STATE OF FLORIDA
DEPARTMENT OF VETERANS' AFFAIRS

RESIDENT 70%-100% APPLICATION PACKET

Baldomero Lopez State Veterans' Nursing Home
6919 Parkway Boulevard
Land O' Lakes, FL 34639
Phone: (813) 558-5000 Fax: (813) 558-5021
www.floridavets.org

Table of Contents

STATE OF FLORIDA
DEPARTMENT OF VETERANS' AFFAIRS

APPLICATION FOR CONSIDERATION FOR ADMISSION GENERAL INFORMATION

This facility is a 120-bed skilled nursing facility of which 58 beds are dedicated to the care of veterans with Alzheimer's. Additionally, we offer rehabilitation services such as: Physical, Occupational & Speech therapy and Restorative Programs, all under the direct supervision of trained qualified therapists. Hospice and Respite Services are also available.

There is a four-step applicant qualifying process that is as follows:

- **All documents required by the home must be completed before the application can be processed**. Most of these documents are VA, Financial and Medical.
- The completed application will be reviewed by our admission team.
- If on our waiting list, a reassessment will be scheduled before actually admitting the resident.
- Whether your application is approved or disapproved for our waiting list or direct admission, you will be notified by telephone or mail.

The basic requirements for Admission to the Nursing Home are as follows:

- A signed and complete application packet must be returned to the facility by mail or in person.
- Veteran as determined under Chapter 1.01 (14), Florida Statutes (Honorably Discharged from Active Duty).
- Resident of Florida at time of application.
- In need of nursing home care for a medical condition that requires services which fall within the level of care the home has resources and functional ability to provide.
- Complete Application for Admission (notarized page 2: Form 54).
- Complete CF-MED 3008 dated within 30 days of admission.
- History and Physical (if applicant is currently hospitalized) stating the applicant is free of communicable diseases.
- Results of a Chest x-ray taken within the 12 months.

The daily rate for all 70% - 100% Service Connected Disabled Veterans will be $0.00 cost and include:

- Room and Board
- 24-hour RN Nursing Services
- Licensed Clinical and BSW Social Services
- Certified and Therapeutic Activities
- Restorative Nursing Care
- Daily meals and snacks designed by a Registered Dietician
- Housekeeping and Laundry Services
- Maintenance and free limited television programming
- Free local private phone calls
- Durable and Medical Supplies

- Unit Dose Prescription Medication
- Nutritional Supplements
- X-ray Services
- Laboratory Charges
- Physical, Occupational and Speech Therapy
- Equipment rental

For the following services, please refer to the Business Office Manager:

- Physician visits such as attending, Podiatrist, Ophthalmologist
- Transportation or non-emergency ambulance travel

Non-routine services, which are not covered in the daily room rate, include but not limited to:

- Dental Care at any level
- Hearing Aide repair / replacements
- Private Sitters or Personal Care Attendants
- Beauty / Barber charges (Cash or Resident Trust Fund needed)

ALZHEIMER / TRANSITIONAL / MEMORY UNIT

PURPOSE: It is the purpose of the Baldomero Lopez State Veterans' Nursing Home Memory Care Unit to offer the most appropriate level of care to meet the physical, mental and psychosocial needs while simultaneously striving to maximize their quality of life in an appropriate and caring environment, through specifically designed programs developed for these particular resident's.

PHILOSOPHY OF CARE: To create a therapeutic, supportive, safe environment considering the sensory, physical, and cognitive losses of the Alzheimer resident (s). Based upon resident needs, memory impaired, dementia, and other appropriate residents who might benefit from our program may also live on this unit.

To provide daily care (taking into consideration the Alzheimer resident sense of reality) along with interacting in an empathetic, accepting and patient manner, so our outcomes enhance their living.

To encourage involvement of families by increasing their perception of control, ability to make decisions and their knowledge base of resident's functioning level as it declines.

PROCEDURE: Pre-screening for this Unit is completed by one of our clinical staff to insure appropriate placement. If the resident's diagnosis and medical condition meets our criteria for placement, the family or responsible party will be contacted.

CHECKLIST FOR FORMS AND INFORMATION REQUIRED

All forms and information required unless noted IF APPLICABLE

REQUIRED FORMS INCLUDED WITH APPLICATION PACKET

___ "FORM 54" APPLICATION FOR ADMISSION - **MUST BE NOTARIZED**
___ "10 10 EZ" APPLICATION FOR HEALTH BENEFITS
n/a- FINANCIAL INFORMATION RELEASE – **MUST BE NOTARIZED**
___ VETERAN'S CONTACT INFO, MORTUARY, AND PRIMARY CONTACT INFORMATION
___ FAMILY QUESTIONNAIRE
___ CUSTOMARY ROUTINES
___ PERSONAL PROFILE
___ AUTHORIZATION TO RELEASE MEDICAL RECORDS AND HEALTH INFORMATION
___ AGENCY FOR HEALTH CARE ADMINISTRATION / DEPT OF ELDER AFFAIRS INFORMED CONSENT

REQUIRED FORMS FOR PHYSICIAN TO COMPLETE (included in application packet)

___ "3008" - MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM
___ PASRR – LEVEL I SCREEN
___ MEDICAL VERIFICATION OF CAPACITY OR INCAPACITY

MEDICAL INFORMATION AND RECORDS REQUIRED

___ MOST RECENT HISTORY AND PHYSICAL
___ CURRENT MEDICATION LIST
___ CARE PLAN (IF VETERAN IS CURRENTLY LIVING IN SKILLED NURSING)
___ MOST RECENT 30 DAYS NURSING PROGRESS NOTES (IF VETERAN IS CURRENTLY LIVING IN SKILLED NURSING)
___ MOST RECENT LAB REPORT
___ MOST RECENT CXR REPORT OR PPD RESULTS (FROM PREVIOUS 12 MONTHS)
___ ORGAN DONOR (IF APPLICABLE)

ADDITIONAL DOCUMENTS AND INFORMATION REQUIRED (do not include original documents)

PROOF OF MILITARY HONORABLE DISCHARGE DOCUMENTS – **ONLY ONE FORM IS NECESSARY**
___ DD214 (required if available)
___ WD ADGO 53
___ VA ELECTRONIC RECORD (SHARE)
___ CERTIFIED STATEMENT OF MILITARY SERVICE

ADVANCED DIRECTIVES

___ DURABLE POWER OF ATTORNEY AS FINANCIAL ADVOCATE **OR** GUARDIANSHIP
___ DURABLE POWER OF ATTORNEY AS MEDICAL ADVOCATE **OR** HEALTH CARE SURROGATE
___ LIVING WILL (IF APPLICABLE)
___ DNR (IF APPLICABLE)
___ PROOF OF FLORIDA RESIDENCY (i.e. COPY OF FL ID, DRIVERS LICENSE, OR VOTER ID CARD)
___ MEDICARE CARD (copy of FRONT and BACK of card)
___ SOCIAL SECURITY CARD (copy of FRONT and BACK of card)
___ OTHER MEDICAL INSURANCE CARDS (copy of FRONT and BACK of card) – (IF APPLICABLE)
___ BIRTH CERTIFICATE
___ MARRIAGE LICENSE (IF APPLICABLE)
___ COPY OF CURRENT VA SUMMARY OF BENEFITS

OTHER:

___ COPY OF SERVICE CONNECTED AWARD LETTER

STATE OF FLORIDA DEPARTMENT OF VETERANS' AFFAIRS STATE VETERANS NURSING HOME PROGRAM

APPLICATION FOR ADMISSION

NO INDIVIDUAL WILL, ON THE GROUNDS OF RACE, COLOR, RELIGIOUS BELIEFS, SEX, GENDER IDENTITY, SEXUAL ORIENTATION, OR NATIONAL ORIGIN, BE DENIED ADMISSION, CARE OR ANY OTHER BENEFIT PROVIDED BY THE STATE HOME

INSTRUCTIONS

a) Print or type and answer all items. **PAGE 2 MUST BE NOTARIZED**
b) Individuals must meet the criteria required by the U.S. Department of Veterans Affairs for veteran status.
c) Must be resident of Florida immediately preceding this application.
d) Must be in need of institutional long term health care services.

