LOUISIANA DEPARTMENT OF VETERANS AFFAIRS

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 SECURITY NUMBER**
PARISH OF RESIDENCE	**SERVICE-CONNECTION PERCENTAGE** (Please provide service-connected Award Letter)	**VA CLAIM # (If Applicable)**
DATE OF BIRTH	**PLACE OF BIRTH (CITY, STATE)**	**EMAIL ADDRESS (If Applicable)**

Does the applicant require an authorized representative?

☐ **Power of Attorney** ☐ **Interdicted** ☐ **Veteran Can Answer for Self**

AUTHORIZED REPRESENTATIVE(S) OR EMERGENCY CONTACT INFORMATION:

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

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

Applicant Name_____ Date _____

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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 _____

Applicant Name_____ Date _____

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/ZIP_____PHONE _____

NAME OF PHYSICIAN _____

CITY/STATE/ZIP_____PHONE _____

FUNERAL HOME PREFERENCE: _____

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

Applicant Name_____ Date _____

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REQUEST FOR MEDICAL INFORMATION (TO BE COMPLETED BY DOCTOR OR NURSE)

APPLICANT'S NAME: _____

SS#_____**MEDICARE #**_____

ALLERGIES:_____

PRIMARY DIAGNOSIS:_____(ICD10 CODE) SECONDARY (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					ELOPMENT RISK				
COMBATIVE									

Applicant Name_____ Date _____

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

	SELF	ASSIST	TOTAL		
				_____IMPAIRED VISION	____IMPAIRED HEARING
EATING	____	____	_____	_____EYEGLASSES	_____HEARING AID
BATHING	____	____	_____	_____INCONTINENT BOWEL	_____DENTURES:
PERSONAL	____	____	_____	_____INCONTINENT BLADDEER	_____UPPER
ORAL CARE	____	____	_____	_____URINARY CATHETER	_____LOWER
AMBULATION	____	____	_____	_____OSTOMYCARE	_____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 _____

OTHER _____

IMMUNIZATIONS: LAST PPD_____LAST FLU VACCINE_____LAST PNEUMONIA VACCINE_____

COVID-19 VACCINE: PFIZER OR MODERNA_____

FIRST DOSE_____SECOND DOSE_____

JOHNSON & JOHNSON DOSE_____

OTHER_____FIRST DOSE_____SECOND DOSE_____

BOOSTER_____DOSE_____

MD/NURSE PRINTED NAME:_____**PHONE NUMBER** _____

MD/NURSE SIGNNATURE: _____

Applicant Name_____ Date _____

Important Note About the 10-10EZ

Please note that the 10-10EZ form is required by the U.S. Department of Veterans Affairs to be completed in order for the veteran's health care benefits to cover care received at any Louisiana veterans long-term care facility. Although the veteran may be presently enrolled in the VA health system, the 10-10EZ is required for long-term care placement in the facility and must be completed prior to admission.

Department of Veterans Affairs

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 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.

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.

Continued ...

Section V - Employment Information:

- Veterans Employment Status
- Date of Retirement
- Company Name
- Company Address
- Company Phone Number

Section VI - 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 VII - 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 VIII - Consent to Copays and to Receive Communications

By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.

Submitting Your Application

1. 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.
2. 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.

OMB Control No. 2900-0091
Estimated Burden Avg. 30 min.
Expiration Date 12/31/2020

Department of Veterans Affairs

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)

1A. VETERAN'S NAME *(Last, First, Middle Name)*	1B. PREFERRED NAME	2. MOTHER'S MAIDEN NAME

3A. BIRTH SEX	3B. SELF-IDENTIFIED GENDER IDENTITY	4. ARE YOU SPANISH, HISPANIC,OR LATINO?	5. WHAT IS YOUR RACE? *(You may check more than one. Information is required for statistical purposes only.)*	6. SOCIAL SECURITY NO.
☐ MALE ☐ FEMALE	☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFICISLANDER	

