



LOUISIANA DEPARTMENT OF VETERANS AFFAIRS VETERANS HOME APPLICATION FOR ADMISSION

TO BE COMPLETED BY APPLICANT OR AUTHORIZED REPRESENTATIVE

APPLICANT INFORMATION:

Please select appropriate choice below:

VETERAN

SPOUSE OF VETERAN

GOLD STAR PARENT

PREFERRED FACILITY		APPLICATION DATE
FULL NAME OF APPLICANT		DATES OF MILITARY SERVICE (Attach Copy of DD-214)
PERMANENT STREET ADDRESS	HOME PHONE NUMBER	CELL PHONE NUMBER
CITY, STATE, ZIP	BRANCH OF SERVICE	SOCIAL SEC. NUMBER
PARISH OF RESIDENCE	SERVICE-CONNECTION PERCENTAGE	VA CLAIM # (If applicable)
DATE OF BIRTH	PLACE OF BIRTH (CITY, STATE)	EMAIL ADDRESS (IF APPLICABLE)

Does the applicant require an authorized representative?

YES

NO

AUTHORIZED REPRESENTATIVE(S) OR EMERGENCY CONTACT INFORMATION:

Please list authorized representative(s) first (if applicable):

FULL NAME	RELATIONSHIP	STREET ADDRESS	CELL PHONE
EMAIL ADDRESS		CITY, STATE, ZIP	HOME PHONE
FULL NAME	RELATIONSHIP	STREET ADDRESS	CELL PHONE
EMAIL ADDRESS		CITY, STATE, ZIP	HOME PHONE

Applicant Name: _____ Date: _____

STATEMENT OF HISTORY

CURRENT LIVING ARRANGEMENTS: (please select the correct box)

- Home Family Hospital Nursing Home
 Other (Please Explain) _____

Marital Status: MARRIED SINGLE DIVORCED WIDOW(ER)

Number Of Children: _____

Religion: (Optional): _____

Highest Education Level: _____

Occupational History: _____

INSURANCE INFORMATION: (PLEASE CHECK ALL THAT APPLY)

- VA Medical Benefits
 Medicare Part A
 Medicare Part B
 Medicare Part D (Pharmaceutical Benefits)
 HMO (Humana, People's Health/Choices 65, WellCare, Coventry, Etc.)
 Commercial Insurance (List information below):

NAME _____ POLICY # _____ GROUP # _____

ADDRESS _____ CITY,STATE,ZIP _____ PHONE _____

ORIGIN OF MEDICATION:

- VA CLINIC VA MAIL PRIVATE INSURANCE OTHER

PLEASE ATTACH A COPY OF ALL INSURANCE CARDS FOR ALL POLICIES (INCLUDING MEDICARE CARDS)

NAME OF HOSPITAL _____ CITY, STATE _____ PHONE _____

NAME OF PHYSICIAN _____ CITY, STATE _____ PHONE _____

FUNERAL HOME PREFERENCE: _____

Please attach a copy of any life insurance or burial policy information

Applicant Name: _____ Date: _____

REQUEST FOR MEDICAL INFORMATION

TO BE COMPLETED BY DOCTOR OR NURSE

APPLICANT'S NAME: _____

SS #: _____ **MEDICARE #:** _____

ALLERGIES _____

PRIMARY DIAGNOSIS: (ICD9 OR ICD10 CODE) _____ **SECONDARY** (ICD9 OR ICD10 CODE) _____

OTHER _____

MEDICATIONS: (Specify diagnosis, dosage, frequency and route. Please attach sheet with additional medications if necessary)

1. _____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

RECENT HOSPITALIZATIONS: (Include psychiatric) _____

PHYSICAL EXAMINATION:

HEIGHT _____ WEIGHT _____ PULSE _____ RESP. _____ TEMPERATURE _____ BLOOD PRESSURE _____

LAB RESULTS: HCT _____ HGB _____ U/A _____ RADIOLOGY _____

GENERAL _____ HEADACHES _____

MOUTH AND EENT _____ CHEST _____

HEART AND CIRCULATION _____ ABDOMEN _____

GENITALIA _____ EXTREMITIES _____

SKIN _____ OTHER _____

MENTAL STATUS/ BEHAVIOR: (Mark correct response)