A. PERSONAL INFORMATION

VETERAN'S LAST NAME FIRST NAME MIDDLE NAME *SOCIAL SECURITY # VA CLAIM #

SPOUSE NAME: SPOUSE'S SSN/DATE OF BIRTH VETERAN'S MEDICARE #

MAILING ADDRESS: Street: ____
City, State Zip Code _____
Phone Number: _____

RESIDENCE ADDRESS: (if different) Street: ____
City, State Zip Code _____
Phone Number: _____
Spouse Address (if different)

PLACE OF RESIDENCE: Own Home ☐ Hospital ☐ Nursing Home ☐
Retirement Home ☐ Boarding Home ☐ Other ☐ explain:

PHONE NUMBERS Home: Work: Other:

Date of Birth Birthplace Sex: Male ☐ Female ☐

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Date of Marriage: _____ Date of Divorce: _____

Have you been a patient or resident in a hospital or nursing home during the past year?
YES ☐ NO ☐ Name of Facility: _____
Address of Facility: _____

Have you been treated in a Federal VA facility before? YES ☐ NO ☐ If so, where? _____
Please give dates: _____

Have you ever been convicted of a Felony? Yes ☐ No ☐ If yes, in what state? _____

B. MILITARY INFORMATION ATTACH A COPY OF MILITARY DISCHARGE PAPERS (DD-214)

BRANCH OF SERVICE	SERVICE NUMBER	DATE ENTERED	DATE DISCHARGED	CHARACTER OF SERVICE

*The State of Florida Department of Veterans' Affairs (FDVA) is asking you to provide your Social Security Number. If you give FDVA your Social Security Number, we will use it to verify honorable Veteran status, for billing purposes or for other purposes as authorized or required by law. The information you supply may be verified through a computer-matching program. FDVA may disclose the information you put on this form as permitted by law. You do not have to provide the information to FDVA, but if you do not, we will be unable to process your application for admission and serve your medical needs.

C. GROSS MONTHLY INCOME INFORMATION

MONTHLY INCOME	APPLICANT Gross	APPLICANT Net	SPOUSE Gross	SPOUSE Net
VA Pension/VA Compensation	Not Applicable		Not Applicable	
Social Security	Not Applicable		Not Applicable	
U.S. Civil Service	Not Applicable		Not Applicable	
U.S. Railroad Retirement	Not Applicable		Not Applicable	
Military Retirement	Not Applicable		Not Applicable	
Employment	Not Applicable		Not Applicable	
Other Retirement, or Income	ASSET VALUE/MONTHLY INCOME		ASSET VALUE/MONTHLY INCOME	
Source: _____	Not Applicable		Not Applicable	
Source: _____				
Source: _____				
Source: _____				
Attach extra page if more space is needed				

D. Legal Representative for Health Care and Financial Authority:_____

Provide name, address, and phone number of designated authority

Name: _____

Address: _____

City, State, Zip code: _____Phone number: _____

THIS SECTION MUST BE SIGNED BY THE VETERAN OR DPOA AND NOTARIZED

E. AFFIDAVIT: I am applying for admission to the State Veterans Nursing Home. I have been a resident of the State of Florida immediately preceding the date of this application. All of the statements on this application are true and complete to the best of my knowledge. I agree to follow the rules of conduct and policies and procedures of the Department of Veterans' Affairs and the State Veterans' Nursing Home. **I agree to the release of all medical and financial information needed to complete this application process.**

NOTE: (Check if applicable) ☐ I have a need for high level nursing home care and am unable to defray the expense of nursing home care.

_____ _____

Applicant's Signature, or person authorized to sign for applicant Date signed

SUBSCRIBED AND SWORN TO ME THIS _____DAY OF _____ YEAR_____.
NOTARY PUBLIC _____
COUNTY _____STATE_____(PERSONALLY KNOWN_____ OR TYPE OF ID)_____

APPLICATION FOR BENEFITS VA FORM 10-10-EZ

OMB Approved No. 2900-0091
Estimated Burden Avg. 30 min.

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 PACIFIC ISLANDER	

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. *(Include area code)*	10G. MOBILE TELEPHONE NO. *(Include area code)*	10H. E-MAIL ADDRESS

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 VII - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS

By submitting this application you are agreeing to pay the applicable VA copays for treatment or services of your NSC conditions as required by law. You also agree 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**

(Sign in ink)

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

OMB Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date: 08/31/2018

Department of Veterans Affairs

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

Note - If you would prefer to have an individual assist you with your claim, you may use VA Form 21-22a, " Appointment of Individual as Claimant's Representative." VA Forms are available at www.va.gov/vaforms.

IMPORTANT - PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN ON REVERSE BEFORE COMPLETING THE FORM.

1. LAST-FIRST-MIDDLE NAME OF VETERAN	2. VA FILE NUMBER *(Include prefix)*

3A. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS *(See list on reverse side before selecting organization)*

3B. NAME AND JOB TITLE OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 3A *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*

3C. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 3A

INSTRUCTIONS - TYPE OR PRINT ALL ENTRIES

4. SOCIAL SECURITY NUMBER (OR SERVICE NUMBER, IF NO SSN)	5. INSURANCE NUMBER(S) *(Include letter prefix)*
6. NAME OF CLAIMANT *(If other than veteran)*	7. RELATIONSHIP TO VETERAN
8. ADDRESS OF CLAIMANT *(No. and street or rural route, city or P.O., State and ZIP Code)*	9. CLAIMANT'S TELEPHONE NUMBERS *(Include Area Code)* A. DAYTIME / B. EVENING
	10. EMAIL ADDRESS *(If applicable)*
	11. DATE OF THIS APPOINTMENT

12. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C.

By checking the box below I **authorize** VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☐ I authorize the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 3A all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named above, either by explicit revocation or the appointment of another representative.

13. LIMITATION OF CONSENT - I authorize disclosure of records related to treatment for all conditions listed in Item 12 except:

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)
☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

14. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS - By checking the box below, I authorize the organization named in Item 3A to act on my behalf to change my address in my VA records.

☐ I authorize any official representative of the organization named in Item 3A to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 3A is not my appointed fiduciary.

I, the claimant named in Items 1 or 6, hereby appoint the service organization named in Item 3A as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 12 and 13), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.608. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

15. SIGNATURE OF VETERAN OR CLAIMANT *(Do Not Print)*	16. DATE SIGNED
17. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 3B *(Do Not Print)*	18. DATE SIGNED

VA USE ONLY	COPY OF VA FORM 21-22 SENT TO: ☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ INSURANCE FILE	DATE SENT	ACKNOWLEDGED *(Date)*	REVOKED *(Reason and date)*

NOTE: As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.

VA FORM AUG 2015 **21-22** SUPERSEDES VA FORM 21-22, OCT 2014, WHICH WILL NOT BE USED.

