

NEVADA STATE VETERANS HOME

Attached is a copy of our application for admission as per your request.

In order to process your loved ones admission we will need all pages to be completed by the applicant and or the Guardian/Power of Attorney. Please have the Attending Physician or Primary Physician complete the MD Certification forms (page 6 – 8) and return to us along with the completed application and required documentation requested on the check list provided.

****Please note that we do not** admit residence on a first come first serve basis instead, we admit on bed availability after first completed application with all required documentation is received and approved by our clinical and financial departments. In addition please know that we **do not** hold or reserve beds on any new admissions so completing the application with required documentation in a timely matter would be most beneficial for an expedited admission.

Feel free to contact our admissions office at (702)332-6730 with any questions or concerns regarding the application process. Completed application and documentation can be faxed directly to our admission office at (702)332-6771, emailed to Shelley or Teri (Shelley: barness@veterans.nv.gov / Teri: buenot@veterans.nv.gov), mailed to us at 100 Veterans Memorial Dr.; Boulder City, NV. 89005 with ATT: Admissions Department on the envelope, or brought in directly to us at the same location. Thank you so much for your interest in our facility, we look forward to hearing from you shortly.

Sincerely,

The Admissions Department
Tel: (702)332-6730
Fax: (702)332-6771

NEVADA STATE VETERANS HOME – BOULDER CITY

PRICING LIST FOR RESIDENCY

RESIDENT TYPE:	<u>VETERAN</u>	<u>SPOUSE</u>	<u>GOLD STAR PARENT</u>
PER DAY Semi Private Room:	\$125.00	\$187.00	\$187.00
PER DAY Private Room:	\$150.00	\$212.00	\$212.00
PER MONTH Semi Private Room:	\$3,875.00 First Month's Rent due upon admission	\$5,797.00 First Month's Rent due upon admission	\$5,797.00 First Month's Rent due upon admission
PER MONTH Private Room:	\$4,650.00 First Month's Rent due upon admission	\$6,572.00 First Month's Rent due upon admission	\$6,572.00 First Month's Rent due upon admission

Some residents may be eligible for VA benefits, Medicaid, Medicare, military retirement, and/or Social Security. Veterans with a service connected disability of 70% or higher may qualify for VA assistance with paying for their care. Assistance for low income applicants may be available through Medicaid and or VA. To obtain an application and information regarding Medicaid please call (800) 992-0900 or visit dwss.nv.gov, you may also contact our admissions office at the number listed below. For VA benefits please contact your local Veterans Service Officer at (702) 791-9000.

NSVH Admissions Office:

Tel: (702) 332-6730 Fax: (702) 332-6771

Monthly rate is based on a 31 day calendar month. Pricing does not include cost of medications, physician visits, supplies, and additional ancillary charges. A list of charges will be provided by the admissions office.

ABOVE RATES EFFECTIVE 1/1/2016 AND ARE SUBJECT TO CHANGE

NEVADA STATE VETERANS HOME-BOULDER CITY

CHECKLIST for APPLICANTS

Thank you for your interest in Nevada State Veterans Home (NSVH). Before an applicant can be considered for admission to our Home we must receive the following documentation:

General

- Completed Application for Admission (pages 1-5)
- Provider's Medical Certification for Skilled Nursing Facility Placement & Behavioral & Psychiatric History (pages 6-8) NOTE: **MUST BE COMPLETED BY YOUR MEDICAL PROVIDER**
- Proof of Income: Bank Statements,(for Previous 3 months) Tax Returns, etc. (For the previous three years)
- Guardianship Papers (if applicable)
- Durable Power of Attorney for Health and Finance (if applicable)
- Framed 8" x 10" Picture of Resident (if available)

Military

- Proof of Military Service: Record of Separation, DD-214
- VA Form 10-10EZ
- Service Connected Disability Rating Award Letter (if applicable)
- Aid & Attendance Award Letter (if applicable)

Identification and Insurance Information

- Health Insurance Cards: Medicare, Medicaid, Private Insurance
- Medicare Part D Information
- Identification Cards: Social Security, Driver's License, State ID, etc.