	NEVER	SELDOM	FREQUENT	ALWAYS		NEVER	SELDOM	FREQUENT	ALWAYS
ORIENTED	_____	_____	_____	_____	CONFUSED	_____	_____	_____	_____
FORGETFUL	_____	_____	_____	_____	HOSTILE	_____	_____	_____	_____
DEPRESSED	_____	_____	_____	_____	WANDER-RISK	_____	_____	_____	_____
COMBATIVE	_____	_____	_____	_____					

PHYSICAL STATUS: (Select appropriate choice) _____ VERBAL _____ NON-VERBAL _____ COMATOSE

	SELF	ASSIST	TOTAL			
EATING	_____	_____	_____	_____	IMPAIRED VISION	_____
BATHING	_____	_____	_____	_____	EYEGGLASSES	_____
PERSONAL	_____	_____	_____	_____	INCONTINENT BOWEL	_____
ORAL CARE	_____	_____	_____	_____	INCONTINENT BLADDER	_____
AMBULATION	_____	_____	_____	_____	URINARY CATHETER	_____
					OSTOMYCARE	_____
						IMPAIRED HEARING
						HEARING AID
						DENTURES:
						UPPER
						LOWER
						PARTIAL

SPECIAL CARE/ PROCEDURES: (Select choice; when appropriate give type, frequency, size, stage and site)

GLUCOSE MONITORING _____ TUBE FEEDING _____

DIET _____ RESTRAINTS _____

MRSA/VRE _____ SEIZURES _____

REHAB _____ SUCTIONING _____

DECUBITUS _____ DIALYSIS _____

OTHER _____

IMMUNIZATIONS: LAST PPD _____ LAST FLU VACCINE _____ LAST PNEUMONIA VACCINE _____

MD/Nurse Printed Name _____ **Phone Number** _____

Address _____ **Date** _____

MD/Nurse Signature _____

Applicant Name: _____ Date: _____

VETERAN BENEFITS DOCUMENTATION

The following documents (if applicable) are required for submission of claims for Veterans Benefits to the U. S. Department of Veterans Affairs

<u>DOCUMENT</u>	<u>Attached</u>	<u>Not Available</u>
Military Discharge (DD-214 Or Discharge Papers)	_____	_____
Monthly Income	_____	_____
Marriage License	_____	_____
Divorce Decree	_____	_____
Birth Certificate (Dependents Age 0 - 17)	_____	_____
Post-High School Enrollment Verification (Dependents Age 18 - 23)	_____	_____
Medical Insurance Verification (Copy Of Insurance Cards)	_____	_____

Is the Veteran enrolled in a VA health care program at any VA medical center?

No _____ Yes _____ If so, which? _____

List the social security numbers for the applicant's spouse (if applicable) and all minor children for whom the applicant is financially responsible:

Full Name Of Spouse _____

Date Of Birth _____ Date Of Death (If Applicable) _____ Social Security # _____

Full Name Of Dependent (Minor Children Only) _____

Date Of Birth _____ Social Security # _____

Full Name Of Dependent (Minor Children Only) _____

Date Of Birth _____ Social Security # _____

Full Name Of Dependent (Minor Children Only) _____

Date Of Birth _____ Social Security # _____

Full Name Of Dependent (Minor Children Only) _____

Date Of Birth _____ Social Security # _____

Full Name Of Dependent (Minor Children Only) _____

Date Of Birth _____ Social Security # _____

Full Name Of Dependent (Minor Children Only) _____

Date Of Birth _____ Social Security # _____

Full Name Of Dependent (Minor Children Only) _____

Date Of Birth _____ Social Security # _____

Applicant Name: _____ Date: _____

LEGAL PROCEDURE DISCLOSURES

A copy of appropriate legal documentation to verify any 'yes' response
MUST BE ATTACHED to this application

1. Has applicant ever been interdicted (declared incompetent by court of law)?

Yes _____ No _____

2. Has applicant authorized anyone to act as his/her agent or attorney (power of attorney)?

Yes _____ No _____

3. Does applicant have a *Do Not Resuscitate* (DNR) request?

Yes _____ No _____

4. Does applicant have a living will?

Yes _____ No _____

5. Does applicant have pending legal charges?

Yes _____ No _____

If yes to any of the above, please give a brief description: _____

I attest that the above information is true and correct to the best of my knowledge.