State of Florida
DEPARTMENT OF VETERANS' AFFAIRS
Baldomero Lopez State Veterans' Nursing Home
6919 Parkway Boulevard
Land O' Lakes, FL 34639
Phone: (813) 558-5000 Fax: (813) 558-5021
www.floridavets.org

Ron DeSantis
Governor
Ashley Moody
Attorney General
Jimmy Patronis
Chief Financial Officer
Nikki Fried
Commissioner of Agriculture

Daniel W. "Danny" Burgess, Jr.
Executive Director
Connie Tolley
Division Director
Marlies Sarrett
Administrator

FINANCIAL INFORMATION RELEASE

Date: _____

To Whom It May Concern:

I hereby grant permission and authorize any bank, building association, employer, insurance company, real estate company, government agency or any financial institution of any kind or character to disclose to any agent of the Florida Department of Veterans' Affairs full information as to my bank accounts, earnings, insurance policies, property or benefits for the time period listed below.

This release is valid from Admission to Discharge.

Applicant's signature or person authorized to sign for the applicant:

_____ Veteran or DPOA

SUBSCRIBED AND SWORN TO ME THIS _____DAY OF _____YEAR_____

NOTARY PUBLIC_____

COUNTY _____STATE_____

Name(s) on Account: _____

Documents Requested: _____

Signed: _____
Florida Department of Veterans' Affairs

State of Florida
DEPARTMENT OF VETERANS' AFFAIRS
Baldomero Lopez State Veterans' Nursing Home
6919 Parkway Boulevard
Land O' Lakes, FL 34639
Phone: (813) 558-5000 Fax: (813) 558-5021
www.floridavets.org

Ron DeSantis
Governor
Ashley Moody
Attorney General
Jimmy Patronis
Chief Financial Officer
Nikki Fried
Commissioner of Agriculture

Daniel W. "Danny" Burgess, Jr.
Executive Director
Connie Tolley
Division Director
Marlies Sarrett
Administrator

MEDICAL RECORDS AND HEALTH INFORMATION RELEASE

I, _____ authorize, _____ to disclose to
(Name of facility making disclosure)

_____ at _____
(Name of person and/or facility to which disclosure is to be made) (Address of person or facility)

the above individual's health information as described below.

The purpose of the disclosure is to _____
_____
Note: Records may be shared with other Florida State Veterans' Homes for placement and/or continuum of care.

Initial below for release of information

_____ 1. The undersigned hereby authorizes the release of copies of all medical records included but not limited to the following:

Physician's orders	Nursing notes
Discharge summary	Care plans
History & physical	Medication list
X-ray/Lab/EKG reports	Dietary notes
MDS	Activity notes
Physician's progress notes	Social Services assessment

Consultations-specify: _____
Other-specify: _____

_____ 2. I understand and hereby authorize the release of information in my medical record, which may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).

_____ 3. I understand and hereby authorize the release of information in my medical record, which may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. (Note: Release of psychiatric or substance abuse progress notes require a separate authorization.)

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke the authorization I must do so in writing and present my written revocation to the health information management department.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire if my application is denied, or if accepted, upon my permanent transfer or discharge from the facility.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to obtain treatment. I understand the potential for the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by the Federal privacy laws

_____

Signature of Resident or Legal Representative Date

_____

If signed by Legal Representative, relationship to Resident Date

_____

Signature of Witness Date

VETERAN'S CONTACT INFORMATION

Veteran's Name: _____

Does the veteran live:

☐ At home

☐ In an Assisted Living Facility Name of facility: _____

☐ In a Skilled Nursing Facility Name of facility: _____

Street Address: _____

City, State, & Zip Code: _____

Telephone: _____ Fax: _____

MORTUARY / FUNERAL HOME CONTACT INFORMATION

Name of Mortuary/Funeral Home: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

EMERGENCY CONTACT INFORMATION

Contact Name: _____

Relationship to Veteran: _____

Telephone: _____ Email: _____

FAMILY QUESTIONNAIRE

We request that you complete this form to the best of your ability in order to ensure that we have sufficient and relevant information to care for your loved one. Our sincere intent in asking you to answer these questions is to obtain information in which may help us to enhance the quality of his/her life to the greatest extent possible.

VETERAN'S NAME: _____ NICKNAME: _____

DATE OF BIRTH: _____/_____/_____ AGE: _____ PLACE OF BIRTH: _____

CURRENT MARITAL STATUS: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated

HIGHEST LEVEL OF EDUCATION COMPLETED:_____

FORMER OCCUPATION(S): _____

NAME OF DURABLE POWER OF ATTORNEY (DPOA) or GUARDIAN: _____

WHAT IS THE RELATIONSHIP OF DPOA OR GUARDIAN TO THE VETERAN? _____

NAME(S) OF CHILDREN OR OTHER RELATIVES	RELATIONSHIP (CHOOSE ONE)
_____	☐DISTANT ☐POOR ☐GOOD
_____	☐DISTANT ☐POOR ☐GOOD
_____	☐DISTANT ☐POOR ☐GOOD
_____	☐DISTANT ☐POOR ☐GOOD

WITH WHOM DOES THE VETERAN HAVE THE BEST RELATIONSHIP? _____

WHY? _____

PRIOR LIVING SITUATION (HOME, ANOTHER FACILITY, LIVING WITH FAMILY MEMBER):
_____

ADMITTED TO STATE VETERANS' HOME FROM: _____

DOES THE VETERAN HAVE A MEMORY PROBLEM? ☐ YES ☐ NO

HOW LONG HAS THE VETERAN HAD A MEMORY PROBLEM?
☐ 1 YEAR ☐ 1-3 YEARS ☐ 3-5 YEARS ☐ 5 YEARS OR MORE

WAS THE ONSET OF THE PROBLEM: ☐ SUDDEN ☐ GRADUAL

HAVE THERE BEEN ANY CHANGES IN THE VETERAN'S MOOD OR BEHAVIOR IN THE LAST 6 MONTHS (I.E., FALLING, INCREASED CONFUSION, MOOD CHANGES)?
☐ NO ☐ YES, EXPLAIN: _____

DOES THE VETERAN HAVE A HISTORY OF PSYCHIATRIC PROBLEMS (I.E., SYMPTOMS OF DEPRESSION, NEEDED PSYCHIATRIC HOSPITALIZATION, MEDICATION, PSYCHOTHERAPY, ETC.)?
_____
_____
_____

WHAT MEDICATIONS IS THE VETERAN CURRENTLY TAKING AND WHY:

_____

_____

_____

_____

MOOD AND BEHAVIOR

Check (√) all behaviors that apply and check (√) the appropriate code number.
Codes: 1 = Behavior occurs less than daily
2 = Behavior occurs daily or more frequently

		1	2
☐	Wandering		
☐	Continuous pacing		
☐	Repetitive behaviors (words, actions)		
☐	Withdrawn/depressed (long periods of time inactive)		
☐	Appears anxious, worried		
☐	Crying, tearful		
☐	Comments about death of self or others		
☐	Sleep disturbances (insomnia or frequent napping)		
☐	Mood swings (sudden changes in mood)		
☐	Over-eating		
☐	Under-eating		
☐	Clinging (to caregiver, can't leave sight)/needs reassurance		
☐	Verbally abusive (curses, screams, threatens)		
☐	Physically abusive (strikes out, grabs)		
☐	Rummaging or hording (goes through garbage or hides things)		
☐	Inappropriate toileting habits		
☐	Inappropriate sexual behavior		
☐	Sun-downing behavior (difficult behaviors or increased confusion occurs in late afternoon)		
☐	Hallucinations (hears or sees things that are not there)		
☐	Delusions (tells stories that are not fact based)		
☐	Suspiciousness, paranoia		
☐	Resistant to care, stiffening, rigidity, refusal		
☐	Repetitive verbalizations or behaviors		
☐	Catastrophic reactions (overacts to stressful situations)		

DOES THE VETERAN HAVE A HISTORY OF: SMOKING ☐ YES ☐ NO ☐ UNKNOWN

(IF YES, SPECIFY CIGARETTES, CIGARS, PIPE, ETC., AND AVERAGE DAILY USE:

_____

ALCOHOL USE ☐ YES ☐ NO ☐ UNKNOWN

EXPLAIN: _____

DRUG USE ☐ YES ☐ NO ☐ UNKNOWN
IF YES, SPECIFY TYPE AND QUANTITY: _____

DESCRIBE BEHAVIOR OF THE VETERAN THAT REFLECTS THEIR:
(A) ANGER: _____

(B) DEPRESSION/SADNESS: _____

(C) OTHER: _____

WHAT TRAUMATIC EVENTS HAS THE VETERAN EXPERIENCED IN THE PAST 10 YEARS (I.E. DEATH OF A LOVED ONE, DIAGNOSED WITH TERMINAL ILLNESS, ETC.) AND HOW DID HE/SHE HANDLE THIS? WHAT COPING SKILLS OR RESOURCES DID THEY UTILIZE (I.E. HELP FROM FAMILY, FRIENDS, COMMUNITY SUPPORT, SPIRITUAL FAITH, ETC.)? WHAT IS AN EFFECTIVE INTERVENTION THAT OUR STAFF MIGHT USE DURING DIFFICULT TIMES?