Other: _____

Upon receipt of all items listed above, the applicant's file will be forwarded to the Admissions Review Committee, who will evaluate the application to determine if NSVH is able to provide the care required by the applicant. The Admissions Coordinator will contact the applicant to let them know of the Committee's decision, and, if appropriate, schedule a date and time for admission.

This process can take as little as two, but no more than five business days.

Occasionally, the Admissions Review Committee will require additional information prior to rendering a decision. In these instances, the Admissions Coordinator will contact the applicant to let them know what information is needed.

If you have questions, please call the NSVH Admission Office, at (702) 332-6730, or call the main number, at (702) 332-NSVH (6784)

Department of Veterans Services
5460 Reno Corporate Drive, Ste. 131
Reno, Nevada 89511
(775) 688-1653 • Fax (775) 688-1656

BRIAN SANDOVAL
Governor



Department of Veterans Services
6900 N. Pecos Road, Room 1C237
North Las Vegas, Nevada 89086
(702) 224-6025 • Fax (702) 224-6927

Northern Nevada
Veterans Memorial Cemetery
P.O. Box 1919
Fernley, Nevada 89408
(775) 575-4441 • Fax (775) 575-5713

STATE OF NEVADA
NEVADA STATE VETERANS HOME
100 Veterans Memorial Drive
Boulder City, Nevada 89005
(702) 332-6784 • Fax (702) 332-6762

Southern Nevada
Veterans Memorial Cemetery
1900 Veterans Memorial Drive
Boulder City, Nevada 89005
(702) 486-5920 • Fax (702) 486-5923

Eligibility for Admission

Qualifications for residency at the Nevada State Veterans Home include the following –

- **Veterans having a military discharge other than dishonorable**
- **Spouse of a veteran meeting the above requirement or a Gold Star Parent**
- **Applicants currently requiring the need for 24-hour skilled nursing**
- **Applicants currently requiring the need for inpatient rehabilitation**

We are unable to provide care for the following:

- Intravenous (IV) narcotics
- Renal or other dialysis
- Mechanical ventilation
- Certain behavioral issues
- Having an HMO insurance plan
- Having a Medicare Advantage Plan
- Or any other required care the facility cannot provide

**If you have any questions in regards to any of the criteria listed above,
please call the Admissions Department**

Teri Bueno LPN III – Admissions Coordinator
Tel: (702) 332-6730 Fax: (702) 332-6771

YOUR ASSISTANCE IS NEEDED!

At the Nevada State Veterans Home, we recognize the importance of knowing our residents. We also understand the importance of getting to know the "whole" person - who they were twenty, forty, sixty years ago - and the role they play in our ability to provide the very best care possible.

Consequently, as part of the admissions process, we need a framed 8" X 10" picture of each resident on the day of admission. This picture will be hung outside the resident's room and assist us in our efforts to help them identify their room. A framed picture taken at the time of the resident's military service, if applicable, would be especially appreciated.

These pictures will also assist NSVH Team Members in their efforts to get to know each resident, not only as they are today, but as they were in years past. This project will also enhance our efforts to create a more home-like environment and is one more way the Nevada State Veterans Home can honor America's heroes.

In addition to a framed 8" X 10" picture of each resident we ask that you provide a brief biography about your loved one to help us learn more about them and their life story and accomplishments.

Thank you, in advance, for providing this framed photo. If you have questions or concerns, please contact the Neighborhood Social Worker, at (702) 332-6784.



TOGETHER, WE ARE...

"Caring for America's Heroes"

NEVADA STATE VETERANS HOME-BOULDER CITY

ADMISSION POLICY

All individuals requesting admission to this facility, regardless of pay source, will be prescreened as required by federal law for appropriateness of placement.

