over 180 days  

**20C. PHYSICIAN’S SIGNATURE**

<table>
<thead>
<tr>
<th>PHYSICIAN (PRINTED NAME)</th>
<th>TELEPHONE</th>
<th>PHYSICIAN SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
</table>

**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.

**21 MEDICALLY ELIGIBLE**

- Yes
- No  

**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**