_____
_____
_____
_____
_____

IS THERE A PARTICULAR ANNIVERSARY, HOLIDAY, EVENT OF THE PAST OR SITUATION THAT MAY TRIGGER SADNESS, WITHDRAWAL, AGITATION, OR IN ANY WAY AFFECT THEIR BEHAVIOR IN THEIR NEW ENVIRONMENT?

_____
_____

IDENTIFY A PLEASANT/FUN ACTIVITY FOR THE VETERAN WHICH COULD BE IMPLEMENTED RIGHT NOW (I.E. SINGING A FAVORITE SONG, WATCHING SPECIAL TV PROGRAM, LISTENING TO HYMNS, ETC.).

_____
_____

WHAT METHOD OF REINFORCEMENT IS THE MOST SATISFYING FOR THE VETERAN? (IE: SOCIAL, TOUCHING, HUGGING, PATS ON THE BACK, PRAISE, COMPLIMENT)

_____
_____

TANGIBLE—PRIZES, FOOD, ETC: _____

IN YOUR OPINION, HOW WILL THE VETERAN ADJUST/ADAPT TO LIFE IN THIS FACILITY?

_____

WHAT CAN OUR STAFF DO TO MAKE THIS TRANSITION EASIER FOR THEM?

_____

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT THIS PERSON?

_____

PERSONAL INFORMATION TO INDIVIDUALIZE CARE

1. WHAT TYPE OF LEISURE ACTIVITIES HAS YOUR RELATIVE ENJOYED IN THE PAST 6 MONTHS?

   _____

2. WHAT TYPE OF LEISURE ACTIVITIES CAN/DOES YOUR FAMILY MEMBER STILL ENJOY DOING?

   _____

3. ARE THERE SITUATIONS THAT UPSET YOUR RELATIVE?
   - ☐ CAR RIDES ☐ BEING ALONE ☐ UNFAMILIAR SURROUNDINGS
   - ☐ DEMANDS (PERSONAL CARE) ☐ BEING TOUCHED
   - ☐ OTHER: _____

4. DO YOU HAVE APPROACHES YOU USE TO HELP CALM YOUR RELATIVE?
   - ☐ HUMOR ☐ AFFECTION ☐ FOOD (SNACK) ☐ GOING FOR A WALK

☐ LEAVING ALONE
☐ OTHER: _____

5. DOES YOUR RELATIVE EXPERIENCE ROUTINE OR OCCASIONAL DISCOMFORT DUE TO PHYSICAL CONDITIONS (HEADACHES, JOINT PAIN, ETC.)?

_____

6. CLUES THAT MAY INDICATE YOUR RELATIVE IS EXPERIENCING PAIN OR ILLNESS (VERBAL OR NON-VERBAL).

_____

7. ARE THERE LIFE EXPERIENCES OR ACCOMPLISHMENTS YOUR RELATIVE ENJOYS RECALLING?

CHILDHOOD_____

MIDDLE YEARS _____

RETIREMENT _____

8. WERE THERE UNPLEASANT OR SENSITIVE LIFE EXPERIENCES WHICH THE VETERAN STILL RECALLS AND WHICH STAFF NEEDS TO BE AWARE? PLEASE INDICATE HOW TO RESPOND.

CHILDHOOD _____

MIDDLE YEARS _____

RETIREMENT _____

Signature of individual completing this form: _____

Relationship to Veteran: _____ Date: _____

CUSTOMARY ROUTINES

VETERAN'S NAME: _____

Cycle of Daily Events (Check all that apply)

☐ Stays up late at night (after 9 PM)
☐ Goes out 1+days a week
☐ Spends most of time alone/watching TV
☐ Moves independently indoors
☐ Use of tobacco products at least daily
☐ Use of OTC drugs at least daily
☐ Early riser (before 7 AM)
☐ Frequent insomnia/other sleep disruptions
☐ Naps regularly during day (at least one hour)
☐ Stays busy with hobbies, reading or fixed daily routine

Eating Patterns (Check all that apply)

☐ Distinct food preferences
☐ Eats between meals all or most days
☐ Diet Restrictions
☐ Eating disorders (bulimia, anorexia)
☐ Hoards food
☐ Ignores dietary precautions
☐ Skips Meals
☐ Prefers sweets
☐ Use of alcoholic beverages at least weekly

ADL Patterns (Check all that apply)

☐ In bed clothes much of the day
☐ Wakens to toilet all or most nights
☐ Has irregular bowel movement pattern
☐ Showers for bathing
☐ Baths in PM
☐ Practices good hygiene
☐ Prefers grooming in AM
☐ Reluctant to change clothing
☐ Fear of water

Involvement Patterns (Check all that apply)

☐ Finds strength in faith
☐ Daily animal companion presence
☐ Involved in group activities
☐ Loner, prefers seclusion
☐ Territorial, draws boundaries
☐ Many friends and companions
☐ Visits per phone
☐ Daily close contacts with relatives or friends
☐ Usually attends church, temple, etc. (TV Services)

Bed Mobility and Transfer (Check only one)

☐Applicant is independent with getting in and out of bed
☐Applicant needs one person to assist getting in and out of bed
☐Applicant needs two people to assist getting in and out of bed

Eating (Check only one)

☐Applicant is independent when eating, and needs no assistance
☐Applicant needs some assistance with eating (set-up of food, cueing)
☐Applicant needs to be fed

Does applicant use any adaptive equipment? ☐No ☐Yes If so, what is used? _____
Does resident have a history of dysphagia? ☐No ☐Yes If so, explain: _____
Is resident on a special diet involving variance in food and liquid consistency? ☐No ☐Yes If so, explain: _____

PERSONAL PROFILE / RESIDENT INFORMATION

Veteran's Name: _____ Date of Birth: _____

Birthplace: _____ Primary Language: _____

DIRECTIONS: Please provide a Social History of Applicant from birth to present that includes but not limited to the following:

Family History- List of Siblings in birth order, Parents names with relationships and experiences.
_____
_____
_____

Parent's Occupations _____

Family Pets _____

Mental Health History _____

Number of Marriages, Children, Etc. _____

Things Loved and Hated _____

Former Lifetime Occupations _____

Places Traveled _____

Foods Liked and Disliked _____

Musical Tastes _____

Hobbies _____

Clubs and Organizations belonged to _____

Church Preferences and Holidays Celebrated _____

Current Interests and Activities (Any Prizes and Awards received in life) _____
_____

Highest Level of Education _____

Personality _____

Traumas and/or Tragedies in Life _____

ASSISTIVE DEVICES USED FOR DAY-TO-DAY FUNCTIONING OR MOBILITY/WALKING

Please check below for any applicable assistive devices used for day-to-day functioning or mobility/walking:

☐ Glasses
☐ Hearing Aids
☐ Dentures
☐ Cane
☐ Artificial limbs
☐ Crutches
☐ Walker
☐ Wheelchair
☐ Motorized Conveyance
☐ Wheel chair cushion,
Who Provided? _____
☐ Other: _____

Please describe any checked items above in detail, and explain how long they have been in use:
_____
_____
_____
_____
_____
_____
_____

How many feet has the applicant been able to walk in the last 60 days (with or without assistive device(s))? _____

Does the applicant have a history of falls or balance issues in the last year? ☐No ☐Yes If so, please describe history. _____
_____

Has the applicant received any physical, occupational, or speech therapy in the past? ☐No ☐ Yes If so, please describe history. _____
_____

Name of Applicant: _____

Name and Phone Number of Contact: _____

Date: _____

Note: ALL MOTORIZED/ELECTRICAL EQUIPMENT MUST BE CERTIFIED BY OUR MAINTANANCE DEPARTMENT BEFORE BEING PLACED IN RESIDENT'S ROOM.