Residents are accepted only as permitted by licensure law that applies to this type of facility. All residents are admitted upon the recommendation of a qualified licensed physician without regard to race, color, national origin, sex, religion, political affiliation, sexual orientation, age and/or handicap/disability (including AIDS and AIDS-related conditions.) Residents will not be accepted if, in the judgment, of the Administrator and/or Director of Nursing Services, the facility itself or in co-operation with community resources or contracted providers of service cannot for any reason provide adequate care.

The facility will accept, for care, those residents with a diagnosis of non contagious tuberculosis after acute treatment has been rendered in one of the area general hospitals. All residents will receive two steps Mantoux tuberculosis testing upon admission and every twelve months thereafter unless proof of positive PPD or treatment of TB disease is provided.

All physically disabled persons will be assisted by facility personnel during the admission process and their subsequent stay as the individual disability warrants. Developmentally disabled residents who exhibit moderate to severe behavioral problems should be transferred to appropriate facilities as soon as possible.

The facility will not admit residents requiring a level of treatment that the facility is not licensed to provide.

Each resident must be under the supervision of a physician who has been credentialed as an active member of the NSVH medical staff and who accepts responsibility for the resident's medical care. Each resident may choose his own physician, whose name, address and phone number and that of his alternative physician will be recorded. Similar information will be recorded when applicable for the resident's dentist, pharmacy, optometrist and others as necessary to care for the resident's needs.

Nevada State Veterans Home-Boulder City
100 Veterans Memorial Drive
Boulder City, NV 89005

NEVADA STATE VETERANS HOME APPLICATION FOR ADMISSION

APPLICANT'S INFORMATION

Applicant is a: Veteran Spouse of Veteran Gold Star Parent

Last Name *First Name* *Middle Name* *Alias/Nickname*

Date of Birth *Place of Birth* *Social Security Number* / ____ / ____

Gender: Male Female _____
Religious Preference

Home Address: _____

Phone Numbers: (____) _____ (____) _____ (____) _____
Home *Cell* *Other*

Current Location: Home Assisted Living Nursing Home Hospital Other

Marital Status: Married Widowed Single Divorced Other

Spouse's Last Name *Spouse's First Name*

Spouse's Date of Birth *Spouse's Social Security #* / ____ / ____ *Date of Marriage*

APPLICANT'S OR SPOUSE'S MILITARY SERVICE INFORMATION

Branch of Service: _____ Service Number: _____

Entry Date: _____ Discharge Date: _____ Type of Discharge: _____

Were you a POW? Yes No Retired from Military? Yes No

Do you have a Service-Connected Disability? No Yes

If Yes: _____% and Reason(s) for disability

We must have copies of your rating decision and disability award letters.

Initial **Date**

EMERGENCY CONTACT INFORMATION

Primary Contact:

First & Last Name: _____

Relationship to Applicant: _____

Home Address: _____

Phone Number: (_____) _____ (_____) _____
Home Cell/Other

E-Mail Address: _____

Secondary Contact:

First & Last Name: _____

Relationship to Applicant: _____

Home Address: _____

Phone Number: (_____) _____ (_____) _____
Home Cell/Other

E-Mail Address: _____

ADDITIONAL INFORMATION

Do you/does the applicant have:

Medicare: [] No [] Yes, Medicare #: _____

Medicare Part D or Other Drug Plan [] No [] Yes, Provider & #: _____

Other Insurance: [] No [] Yes, Provider & #: _____

Prepaid Burial Plan: [] No [] Yes, Name: _____

Financial Power of Attorney: [] No [] Yes, Name: _____

Health Power of Attorney: [] No [] Yes, Name: _____

Advanced Directive/Living Will: [] No [] Yes

Court Ordered Guardian: [] No [] Yes, Name: _____

Revocable/Irrevocable Trust: [] No [] Yes

FINANCIAL INFORMATION

PLEASE PROVIDE SUPPORTING DOCUMENTATION FOR ALL INCOME AND ASSETS

MONTHLY INCOME:	APPLICANT	SPOUSE
Income from Farm/Ranch/Business:	\$	\$
Social Security Retirement/Disability:	\$	\$
Non Service-Connected VA Pension/A&A:	\$	\$
Service-Connected Disability Compensation:	\$	\$
Military Retirement Pay:	\$	\$
Retirement Income from Employer:	\$	\$
Civil Service Retirement Income:	\$	\$
U.S. Railroad Retirement Income:	\$	\$
Interest/Dividend (i.e. interest or standard dividend income from non tax deferred annuities):	\$	\$
Rental Income from Rental Property:	\$	\$
Real Estate Contract Held for Property Sold:	\$	\$
Other Income:	\$	\$
TOTAL MONTHLY INCOME:	\$	\$

TYPE OF ASSET:	APPLICANT	SPOUSE
Interest Bearing Checking/Savings Accounts:	\$	\$
Non-Interest Bearing Savings Account:	\$	\$
Life Insurance:	\$	\$
Interest in a Trust Fund:	\$	\$
Mutual Funds:	\$	\$
Stocks and Bonds:	\$	\$
Certificates of Deposits (CDs):	\$	\$
IRAs/Keoghs/401Ks:	\$	\$
Real Estate/Real Estate Contracts:	\$	\$
Other Assets:	\$	\$
TOTAL ASSETS:	\$	\$

Initial Date

Has the applicant sold, transferred ownership, or gifted any property or financial assets in the last five (5) years? No Yes

Are you/is the applicant:

Capable of making informed decisions relative to their healthcare? No Yes

Capable of making informed decisions relative to their finances? No Yes

COMMENTS

WITH MY SIGNATURE BELOW, I CERTIFY THE INFORMATION PROVIDED HEREIN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF:

Signature

Printed Name

Date

Relationship to Applicant

THANK YOU FOR YOUR INTEREST IN THE NEVADA STATE VETERANS HOME!
We are "Caring for America's Heroes"



Initial

Date

NEVADA STATE VETERANS HOME
AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

I authorize _____ to release the protected health information of:

Name: _____ Date of Birth: _____

Social Security No: _____

<p>Information to be disclosed:</p> <p><input type="checkbox"/> Last 2 years- Medical Records. (Please include Immunization history)</p> <p><input type="checkbox"/> Restrict to the following dates/conditions: _____</p>	<p>Purpose for Use and/or Disclosure: (check all that may apply)</p> <p><input type="checkbox"/> At the request of the individual</p> <p><input type="checkbox"/> Physician Follow Up</p> <p><input type="checkbox"/> Application for Admission to Nevada State Veterans Home</p>
---	---

_____ (initial) I agree to the release of the following information should it be contained in my medical record: behavioral or mental health services. If I do not specifically agree, this information will not be disclosed.

Unless otherwise revoked, this authorization will expire on the following date or event: _____. If a date or event is not specified, this authorization will expire one year from the date of my signature below.

I understand I have the right to revoke this authorization at any time. My revocation must be in writing, addressed to HIPAA Privacy Officer, Nevada State Veterans Home. I am aware that my revocation is not effective to the extent that the persons I have authorized to use/disclose my protected health information have acted in reliance upon this authorization.

I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy regulations.

I understand I have the right to inspect and copy my own protected health information to be used or disclosed in accordance with the requirements of federal privacy regulations.

I understand that I have a right to receive a copy of this authorization upon my request.

Signature of Resident or Personal Representative

Date

Relationship to Resident

NEVADA STATE VETERANS HOME-BOULDER CITY
PROVIDER'S MEDICAL CERTIFICATION FOR SKILLED NURSING FACILITY PLACEMENT

THIS CERTIFICATION SHALL REMAIN VALID FOR THREE MONTHS.