7. VA CLAIM NUMBER	8A. DATE OF BIRTH *(mm/dd/yyyy)*	8B. PLACE OF BIRTH *(City and State)*	9. RELIGION

10A. PERMANENT ADDRESS *(Street)*	10B. CITY	10C. STATE	10D. ZIP CODE	10E.COUNTY

10F. HOME TELEPHONE NO. *(optional)* *(Include Area Code)*	10G. MOBILE TELEPHONE NO. *(optional)* *(Include Area Code)*	10H. E-MAIL ADDRESS *(optional)*

11A. RESIDENTIAL ADDRESS *(Street)*	11B. CITY	11C. STATE	11D. ZIP CODE	11E.COUNTY

12. TYPE OF BENEFIT(S) APPLYING FOR *(You may check more than one)*	13. CURRENT MARTIAL STATUS
☐ ENROLLMENT/HEALTH SERVICES ☐ DENTAL	☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

14A. NEXT OF KIN NAME	14B. NEXT OF KIN ADDRESS	14C. NEXT OF KIN RELATIONSHIP

14D. NEXT OF KIN TELEPHONE NO. *(Include Area Code)*	14E. NEXT OF KIN WORK TELEPHONE NO. *(Include Area Code)*	15. DESIGNEE - INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH (*Note: This does not constitute a will or transfer of title*)

16. I AM ENROLLING TO OBTAIN MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT	17. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/directory)*	18. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT?
☐ YES ☐ NO		☐ YES ☐ NO

SECTION II - MILITARY SERVICE INFORMATION

1A. LAST BRANCH OF SERVICE	1B. LAST ENTRY DATE	1C. FUTURE DISCHARGE DATE	1D. LAST DISCHARGE DATE

1E. DISCHARGE TYPE	1F. MILITARY SERVICE NUMBER

2. MILITARY HISTORY *(Check yes or no)*	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	G. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	IF "YES", WHAT IS YOUR RATED PERCENTAGE_____%		
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	☐	☐	H. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975?	☐	☐
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	☐	☐	I. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	☐	☐
E. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	☐	☐	J. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
F. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐	K. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1987?	☐	☐

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

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? ☐ YES ☐ NO	6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? ☐ YES ☐ NO 6B. EFFECTIVE DATE *(mm/dd/yyyy)*

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

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

SECTION V - EMPLOYMENT INFORMATION

1A. VETERAN'S EMPLOYMENT STATUS *(Check one)*. ☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ RETIRED	1B. DATE OF RETIREMENT	
1C. COMPANY NAME. *(Complete if employed or retired)*	1D. COMPANY ADDRESS *(Complete if employed or retired - Street, City, State, ZIP)*	1E. COMPANY PHONE NUMBER *(Complete if employed or retired) (Include area code)*

SECTION VI - 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 *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
3. LIST OTHER INCOME AMOUNTS *(e.g., Social Security, compensation, pension interest, dividends)* EXCLUDING WELFARE.	$	$	$

SECTION VII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) 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 *(Also enter spouse or child's information in Section VI.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION VIII - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS

By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.

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
(Sign in ink) _____

DATE _____

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LOUISIANA DEPARTMENT OF VETERANS AFFAIRS

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

DOCUMENT	**Attached**	**Not Available**
Military Discharge (DD-214 or Discharge Papers)		
Monthly Income		
Marriage License		
Spouse Death Certificate		
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? Yes_____No _____

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_____SS# _____

Full Name of Dependent (Minor Children Only) _____

Date of Birth_____SS#_____

Full Name of Dependent (Minor Children Only) _____

Date of Birth_____SS#_____

Full Name of Dependent (Minor Children Only) _____

Date of Birth_____SS#_____

Full Name of Dependent (Minor Children Only) _____

Date of Birth_____SS#_____

Full Name of Dependent (Minor Children Only) _____

Date of Birth_____SS#_____

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LOUISIANA DEPARTMENT OF VETERANS AFFAIRS

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 a 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.