Individual Completing Form: _____ Date: _____

Relationship to Applicant: _____

MEDICAL CERTIFICATION MEDICAID LONG-TERM CARE AND PATIENT TRANSFER FORM

MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM

*Patient Name: *Last 4 SSN: *DOB:

***A. PATIENT INFORMATION**

*Gender: ☐ Male ☐ Female
*Hispanic Ethnicity: ☐ Yes ☐ No
*Race: ☐ White ☐ Black ☐ Other: _____
*Language: ☐ English ☐ Other:

***B. SIGHT** **HEARING**

☐ Normal ☐ Impaired ☐ Deaf ☐ Normal ☐ Impaired
☐ Blind ☐ Hearing Aid L ☐ R ☐

C. DECISION MAKING CAPACITY (PATIENT)

☐ Capable to make healthcare decisions ☐ Requires a surrogate

***D. EMERGENCY CONTACT**

Name: _____ Name: _____
Phone: Phone:

***E. MEDICAL CONDITION**

*Primary diagnosis:
*Other diagnoses:

If Hospitalized:
Primary diagnosis at discharge:
Reason for transfer:
Surgical procedures performed:

F. INFECTION CONTROL ISSUES

PPD Status: ☐ Positive ☐ Negative ☐ Not known
Screening date: _____
Associated Infections/resistant organisms:

☐ MRSA Site: _____
☐ VRE Site: _____
☐ ESBL Site: _____
☐ MDRO Site: _____
☐ C-Diff Site: _____
☐ Other: Site: _____

Isolation Precautions: ☐ None
☐ Contact ☐ Droplet ☐ Airborne

***G. PATIENT RISK ALERTS**

☐ *None Known ☐ *Harm to self ☐ *Difficulty swallowing
☐ *Elopement ☐ *Harm to others ☐ *Seizures
☐ *Pressure Ulcers ☐ *Falls ☐ *Other: _____

RESTRAINTS: ☐ Yes ☐ No
Types: _____
Reasons for use: _____

ALLERGIES: ☐ None Known ☐ Yes, List below: _____

Latex Allergy: ☐ Yes ☐ No Dye Allergy/Reaction: ☐ Yes ☐ No

H. ADVANCE CARE PLANNING

Please ATTACH any relevant documentation:

Advance Directive	☐ Yes	☐ No
Living Will	☐ Yes	☐ No
DO NOT Resuscitate (DNR)	☐ Yes	☐ No
DO NOT Intubate	☐ Yes	☐ No
DO NOT Hospitalize	☐ Yes	☐ No
No Artificial Feeding	☐ Yes	☐ No
Hospice	☐ Yes	☐ No

I. TRANSFERRED FROM

Facility Name:
Date: Unit:
Phone: Fax:
Discharge Nurse: Phone:
Admit Date: Discharge Date:
Admit Time: AM ☐ PM ☐ Discharge Time: AM ☐ PM ☐

J. TRANSFERRED TO

Facility Name:
Address 1:
Address 2:
Phone: Fax:

K. PHYSICIAN CONTACTS

Primary Care Name:
Phone:
Hospitalist Name:
Phone:

L. TIME SENSITIVE CONDITION SPECIFIC INFORMATION

Medication due near time of transfer / list last time administered
Script sent for controlled substances (attached): ☐ Yes ☐ No

☐ Anticoagulants	Date:	Time:	AM ☐ PM ☐
☐ Antibiotics	Date:	Time:	AM ☐ PM ☐
☐ Insulin	Date:	Time:	AM ☐ PM ☐
☐ Other:	Date:	Time:	AM ☐ PM ☐

Has CHF diagnosis: ☐ Yes ☐ No
If yes; new/worsened CHF present on admission?
☐ Yes ☐ No
Last echocardiogram: Date: LVEF %

On a proton pump inhibitor? ☐ Yes ☐ No
If yes, was it for: ☐ In-hospital prophylaxis and can be discontinued
☐ Specific diagnosis:

On one or more antibiotics? ☐ Yes ☐ No
If yes, specify reason(s):

Any critical lab or diagnostic test pending at the time of discharge? ☐ Yes ☐ No
If yes, please list:

M. PAIN ASSESSMENT:

Pain Level (between 0 - 10):
Last administered: Date: Time: AM ☐ PM ☐

***N. FOLLOWING REPORTS ATTACHED**

☐ Physicians Orders	☐ Treatment Orders	
☐ Discharge Summary	☐ Includes Wound Care	
☐ Medication Reconciliation	☐ Lab reports	
☐ Discharge Medication List	☐ X-ray	☐ EKG
☐ PASRR Forms	☐ CT Scan	☐ MRI
☐ Social and Behavioral History	☐ History & Physical	

*ALL MEDICATIONS: (MUST ATTACH LIST)

AHCA Form 5000-3008, (JUN 2016), Incorporated by reference in Rule 59G-1.045, F.A.C. *Data required for Medicaid

MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM

*Patient Name: *Last 4 SSN: *DOB:

O. VITAL SIGNS

Date: Time Taken: AM ☐ PM ☐

HT: FEET INCHES WT:

Temp: BP: /

HR: RR: Sp02:

*P. PATIENT HEALTH STATUS

***Bladder:** ☐ Continent ☐ Incontinent

☐ Ostomy ☐ Catheter Type:_____ date inserted: _____

Foley Catheter: ☐ Yes ☐ No **If yes, date inserted:** _____

Indications for use:

☐ Urinary retention due to:_____

☐ Monitoring intake and output

☐ Skin Condition:_____

☐ Other:_____

Attempt to remove catheter made in hospital? ☐ Yes ☐ No

Date Removed: _____

***Bowel:** ☐ Continent ☐ Incontinent ☐ Ostomy

Date of Last BM:_____

Immunization status:

Influenza: ☐ Yes ☐ No Date:_____

Pneumococcal: ☐ Yes ☐ No Date:

*Q. NUTRITION / HYDRATION

*Dietary Instructions:

Tube Feeding: ☐ G-tube ☐ J-tube ☐ PEG

Insertion Date:

Supplements (type): ☐ TPN ☐ Other Supplements:

Eating: ☐ Self ☐ Assistance ☐ Difficulty Swallowing

R. TREATMENTS AND FREQUENCY

☐ PT - *Frequency:*

☐ OT - *Frequency:*

☐ Speech - *Frequency:*

☐ Dialysis - *Frequency:*

*S. PHYSICAL FUNCTION

***Ambulation:**
- ☐ Not ambulatory
- ☐ Ambulates independently
- ☐ Ambulates with assistance
- ☐ Ambulates with assistive device

***Transfer:**
- ☐ Self
- ☐ Assistance
- ☐ 1 Assistant
- ☐ 2 Assistants

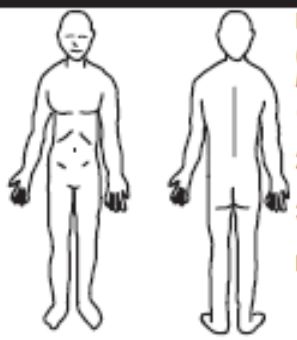
Devices:
- ☐ Wheelchair (type):
- ☐ Appliances:
- ☐ Prosthesis:
- ☐ Lifting Device:

Weight-bearing:

Left:
☐ Full ☐ Partial ☐ None

Right:
☐ Full ☐ Partial ☐ None

T. SKIN CARE – STAGE & ASSESSMENT



Pressure Ulcers

(Indicate stage and location(s) of lesions using corresponding number:

1.

