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**

PREFFERED FACILITY	APPLICATION DATE

FULL NAME OF APPLICANT	DATES OF MILITARY SERVICE (Attach Copy of DD-214)

PERMANENT STREET ADDRESS	HOME PHONE NUMBER	MOBILE 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	MOBILE PHONE

EMAIL ADDRESS	CITY, STATE, ZIP	HOME PHONE

FULL NAME	RELATIONSHIP	STREET ADDRESS	MOBILE PHONE

EMAIL ADDRESS	CITY, STATE, ZIP	HOME PHONE

STATEMENT OF HISTORY

CURRENT LIVING ARRANGEMENTS: (PLEASE SELECT THE CORRECT BOX)

☐ HOME ☐ FAMILY ☐ HOSPITAL ☐ NURSING HOME

☐ OTHER (PLEASE EXPLAIN IN NEXT BOX)

MARITAL STATUS:

☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOW(ER)

RELIGION: (OPTIONAL)

NUMBER OF CHILDREN:

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, ETC.)

☐ COMMERCIAL INSURANCE (LIST INFORMATION IN NEXT BOX)

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

REQUEST FOR MEDICAL INFORMATION

TO BE COMPLETED BY DOCTOR OR NURSE

APPLICANT'S NAME:_____ **SS #:**_____ **MEDICARE #:** _____

ALLERGIES_____

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

OTHER_____

MEDICATIONS: (SPECIFY DIAGNOSIS, DOSAGE, FREQUENCY AND ROUTE. PLEASE ATTACH SHEET WITH ADDITIONAL MEDICATIONS IF NECESSARY)

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 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
ORIENTED	_____	_____	_____	_____
FORGETFUL	_____	_____	_____	_____
DEPRESSED	_____	_____	_____	_____
COMBATIVE	_____	_____	_____	_____

	NEVER	SELDOM	FREQUENT	ALWAYS
CONFUSED	_____	_____	_____	_____
HOSTILE	_____	_____	_____	_____
WANDER-RISK	_____	_____	_____	_____

PHYSICAL STATUS: (SELECT APPROPRIATE CHOICE)

_____ VERBAL _____ NON-VERBAL _____ COMATOSE

	SELF	ASSIST	TOTAL
EATING	_____	_____	_____
BATHING	_____	_____	_____
PERSONAL	_____	_____	_____
ORAL CARE	_____	_____	_____
AMBULATION	_____	_____	_____

_____ IMPAIRED VISION _____ IMPAIRED HEARING
_____ EYEGLASSES _____ HEARING AID
_____ INCONTINENT BOWEL _____ DENTURES:
_____ INCONTINENT BLADDER ____ UPPER
_____ URINARY CATHETER ____ LOWER
_____ OSTOMYCARE ____ PARTIAL

SPECIAL CARE/ PROCEDURES: (SELECT CHOICE; WHEN APPROPRIATE GIVE TYPE, FREQUENCY, SIZE, STAGE AND SITE)

GLUCOSE MONITORING _____ TUBE FEEDING _____
RESTRAINTS_____ DIET _____
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 _____

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**	**N/A**
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 #

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 INCOMPTENT 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, PLEASE GIVE A BRIEF DESCRIPTION: _____
   _____
   _____
   _____

I ATTEST THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____
SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE

_____
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 FEE FOR THE VETERAN IS CURRENTLY $1,732 PER MONTH. THE CARE AND MAINTENANCE FEE FOR THE SPOUSE OF A VETERAN OR A "GOLD STAR PARENT" IS $4,500 PER MONTH. PLEASE NOTE THAT THE CARE AND MAINTENANCE FEE RATE IS NOT GUARANTEED AND IT IS BASED ON QUALIFICATIONS. AT THE TIME OF ADMISSION, CARE AND MAINTENANCE FEES WILL BE ASSESSED ON ALL FAMILY INCOME SOURCES. FEES WILL BE ADJUSTED WHEN THERE IS A CHANGE IN FAMILY INCOME, RETROACTIVE TO THE CHANGE.

_____ _____

SIGNATURE OF APPLICANT/AUTHORIZED REPRESENTATIVE DATE

_____ _____

WITNESS 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		
		LA	
	ATTN:		

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 Codes		
☐ Immunization Records		
☐ Other:		

The following information will be released:

☐ 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. 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.
3. I HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT.
4. A PHOTOCOPY OF THIS AUTHORIZATION WILL HAVE THE SAME EFFECT AS AN ORIGINAL.
5. THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE AND BE INEFFECTIVE TWELVE MONTHS AFTER DATE SIGNED.

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