_____ Date _____
Signature of Applicant/Authorized Representative

Applicant Name_____ Date _____

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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 Compensation	Award letter, copy of most recent check
Social Security	Copy of most recent check, last statement showing monthly oncome 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 **$1,936.00** 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 C&M 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.

_____ Date _____

Signature of Applicant/Authorized Representative

_____ Date _____

Witness

Applicant Name_____ Date _____

LDVA
LOUISIANA DEPARTMENT OF VETERANS AFFAIRS

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
	Attention:

Purpose of this Disclosure: ADMISSION TO VETERANS HOME

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

The following information will be released:

☑	Description
	AIDS or HIV test results
	Alcohol, drug or substance abuse treatment
	Psychiatric or mental care/treatment
	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 effect 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.

_____ Date_____
Signature of Patient

_____ Date_____
Signature of Representative (if necessary)

_____ Date _____
Personal Representative's Relationship to Patient

Applicant Name_____ Date _____

PRIVACY ACT STATEMENT – HEALTH CARE RECORDS

THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974 (5USC 552a).
THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. **AUTHORITY FOR COLLECTION OF INFORMATION, INCLUDING SOCIAL SECURITY NUMBER AND WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY.** Authority for maintenance of the system is given under Sections 1102(a), 1819(b)(3)(A), 1819(f), 1919(b)(3)(A) and 1864 of the Social Security Act.

   The system contains information on all residents of long-term care (LTC) facilities that are Medicare certified or VA beds, including private pay individuals and not limited to Medicare enrollment and entitlement, and Medicare Secondary Payer data containing other party liability insurance information necessary for appropriate Medicare claim payment.

   Medicare and VA participating LTC facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information is also used by the Centers for Medicare & Medicaid Services, Federal VA to ensure that the facility meets quality standards and provides appropriate care to all residents. 42 CFR §483.20, requires LTC facilities to establish a database, the Minimum Data Set (MDS), of resident assessment information. The MDS data are required to be electronically transmitted to the CMS National Repository and Federal VA.

   Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have a right to refuse consent to these disclosures. These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS LTC System of Records.

2. **PRINCIPAL PURPOSES OF THE SYSTEM FOR WHICH INFORMATION IS INTENDED TO BE USED.** The primary purpose of the system is to aid in the administration of the survey and certification, and payment to Medicare LTC services which include skilled nursing facilities (SNFs), nursing facilities (NFs) and non-critical access hospitals with a swing bed agreement.

   Information in this system is also used to study and improve the effectiveness and quality of care given in these facilities. This system will only collect the minimum amount of personal data necessary to achieve the purposes of the MDS, reimbursement, policy and research functions.

3. **ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM.** The information collected will be entered into the LTC MDS System of Records, System No. 09-07-0528.

Applicant Name_____ Date _____

This system will only disclose the minimum amount of personal data necessary to accomplish the purposes of disclosure. Information from this system may be disclosed to the following entities under specific circumstances (routine uses), which include:

1) To support Agency contractors, consultants, or grantees who have been contracted by the Agency to assist in accomplishment of a CMS function relating to the purposes for this system and who need to have access to the records in order to assist CMS and Federal VA;
2) To assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent for purposes of contributing to the accuracy requirement of a Federal statute or regulation that implements a health benefits program funded in whole or part with Federal funds for the purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State, and determine Medicare eligibility;
3) To assist Quality Improvement Organizations (QIOs) in connection with review of claims, or in connection with studies or other review activities, conducted pursuant to Title XI or Title XVIII of the Social Security Act in performing affirmative outreach activities to individuals for the purpose of establishing and maintaining their entitlement to Medicare benefits or health insurance plans;
4) To assist insurers and other entities or organizations that process individual insurance claims or oversees administration of health care services for coordination of benefits with the Medicare program and for evaluating and monitoring Medicare claims information of beneficiaries including proper reimbursement for services provided;
5) To support an individual or organization to facilitate research, evaluation, or epidemiological projects related to effectiveness, quality of care, prevention of disease or disability, the restoration or maintenance of health, or payment related projects;
6) To support litigation involving the agency, this information may be disclosed to the Department of Justice, courts of adjudicatory bodies;
7) To support a national accrediting organization whose accredited facilities, meet certain Medicare requirements for inpatient hospital (including swing beds) services;
8) To assist a CMS contractor (including but not limited to fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program to combat fraud, waste and abuse in certain health benefit programs; and
9) To assist another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any state or local governmental agency), that administers, or that has the authority to investigate potential fraud, waste and abuse in a health benefits program funded in whole or in part by Federal funds.