2

3.

List any other lesions or wounds:

*U. MENTAL / COGNITIVE STATUS AT TRANSFER

- ☐ Alert, oriented, follows instructions
- ☐ Alert, disoriented, but can follow simple instructions
- ☐ Alert, disoriented, and cannot follow simple instructions
- ☐ Not Alert

V. TREATMENT DEVICES

☐ Heparin Lock - Date changed:

☐ IV / PICC / Portacath Access - Date inserted:

Type:_____

☐ Internal Cardiac Defibrillator ☐ Pacemaker

☐ Wound Vac

☐ Other:_____

Respiratory - Delivery Device: ☐ CPAP ☐ BiPAP

☐ Nebulizer ☐ Other:_____ ☐ Nasal Cannula

☐ Mask: Type_____

☐ Oxygen - liters: ____% ☐ PRN ☐ Continuous

☐ Trach Size:_____ Type:_____

Ventilator Settings:_____

☐ Suction

W. PERSONAL ITEMS

☐ Artificial Eye	☐ Prosthetic	☐ Walker
☐ Contacts	☐ Cane	☐ Other
☐ Eyeglasses	☐ Crutches	
☐ Dentures	☐ Hearing Aids	
☐ U ☐ L ☐ Partial	☐ L ☐ R	

X. COMMENTS (Optional)

Signature:_____

Printed Name:_____

*Y. PHYSICIAN CERTIFICATION

- ☐ *I certify the individual requires nursing facility (NF) services.
- ☐ The individual received care for this condition during hospitalization.
- ☐ *I certify the individual is in need of Medicaid Waiver Services in lieu of nursing facility placement.

Rehab Potential (check one) ☐ Good ☐ Fair ☐ Poor

*Effective date of medical condition: _____ *Physician/ARNP/PA License #: _____

*Physician/ARNP/PA Signature: _____ *Date: _____

*Printed Physician/ARNP/PA Name & Title:_____ *Phone Number: _____

Z. PERSON COMPLETING FORM

Name: _____ Phone Number: _____ Date: _____

AHCA Form 5000-3008, (JUN 2016), incorporated by reference in Rule 59G-1.045, F.A.C. * Sections required for Medicaid

State of Florida Agency for Health Care Administration
Preadmission Screening and Resident Review (PASRR)

LEVEL I SCREEN

For Serious Mental Illness (SMI) and/or Intellectual Disability or Related Conditions (ID)

For Medicaid Certified Nursing Facility (NF) Only

Name of Individual Being Evaluated (print) _____ Social Security Number* _____ Date of Birth _____

☐ Male ☐ Female Age _____ Individual's or Residency Phone Number _____

Present Location of Individual Being Evaluated _____ Street Address, City _____ State, Zip _____

☐ NF ☐ Hospital ☐ Home ☐ Assisted Living Facility ☐ Group Home ☐ Other_____

Legal Representative's Name (if applicable) _____ Street Address, City _____ State, Zip _____

Representative's Phone Number _____

Medicaid Identification Number if Applicable _____ Other Health Insurance Name and Number if Applicable _____

☐ Private Pay

Requesting Admission to:
(May document up to three facilities)

NF Name	Street Address	City, State, Zip Code	Phone

*WHY ARE WE ASKING FOR YOUR SOCIAL SECURITY NUMBER (SSN)? Federal law permits the State to use your SSN for screening and referral to programs or services that may be appropriate for you. 42 CFR § 435.910. We use the number to create a unique record for every individual that we serve, and the SSN ensures that every person we serve is identified correctly so that services are provided appropriately. Any information the State collects will remain confidential and protected under penalty of law. We will not use it or give it out for any other reason unless you have signed a separate consent form that releases us to do so or if required by law.

Name of Individual Being Evaluated _____ Date of Birth _____

Section I: PASRR Screen Decision-Making

A. MI or suspected MI (check all that apply):

- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Depressive Disorder
- ☐ Dissociative Disorder
- ☐ Panic Disorder
- ☐ Personality Disorder
- ☐ Psychotic Disorder
- ☐ Schizoaffective Disorder
- ☐ Schizophrenia
- ☐ Somatic Symptom Disorder
- ☐ Substance Abuse
- ☐ Other (specify):_____

B. ID or suspected ID (check all that apply):

- ☐ Current diagnosis of an ID, mild, moderate, severe or profound.
- ☐ IQ of 70 or less, if available.
- ☐ Onset prior to 18 years of age. Age of onset: _____
- ☐ Impaired adaptive behavior

Related Condition:

- ☐ Onset prior to 22 years of age. Age of onset: _____
- ☐ Autism
- ☐ Cerebral Palsy
- ☐ Down Syndrome
- ☐ Epilepsy
- ☐ Muscular Dystrophy
- ☐ Prader Willi
- ☐ Spina Bifida
- ☐ Traumatic Brain Injury
- ☐ Other (specify): _____

Functional Criteria:

- ☐ Likely to continue indefinitely

Results in substantial functional limitations in three or more major life activities (**check all that apply**):

- ☐ Capacity for independent living
- ☐ Learning
- ☐ Mobility
- ☐ Self care
- ☐ Self direction
- ☐ Understanding and use of language

Services:

- ☐ Currently receiving services for MI.
- ☐ Previously received services for MI.
- ☐ Referred for MI services.

- ☐ Currently receiving services for ID.
- ☐ Previously received services for ID.
- ☐ Referred for ID services.

Additional Information: _____

Finding is based on (check all that apply):

☐ Documented History ☐ Behavioral Observations ☐ Individual, Legal Representative or Family Report

☐ Medications ☐ Other (specify): _____

Name of Individual Being Evaluated

Date of Birth

Section II: Other Indications for PASRR Screen Decision-Making

1. Is there an indication the individual has or may have had a disorder resulting in functional limitations in major life activities that would otherwise be appropriate for the individual's developmental stage? ☐Yes ☐No

2. Does the individual typically have or may have had at least one of the following characteristics on a continuing or intermittent basis?

A. Interpersonal functioning: The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, fear of strangers, avoidance of interpersonal relationships, social isolation, or has been dismissed from employment. ☐Yes ☐No

B. Concentration, persistence, and pace: The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks. ☐Yes ☐No

C. Adaptation to change: The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system. ☐Yes ☐No

3. Is there an indication that the individual has received recent treatment for a mental illness with an indication that the individual has experienced at least one of the following?

A. Psychiatric treatment more intensive than outpatient care. (e.g., partial hospitalization or inpatient hospitalization). ☐Yes ☐No

B. Due to the mental illness, the individual has experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials. ☐Yes ☐No

A Level II PASRR evaluation must be completed prior to admission if any box in Section I.A. or I.B. is checked and there is a 'yes' checked in Section II.1, II.2, or II.3, unless the individual meets the definition of a provisional admission or a hospital discharge exemption.