APPLICANT NAME: _____

WHAT IS THE REASON THE APPLICANT REQUIRES 24-HOUR NURSING HOME CARE: _____

DATE OF BIRTH: ____/____/____ AGE: _____ MALE FEMALE

ALLERGIES: _____ HEIGHT: _____ WEIGHT: _____

DIET: REGULAR NO ADDED SALT CONSISTENT CARBOHYDRATES

LOW FAT/LOW CHOLESTEROL LOW POTASSIUM

TEXTURE: REGULAR MECHANICAL SOFT PUREE

THICKENED LIQUIDS TUBE FEEDING – TYPE _____

OXYGEN: NO YES – LITERS PER MINUTE: _____ FREQUENCY: _____

TREATMENTS: PT OT ST WOUND CARE/DECUBS: _____

FOLSTEIN MINI MENTAL STATE EXAMINATION SCORE: _____ DATE: ____/____/____

MEMORY IMPAIRMENT: NONE MILD MODERATE SEVERE

COMMUNICATION ABILITY:

CAN SPEAK: NO YES UNDERSTAND SPEECH: NO YES

CAN HEAR: NO YES USES HEARING AIDE: NO YES

VISION: ADEQUATE MODERATELY IMPAIRED GLASSES SEVERELY IMPAIRED

HISTORY OF ALCOHOL USE: NO YES HISTORY OF DRUG USE: NO YES

HISTORY OF PSYCHIATRIC ILLNESS: NO YES, DIAGNOSIS: _____

CURRENT SMOKER: YES NO HISTORY OF SMOKING: YES NO

Initial Date

NEVADA STATE VETERANS HOME-BOULDER CITY
PROVIDER'S MEDICAL CERTIFICATION FOR SKILLED NURSING FACILITY PLACEMENT

HISTORY OF FALLS: NO YES, DATE OF LAST FALL: ____/____/____

IS APPLICANT AWARE OF HIS/HER MEDICAL CONDITION? NO YES

DOES APPLICANT REQUIRE A SECURED CARE AREA DUE TO WANDERING? NO YES

IS APPLICANT ABLE TO HANDLE HIS/HER OWN FINANCIAL/MEDICAL AFFAIRS? NO YES

LAST 2-STEP PPD/TB SKIN TEST DATE: ____/____/____ RESULTS: _____

LAST FLU VACCINE DATE: ____/____/____ LAST PNEUMOVAX DATE: ____/____/____

CAN APPLICANT PARTICIPATE IN SUPERVISED OUTINGS? NO YES

EVALUATION OF CARE NEEDS:

BATHING:

- INDEPENDENT
- LIMITED ASSIST/CUEING
- TOTAL ASSIST

- DRESSING:
- INDEPENDENT
 - LIMITED ASSIST/CUEING
 - TOTAL ASSIST

GROOMING:

- INDEPENDENT
- LIMITED ASSIST/CUEING
- TOTAL ASSIST

- EATING:
- INDEPENDENT
 - LIMITED ASSIST
 - FULL ASSISTANCE
 - SWALLOWING DISORDER

TRANSFER:

- INDEPENDENT
- DEPENDENT
- #____ PERSON ASSIST

- TOILETING:
- CONTINENT
 - INCONTINENT
 - FOLEY CATHETER

AMBULATION:

- CAN WALK _____ FEET WITHOUT ASSISTANCE
- USES CANE / WALKER / #____ PERSON ASSIST
- USES WHEELCHAIR PROTHESIS

PLEASE ATTACH A LIST OF ALL CURRENT MEDICATIONS

I CERTIFY THIS APPLICANT REQUIRES 24-HOUR NURSING CARE: NO YES

PHYSICIAN'S PRINTED NAME: _____ LICENSE #: _____

PHYSICIAN'S SIGNATURE: _____ DATE: ____/____/____

PHYSICIAN'S PHONE #: (____) _____ FAX #: (____) _____

Initial Date

**NEVADA STATE VETERANS HOME-BOULDER CITY
BEHAVIORAL AND PSYCHIATRIC HISTORY
TO BE COMPLETED BY PROVIDER**

APPLICANT NAME: _____ DATE: ____/____/____

	BEHAVIORS	FREQUENCY					COMMENTS
		NOT IN LAST 6 MONTHS	NOT IN LAST 30 DAYS	UP TO 5 DAYS WEEK	DAILY	NEVER	
1.	Wandering...getting lost						
2.	Hiding things (money, jewelry, keys, etc.)						
3.	Resisting necessary care						
4.	Hoarding things						
5.	Rummaging through others belongings						
6.	Begin suspicious or accusative						
7.	Verbally abusive to others						
8.	Seeing people or things that are not there						
9.	Physically aggressive behavior toward self						
10.	Bangs head on wall, floor, or furniture						
11.	Attempts to bruise or cut self						
12.	Attempt to throw self on floor						
13.	Physically aggressive toward others						
14.	Attempts to hit, punch, kick, or choke others unprovoked						
15.	Attempting to break furniture or glass						
16.	Indiscriminately attempting to touch breast, genitals, undress others						
17.	Attempting to have non-consensual sexual intercourse with others						
18.	Exposing self to others						
19.	Talking about killing self						
20.	Attempting to eat non food items						
21.	Voiding or defecating in inappropriate locations						
22.	Other						

Initial Date



INSTRUCTIONS FOR COMPLETING ENROLLMENT APPLICATION FOR HEALTH BENEFITS

Please Read Before You Start . . . What is VA Form 10-10EZ used for?

For Veterans to apply for enrollment in the VA health care system. The information provided on this form will be used by VA to determine your eligibility for medical benefits and on average will take 30 minutes to complete. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Where can I get help filling out the form and if I have questions?

You may use ANY of the following to request assistance:

- Ask VA to help you fill out the form by calling us at 1-877-222-VETS (8387).
- Access VA's website at <http://www.va.gov> and select "Contact the VA."
- Contact the Enrollment Coordinator at your local VA health care facility.
- Contact a National or State Veterans Service Organization.

Definitions of terms used on this form:

SERVICE-CONNECTED (SC): A VA determination that an illness or injury was incurred or aggravated in the line of duty, in the active military, naval or air service.

COMPENSABLE: A VA determination that a service-connected disability is severe enough to warrant monetary compensation.

NONCOMPENSABLE: A VA determination that a service-connected disability is not severe enough to warrant monetary compensation.

NONSERVICE-CONNECTED (NSC): A Veteran who does not have a VA determined service-related condition.

Getting Started:

ALL VETERANS MUST COMPLETE SECTIONS I - III.

Directions for Sections I - III:

Section I - General Information: Answer all questions.

Section II - Military Service Information: If you are not currently receiving benefits from VA, you may attach a copy of your discharge or separation papers from the military (such as DD-214 or, for WWII Veterans, a "WD" Form), with your signed application to expedite processing of your application. If you are currently receiving benefits from VA, we will cross-reference your information with VA data.

Section III - Insurance Information: Include information for all health insurance companies that cover you, this includes coverage provided through a spouse or significant other. Bring your insurance cards, Medicare and/or Medicaid card with you to each health care appointment.

Directions for Sections IV-VI:

Financial Disclosure: ONLY NSC AND 0% NONCOMPENSABLE SC VETERANS MUST COMPLETE THIS SECTION TO DETERMINE ELIGIBILITY AND COPAY RESPONSIBILITY FOR VA HEALTH CARE ENROLLMENT AND/OR CARE OR SERVICES.

Financial Disclosure Requirements Do Not Apply To:

- a former Prisoner of War; or
- those in receipt of a Purple Heart; or
- a recently discharged Combat Veteran; or
- those discharged for a disability incurred or aggravated in the line of duty; or
- those receiving VA SC disability compensation; or
- those receiving VA pension; or
- those in receipt of Medicaid benefits; or
- those who served in Vietnam between January 9, 1962 and May 7, 1975; or
- those who served in SW Asia during the Gulf War between August 2, 1990 and November 11, 1998; or
- those who served at least 30 days at Camp Lejeune between August 1, 1953 and December 31, 1987.