Signature of Applicant/Authorized Representative

Date

Applicant Name: _____ Date: _____

MONTHLY INCOME VERIFICATION

SOURCE	APPLICANT	SPOUSE	TOTAL
VA Service-Connected Compensation	\$	\$	\$
VA Non-Service Connected Pension	\$	\$	\$
Social Security	\$	\$	\$
Retirement	\$	\$	\$
Dividends And Interest	\$	\$	\$
Real Estate	\$	\$	\$
All Other Assets	\$	\$	\$

PLEASE PROVIDE SUPPORTING DOCUMENTATION TO VERIFY THE INCOME NOTED ABOVE.

Some examples are listed below:

VA Compensation	award letter, copy of most recent check
VA Non-Service Connected Pension	award letter, copy of most recent check
Social Security	copy of most recent check, last statement showing monthly income or bank statement records showing most recent deposit
Retirement	copy of most recent check, last statement showing monthly income or bank statement records showing most recent deposit
Dividends and Interest	copy of most recent check, last statement showing monthly income or bank statement records showing most recent deposit
Real Estate	copy of real estate agreement or copy of most recent canceled rent check
All Other Assets	copy of most recent statement of the income

Every resident of the facility shall be responsible for payment of the full resident care and maintenance fee. The facility's administrator may consider waiver of payment of care and maintenance fees only for the amount of difference of total income of the Veteran and spouse, when applicable, and the total charge for care and maintenance.

The Care and Maintenance (C&M) fee for the Veteran is currently **\$1,788.00** per month. The C&M fee for the spouse of a Veteran or a "Gold Star Parent" is **\$4,500.00** per month. Please note that the C&M rate is not guaranteed and is based on total combined household financial resources. The rate is reviewed annually by Federal VA and tends to fluctuate. Every effort will be made by the facility to communicate any changes to the care and maintenance fee at least 30 days in advance of any change. At the time of admission, per Federal VA guidelines, C&M fees will be assessed based on all family income sources. Fees are subject to change when there is a change in family income, retroactive to the change. Our facility Veteran Assistance Counselor will assist you in applying for a Federal VA pension and "Aid and Attendance" (A&A), which is a Federal VA program designed to help reduce any financial burden related to the cost of admission to our facility.

Signature of Applicant/Authorized Representative

Date

Witness

Date

Applicant Name: _____ Date: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Name of applicant	DOB
Address	SSN
City	State Zip

PROVIDER AUTHORIZED TO RELEASE THE PHI	ENTITY RECEIVING THE PHI
	Name
	Address
	City LA Zip
	ATTN:

Purpose of this Disclosure: ADMISSION TO VETERANS HOME

PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE		
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Description	Start Date	End Date
<input type="checkbox"/> Complete Health Record		
<input type="checkbox"/> Progress Notes		
<input type="checkbox"/> Laboratory Tests		
<input type="checkbox"/> X-Ray Tests / Reports/ Images		
<input type="checkbox"/> History and Physical Examination		
<input type="checkbox"/> Discharge Summary		
<input type="checkbox"/> Consultation Reports		
<input type="checkbox"/> Itemized Billing Statement		
<input type="checkbox"/> Diagnosis and Treatment Codes		
<input type="checkbox"/> Immunization Records		
<input type="checkbox"/> Other:		

The following information will be released:

- | | |
|---|---|
| <input type="checkbox"/> AIDS or HIV test results | <input type="checkbox"/> Psychiatric or mental care / treatment |
| <input type="checkbox"/> Alcohol, drug or substance abuse treatment | <input type="checkbox"/> Other (specify) |

I UNDERSTAND THAT:

1. I may refuse to sign this authorization, and it is strictly voluntary.
2. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on my signing this authorization.
3. I may revoke the authorization at any time, in writing, to the provider authorized to release the protected health information, but, if I do, it will not have any affect on any actions taken prior to receiving the revocation.
4. I have the right to receive a copy of this form after I sign it.
5. A photocopy of this authorization will have the same effect as an original.
6. This authorization will automatically expire and be ineffective twelve months after date signed.

Signature of Patient	Date
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Signature of Representative (if necessary)	Date
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Personal Representative's Relationship to Patient _____

Applicant Name: _____ Date: _____