4. Has the individual exhibited actions or behaviors that may make them a danger to themselves or others? ☐Yes ☐No

Name of Individual Being Evaluated _____ Date of Birth _____

Section II: Other Indications for PASRR Screen Decision-Making, Continued:

5. Does the individual have a primary diagnosis of:

Dementia? ☐Yes ☐No
Related Neurocognitive Disorder (including Alzheimer's disease)? ☐Yes ☐No

6. Does the individual have a secondary diagnosis of dementia, related neurocognitive disorder (including Alzheimer's disease) and the primary diagnosis is an SMI or ID?

☐Yes ☐No

7. Does the individual have validating documentation to support the dementia or related neurocognitive disorder (including Alzheimer's disease)?

☐ No

☐ Yes (**Check all that apply.** Send accompanying documentation with completed Level I PASRR screen):

- ☐ Dementia work-up
- ☐ Comprehensive mental status exam
- ☐ Medical/functional history prior to onset
- ☐ Other – Specify: _____

A Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder, and a suspicion or diagnosis of an SMI, ID, or both. A Level II PASRR may only be terminated by the Level II PASRR evaluator in accordance with 42 CFR §483.128(m)(2)(i) or 42 CFR §483.128(m)(2)(ii).

Section III: PASRR Screen Provisional Admission or Hospital Discharge Exemption

☐ **Not a provisional admission**
☐ **Provisional admission (choose one)**

☐ **Hospital Discharge Exemption**

If a provisional admission or hospital discharge exemption is indicated, the individual may enter an NF without a Level II PASRR evaluation/determination if the Level I screen indicates a suspicion of SMI, ID or both, and the box in Section II.4 is checked 'no'. A Level II evaluation must be completed, if required, by submitting the documentation for the Level II evaluation to CARES for adults or DOH*** for individuals under the age of 21 years within the time frames indicated in this section.**

☐ The individual being admitted has delirium. The Level II evaluation must be completed within 7 days after the delirium clears.

☐ The individual is being admitted on an emergency basis requiring protective services. The Level II evaluation must be completed within 7 days of admission, on or before (date): _____

☐ The individual is being admitted for caregiver's respite. The Level II evaluation must be completed in advance of the expiration of 14 days if the stay is expected to exceed the 14-day time limit, on or before (date): _____

☐ The individual is being admitted under the 30-day hospital discharge exemption. If the individual's stay is anticipated to exceed 30 days, the NF must notify the Level I screener on the 25th day of stay and the Level II evaluation must be completed no later than the 40th day of admission, on or before (date): _____

An attending physician's signature is required for those individuals admitted under a 30-day hospital discharge exemption.

_____ _____
ATTENDING PHYSICIAN'S SIGNATURE DATE

Name of Individual Being Evaluated

Date of Birth

Section IV: PASRR Screen Completion

Individual may be admitted to an NF (check one of the following):	**Individual may not be admitted to an NF. Use this form and required documentation to request a Level II PASRR evaluation because there is a diagnosis of or suspicion of (check one of the following):**
☐ No diagnosis or suspicion of SMI or ID indicated. Level II PASRR evaluation not required.	☐ SMI ☐ ID ☐ SMI and ID
☐ Provisional admission	
☐ Hospital Discharge Exemption	

******Incomplete forms will not be accepted******

By signing this form below, I attest that I have completed the above Level I PASRR screen for the individual to the best of my knowledge.

Screener's Name (Printed) **Signature**

Credentials **Date** **Phone**

Place of Employment **Fax**

Completed Level I screen **distributed to (check all that apply)**:

☐ Local DOH*** office, for individuals under the age of 21 years

☐ Accompanying documents attached

Date:_____

☐ Local CARES** office, for adults age 21 years or older

Date: _____

☐ Accompanying documents attached

☐ Nursing Facility

Date: _____

☐ Discharging Hospital (if applicable):

Date: _____

Name: **Date:**

Consent for Level II Evaluation and Determination

In order to assess my needs, by signing above, I consent to an evaluation of my medical, psychological and social history. I understand and agree that evaluators may need to talk to my doctor, my family, and close friends to talk about my situation.

If the individual requires a Level II PASRR evaluation, submit the completed Level I PASRR screen, documented informed consent, completed AHCA 5000-3008 form, and other relevant medical documentation including case notes, medication administration records, and any available psychiatric evaluation, or supporting documentation to CARES or DOH for facilitation to the state authority for SMI or ID.

If an individual is unwilling, unable, or has no legal representative or health care agent to sign the consent for Level II PASRR evaluation, information regarding the reason for the inability to obtain the signature must be documented here:

_____

_____

_____

_____

_____

****Florida Department of Elder Affair's Comprehensive Assessment and Review for Long-Term Care Services**

*****Florida Department of Health**

State of Florida
DEPARTMENT OF VETERANS' AFFAIRS
Baldomero Lopez State Veterans' Nursing Home
6919 Parkway Boulevard
Land O' Lakes, FL 34639
Phone: (813) 558-5000 Fax: (813) 558-5021
www.floridavets.org

Ron DeSantis
Governor
Ashley Moody
Attorney General
Jimmy Patronis
Chief Financial Officer
Nikki Fried
Commissioner of Agriculture

Daniel W. "Danny" Burgess, Jr.
Executive Director
Connie Tolley
Division Director
Marlies Sarrett
Administrator

MEDICAL VERIFICATION OF CAPACITY OR INCAPACITY TO GIVE INFORMED CONSENT AND / OR MAKE MEDICAL DECISIONS UPON ADMISSION OR FROM A CHANGE IN CONDITION

I, Dr. _____, the attending / referring physician for

_____, a potential or current resident at Baldomero
(Patient name)

Lopez State Veterans' Nursing Home have evaluated my patient on ____/____/____, and determined that he/she **_____ HAS** or **_____LACKS** capacity to make informed consent and/or medical decisions due to the following conditions:

_____

_____

_____ _____
Attending/Referring Physician Signature Date

This determination is being made as part of the medical record for the purpose of:

1. Initiating the resident's Living Will
2. Commencing and delegating the authority of the resident's Health Care Surrogate
3. Designating a Health Care Proxy for the resident
4. Signing Admission documents to a skilled nursing facility

STATE OF FLORIDA

AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA)
DEPARTMENT OF ELDER AFFAIRS (DOEA)

INFORMED CONSENT FORM

CLIENT'S NAME: _____

DATE OF BIRTH: _____

An assessment is required for all persons applying for or receiving assistance for long-term care. This includes the Institutional Care Program (ICP) and Home and Community-Based Services (HCBS) waiver programs.

In order to evaluate my needs, I am giving my consent to the following:

- **I agree to an assessment to identify my need for long-term care, and to determine if my needs can be met in the community instead of a nursing facility.**

- **I authorize DOEA staff to access my medical records. I understand and agree that DOEA may need to talk to my doctor and other health professionals. I also understand that they may need to interview my family members, close friends and social services professionals about my situation.**

_____
Individual or Representative

_____
Relationship (if representative signs)

_____
Date

AHCA--Med Serv 2040, May 2008

DO NOT RESUSCITATE ORDER

State of Florida
DO NOT RESUSCITATE ORDER
(please use ink)

Patient's Full Legal Name:_____ Date: _____
(Print or Type Name)

PATIENT'S STATEMENT

Based upon informed consent, I, the undersigned, hereby direct that CPR be withheld or withdrawn.
(If not signed by patient, check applicable box):

- ☐ Surrogate
- ☐ Court appointed guardian
- ☐ Proxy (both as defined in Chapter 765, F.S.)
- ☐ Durable power of attorney (pursuant to Chapter 709, F.S.)

_____
(Applicable Signature) (Print or Type Name)

PHYSICIAN'S STATEMENT

I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient's cardiac or respiratory arrest.