You are not required to disclose your financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have other qualifying eligibility factors. If a financial assessment is not used to determine your priority for enrollment you may choose not to disclose your information. However, if a financial assessment is used to determine your eligibility for cost-free medication, travel assistance or waiver of the travel deductible, and you do not disclose your financial information, you will not be eligible for these benefits.

Continued ...

Section IV - Dependent Information: Include the following:

- Your spouse even if you did not live together, as long as you contributed support last calendar year.
- Your biological children, adopted children, and stepchildren who are unmarried and under the age of 18, or at least 18 but under 23 and attending high school, college or vocational school (full or part-time), or became permanently unable to support themselves before age 18.
- Child support contributions. Contributions can include tuition or clothing payments or payments of medical bills.

Section V - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children. Report:

- Gross annual income from employment, except for income from your farm, ranch, property or business. Include your wages, bonuses, tips, severance pay and other accrued benefits and your child's income information if it could have been used to pay your household expenses.
- Net income from your farm, ranch, property, or business.
- Other income amounts, including retirement and pension income, Social Security Retirement and Social Security Disability income, compensation benefits such as VA disability, unemployment, Workers and black lung, cash gifts, interest and dividends, including tax exempt earnings and distributions from Individual Retirement Accounts (IRAs) or annuities.

Do Not Report:

Donations from public or private relief, welfare or charitable organizations; Supplemental Security Income (SSI) and need-based payments from a government agency; profit from the occasional sale of property; income tax refunds, reinvested interest on Individual Retirement Accounts (IRAs); scholarships and grants for school attendance; disaster relief payments; reimbursement for casualty loss; loans; Radiation Compensation Exposure Act payments; Agent Orange settlement payments; Alaska Native Claims Settlement Acts Income, payments to foster parent; amounts in joint accounts in banks and similar institutions acquired by reason of death of the other joint owner; Japanese ancestry restitution under Public Law 100-383; cash surrender value of life insurance; lump-sum proceeds of life insurance policy on a Veteran; and payments received under the Medicare transitional assistance program.

Section VI - Previous Calendar Year Deductible Expenses.

Report non-reimbursed medical expenses paid by you or your spouse. Include expenses for medical and dental care, drugs, eyeglasses, Medicare, medical insurance premiums and other health care expenses paid by you for dependents and persons for whom you have a legal or moral obligation to support. Do not list expenses if you expect to receive reimbursement from insurance or other sources. Report last illness and burial expenses, e.g., prepaid burial, paid by the Veteran for spouse or dependent(s).

Section VII - Submitting your application.

1. Read Paperwork Reduction and Privacy Act Information, Section VIII Consent to Copays and Assignment of Benefits.
2. In Section VIII, you or an individual to whom you have delegated your Power of Attorney must sign and date the form. If you sign with an "X", 2 people you know must witness you as you sign. They must sign the form and print their names. If the form is not signed and dated appropriately, VA will return it for you to complete.
3. Attach any continuation sheets, a copy of supporting materials and your Power of Attorney documents to your application.

Where do I send my application?

Mail the original application and supporting materials to the Health Eligibility Center, 2957 Clairmont Road, Suite 200
Atlanta, GA 30329.

PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705, 1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified from initial submission forward through a computer-matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.



APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

1. VETERAN'S NAME (Last, First, Middle Name)		2. MOTHER'S MAIDEN NAME	3. GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
4. ARE YOU SPANISH, HISPANIC, OR LATINO? <input type="checkbox"/> YES <input type="checkbox"/> NO		5. WHAT IS YOUR RACE? (You may check more than one. Information is required for statistical purposes only.) <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE AMERICAN OR OTHER PACIFIC ISLANDER		
6. SOCIAL SECURITY NUMBER	7. DATE OF BIRTH (mm/dd/yyyy)	7A. PLACE OF BIRTH (City and State)		
8. PERMANENT ADDRESS (Street)		8A. CITY	8B. STATE	8C. ZIP CODE
8D. COUNTY	8E. HOME TELEPHONE NUMBER (include area code)		8F. MOBILE TELEPHONE NUMBER (include area code)	
8G. E-MAIL ADDRESS		9. CURRENT MARTIAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		
10. I AM ENROLLING TO OBTAIN MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT <input type="checkbox"/> YES <input type="checkbox"/> NO		11. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? (for listing of facilities visit www.va.gov/directory)		12. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO

SECTION II - MILITARY SERVICE INFORMATION

1. LAST BRANCH OF SERVICE	1A. LAST ENTRY DATE	1B. LAST DISCHARGE DATE	1C. DISCHARGE TYPE		
2. MILITARY HISTORY (Check yes or no)		YES	NO	YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. ARE YOU A FORMER PRISONER OF WAR?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1987?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION III - INSURANCE INFORMATION (Use a separate sheet for additional information)

1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER (include coverage through spouse or other person)					
2. NAME OF POLICY HOLDER	3. POLICY NUMBER	4. GROUP CODE	5. ARE YOU ELIGIBLE FOR MEDICAID? <input type="checkbox"/> YES <input type="checkbox"/> NO	6. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? <input type="checkbox"/> YES <input type="checkbox"/> NO	
				6A. EFFECTIVE DATE (mm/dd/yyyy)	

APPLICATION FOR HEALTH BENEFITS, Continued	VETERAN'S NAME <i>(Last, First, Middle)</i>	SOCIAL SECURITY NUMBER
---	---	------------------------

SECTION IV - DEPENDENT INFORMATION (Use a separate sheet for additional dependents)

1. SPOUSE'S NAME <i>(Last, First, Middle Name)</i>	2. CHILD'S NAME <i>(Last, First, Middle Name)</i>	
1A. SPOUSE'S SOCIAL SECURITY NUMBER	2A. CHILD'S DATE OF BIRTH <i>(mm/dd/yyyy)</i>	2B. CHILD'S SOCIAL SECURITY NUMBER
1B. SPOUSE'S DATE OF BIRTH <i>(mm/dd/yyyy)</i>	2C. DATE CHILD BECAME YOUR DEPENDENT <i>(mm/dd/yyyy)</i>	
1C. DATE OF MARRIAGE <i>(mm/dd/yyyy)</i>	2D. CHILD'S RELATIONSHIP TO YOU <i>(Check one)</i> <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEPSON <input type="checkbox"/> STEPDAUGHTER	
1D. SPOUSE'S ADDRESS AND TELEPHONE NUMBER <i>(Street, City, State, ZIP - if different from Veteran's)</i>	2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? <input type="checkbox"/> YES <input type="checkbox"/> NO	
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO	2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO	
2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING <i>(e.g., tuition, books, materials)</i>		

SECTION V - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN (Use a separate sheet for additional dependents)

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT <i>(wages, bonuses, tips, etc.)</i> EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	\$ _____	\$ _____	\$ _____
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	\$ _____	\$ _____	\$ _____
3. LIST OTHER INCOME AMOUNTS <i>(e.g., Social Security, compensation, pension interest, dividends)</i> EXCLUDING WELFARE	\$ _____	\$ _____	\$ _____

SECTION VI - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE <i>(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home)</i> VA will calculate a deductible and the net medical expenses you may claim.	\$ _____
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD <i>(Also enter spouse or child's information in Section VI.)</i>	\$ _____
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES <i>(e.g., tuition, books, fees, materials)</i> DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.	\$ _____

SECTION VII - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS

By submitting this application you are agreeing to pay the applicable VA copays and to receive communications from VA to your supplied email or mobile number.

ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT _____ DATE _____