4. **EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION.** The information contained in the LTC MDS System of Records is generally necessary for the facility to provide appropriate and effective care to each resident.

Applicant Name_____ Date _____

If a resident fails to provide such information, e.g. thorough medical history, inappropriate and potentially harmful care may result. Moreover, payment for services by Medicare, and third parties, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

NOTE: This notice will be included in the admission packet for all new nursing home admissions. Although signature of receipt is NOT required, providers may request to have the Resident or his or her Representative sign a copy of this notice as a means to document that notice was provided and merely acknowledges that they have been provided with this information.

Your signature is merely acknowledging that you have been advised of the foregoing. Residents or their Representative must be supplied with a copy of this notice.

Applicant Name_____ Date _____

LDVA VETERANS HOME VISITATION POLICY

The *Louisiana Veterans Homes* recognizes the right of the individual resident to live the lifestyle of his or her choosing. Families and friends are encouraged to visit regularly and maintain contact by letters, social media or telephone with the residents.

- Visitors will be welcomed at all reasonable times and may need to take into consideration when times are most suitable for the resident. This will ensure all visitors enjoy full and equal visitation privileges consistent with resident preferences.

- The facility requires that all visitors sign in the visitor's book in order to comply with fire safety regulations.

- There is no age limit for our visitors, although it is advisable to check with senior staff before bringing very young children into the home in case of infection. (During influenza season visitation may be limited due to confining the spread of the virus. Visitors who are symptomatic are encouraged to not visit the facility).

- When visiting late in the evening hours, we do ask that visitors telephone the facility ahead of the visit for reasons of security. Doors are securely locked by 8 p.m. evenings.

- During evening hours, visitors are asked to use the main gathering areas for visiting purposes; this allows the facility staff free access to rooms when preparing residents for the night. We also ask that visitors do not walk resident room corridors after 8 p.m. to ensure that those residents that want to keep their doors open can do so with privacy.

- Visitors are encouraged to use facility grounds and if arranged with facility staff, to accompany the resident on walks or shopping trips. Facility staff will ensure the resident is signed out on pass, is safe for the resident to leave the facility and agree to any special arrangements with the visitor including overnight stays providing any care related instructions and medications for the resident.

- During times of illness and end of life, when families and residents may wish to be together, the facility will do the utmost to accommodate a family member within the home.

- Unwanted Visitors- The residents of the Louisiana Veterans Homes have the right to refuse visitors, with or without explanation. The facility is their home and it is their right to see in their home whom they wish. Staff is to act according to the wishes of the residents and only admit to the home welcomed visitors.

Applicant Name_____ Date _____

- The Louisiana Veterans Homes will not tolerate any form of aggression, violence, harassment or discrimination from any visitor toward residents.

- Visitors are encouraged to direct any concerns, complaints, or suggestions to facility staff in order to safeguard and protect any residents from vulnerability.

- The Louisiana Veterans Homes do not restrict, limit, or otherwise deny visitation privileges onthe basis of race, color, national origin, religion, sex, gender identity, sexual orientation, ordisability.

Applicant Name_____ Date _____