_____ (___)___-____
(Signature of Physician) (Date) Telephone Number (Emergency)

_____
(Print or Type Name) (Physician's Medical License Number)

DH Form 1896, Revised December 2004

HEALTH CARE ADVANCED DIRECTIVES

The Patient's Right to Decide

The following information is being provided from the Agency for Healthcare Administration: www:ahca.myflorida.com/mchq

Introduction

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment.

When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about health care will still be respected, the Florida legislature enacted legislation pertaining to health care advance directives (Chapter 765, Florida Statutes). The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold or withdraw life-prolonging procedures, to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions and/or to indicate the desire to make an anatomical donation after death.

By law hospitals, nursing homes, home health agencies, hospices and health maintenance organizations (HMOs) are required to provide their patients with written information, such as this pamphlet, concerning health care advance directives. The state rules that require this include 58A-2.0232, 59A-3.254, 59A-4.106, 59A-8.0245 and 59A-12.013, Florida Administrative Code.

Questions About Health Care Advance Directives

What is an advance directive?

It is a written or oral statement about how you want medical decisions made should you not be able to make them yourself. It can also express your wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with a life-threatening illness and others put their wishes into writing while they are healthy, often as part of their estate planning.

Three types of advance directives are:

- A Living Will
- A Health Care Surrogate Designation
- An Anatomical Donation

You might choose to complete one, two or all three of these forms. This pamphlet provides information to help you decide what will best serve your needs.

What is a living will?

It is a written or oral statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. You may wish to speak to your health care provider or attorney to be certain you have completed the living will in a way that your wishes will be understood.

What is a health care surrogate designation?

It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will. You can also designate an alternate surrogate.

Which is best?

Depending on your individual needs you may wish to complete any one or a combination of the three types of advance directives.

What is an anatomical donation?

It is a document that indicates your wish to donate at death, all or part of your body. This can be an organ and tissue donation to persons in need, or donation of your body for training of health care workers. You can indicate your choice to be an organ

donor by designating it on your driver's license or state identification card (at your nearest driver's license office), signing a uniform donor form (seen elsewhere in this pamphlet) or expressing your wish in a living will.

Am I required to have an advance directive under Florida law?
No, there is no legal requirement to complete an advance directive. However, if you have not made an advance directive, decisions about your health care or an anatomical donation may be made for you by a court-appointed guardian, your wife or husband, your adult child, your parent, your adult sibling, an adult relative or a close friend. The person making decisions for you may or may not be aware of your wishes. When you make an advance directive and discuss it with the significant people in your life, it will better assure that your wishes will be carried out the way you want.

Must an attorney prepare the advance directive?
No, the procedures are simple and do not require an attorney, though you may choose to consult one. However, an advance directive, whether it is a written document or an oral statement, needs to be witnessed by two individuals. At least one of the witnesses cannot be a spouse or a blood relative.

Where can I find advance directive forms?
Florida law provides a sample of each of the following forms: a living will, a health care surrogate and an anatomical donation. Elsewhere in this pamphlet are included sample forms as well as resources where you may find more information and other types of advance directive forms.

Can I change my mind after I write an advance directive?
Yes, you may change or cancel an advance directive at any time. Any changes should be written, signed and dated. However, you may also change an advance directive by oral statement; physical destruction of the advance directive or by writing a new advance directive. If your driver's license or state identification card indicates you are an organ donor but you no longer want this designation, contact the nearest driver's license office to cancel the donor designation and a new license or card will be issued to you.

What if I have filled out an advance directive in another state and need treatment in Florida?
An advance directive completed in another state, as described in that state's law, may be honored in Florida.

What should I do with my advance directive if I choose to have one?
- If you designate a health care surrogate and an alternate surrogate be sure to ask them if they agree to take this responsibility, discuss how you would like matters handled and give them a copy of the document.
- Make sure that your health care provider, attorney, and the significant persons in your life know that you have an advance directive and where it is located. You also may want to give them a copy.
- Set up a file where you keep a copy of your advance directive (and other important paperwork). Some people keep original papers in a bank safety deposit box. If you do, you may want to keep copies at your house or information concerning the location of your safety deposit box.
- Keep a card or note in your purse or wallet that states that you have an advance directive and where it is located.
- If you change your advance directive, make sure your health care provider, attorney and the significant persons in your life have the latest copy.

If you have questions about your advance directive you may want to discuss these with your health care provider, attorney or the significant persons in your life.

Additional Information Regarding Health Care Advance Directives

Before making a decision about advance directives you might want to consider additional options and other sources of information, including the following:

- As an alternative or in addition to a health care surrogate, you might want to designate a durable power of attorney. Through a written document you can name another person to act on your behalf. It is similar to a health care surrogate, but the person can be designated to perform a variety of activities (financial, legal, medical, etc.). You may consult an attorney for further information or read Chapter 709, Florida Statutes.

If you choose someone as your durable power of attorney be sure to ask the person if he or she will agree to take this responsibility, discuss how you would like matters handled, and give the person a copy of the document.

- If you are terminally ill (or if you have a loved one who is in a persistent vegetative state) you may want to consider having a pre-hospital Do Not Resuscitate Order (DNRO). A DNRO identifies people who do not wish to be resuscitated from respiratory or cardiac arrest. The pre-hospital DNRO is a specific yellow form available from the Florida Department of Health (DOH). Your attorney, health care provider or an ambulance service may also have copies available for your use. You, or your legal representative and your physician sign the DNRO form. More information is available on the DOH website, www.doh.state.fl.us or www.MyFlorida.com (type DNRO in these website search engines) or call (850) 245-4440.

  If you are admitted to a hospital the pre-hospital DNRO may be used during your hospital stay or the hospital may have its own form and procedure for documenting a Do Not Resuscitate Order.

- If a person chooses to donate, after death, his or her body for medical training and research the donation will be coordinated by the Anatomical Board of the State of Florida. You, or your survivors must arrange with a local funeral home and pay for a preliminary embalming and transportation of the body to the Anatomical Board located in Gainesville, Florida. After being used for medical education or research, the body will ordinarily be cremated. The remains will be returned to the loved ones, if requested at the time of donation or the Anatomical Board will spread the remains over the Gulf of Mexico. For further information contact the Anatomical Board of the State of Florida at (800) 628-2594 or visit their website at www.med.ufl.edu/anatbd.

- If you would like to read more about organ and tissue donation to persons in need you can view the Agency for Health Care Administration's website at www.fdhc.state.fl.us (Click on "Site Index," then scroll down to "Organ Donors") or the federal government site www.organdonor.gov. If you have further questions you may want to talk with your health care provider.

- Various organizations also make advance directive forms available. One such document is "Five Wishes" that includes a living will and a health care surrogate designation. "Five Wishes" gives you the opportunity to specify if you want tube feeding, assistance with breathing, pain medication and other details that might bring you comfort such as what kind of music you might like to hear, among other things. You can find out more at:

Aging with Dignity
www.agingwithdignity.org
(888) 594-7437

Other resources include:

American Association of Retired Persons (AARP)
www.aarp.org
(Type "advance directives" in the website's search engine)
Partnership for Caring
www.partnershipforcaring.org
(800) 989-9455

Your local hospital, nursing home, hospice, home health agency and your attorney or health care provider may be able to assist you with forms or further information.

Brochure: End of Life Issues
www.FloridaHealthStat.com (Under Reports and Guides)
(888) 419-3456

FACILITY CHARACTERISTICS/LIMITATIONS

Special Characteristics:

This is a 120-bed facility providing skilled nursing care and can accommodate 58 residents with dementia/Alzheimer's disease.

Service Limitations:

This facility will assess all potential and current residents, and determine admission or continued residency based on the facility's ability to accommodate the needs of the resident.