

STATE OF FLORIDA DEPARTMENT OF VETERANS' AFFAIRS



RESIDENT STANDARD APPLICATION PACKET

**Emory L. Bennett Veteran's Nursing Home
1920 Mason Ave.
Daytona Beach, FL 32117
386-274-3460**

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STATE OF FLORIDA
DEPARTMENT OF VETERANS' AFFAIRS

**APPLICATION FOR CONSIDERATION FOR ADMISSION
GENERAL INFORMATION**

This facility is a 120-bed skilled nursing facility. 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.

Room and board monthly payments are calculated based on each resident's personal income (SS, VA benefits, pensions, interest, required minimum distribution(s), etc.), minus \$105.00 monthly allowance for personal needs. The maximum cost per day is \$___191.03___ for a semi-private room and \$___192.56___ for a private room. Should the resident's income exceed the maximum cost per day, other charges may ensue (medications). We require the resident to apply for Medicaid upon admission to help defray the cost of care. The daily rate will 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

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
- X-ray Services
- Laboratory Charges
- Physical, Occupational and Speech Therapy
- Physician visits such as attending, Podiatrist, Ophthalmologist
- Private Sitters or Personal Care Attendants
- Transportation or non-emergency ambulance travel
- Beauty / Barber charges (Cash or Resident Trust Fund needed)

If over the daily maximum monetary limit, then the following services are not covered in the daily room rate:

- Unit Dose Prescription Medication

MEDICAID

Medicaid pays the Nursing Home an established daily room rate per day minus the resident's gross income and \$105.00 monthly allowance for personal needs.

ELIGIBILITY FOR THE PERSON IN THE NURSING HOME:

For an individual to be eligible for ICP Medicaid assistance, there are four requirements considered, which are: an assessment by the Department of Elder Affairs, income limits, asset limits, and a five-year "look back" period.

The income limit to determine eligibility changes yearly and changes are made per Medicaid guidelines as established by the Department of Children and Families.

FOR YOUR SPOUSE AT HOME:

When an individual qualifies for Medicaid, the spouse gets to keep his or her own income regardless of the amount. To find out if you qualify for this benefit, you must check with the Medicaid program office handling your application.

HOW DO I APPLY FOR BENEFITS?

If we feel as though the resident meets the above criteria, or will meet the criteria soon after entering a skilled nursing home, we will assist with the Medicaid application within 10 days of admission. If criteria are met before admission to a skilled nursing home, an application can be filed with Department of Children and Families Services 30 days prior to admission.

MEDICARE

While it is true that Medicare will pay for up to 100 days of skilled nursing home care, the resident must first have a three day hospital qualifying stay and the care received must not be primarily for custodial purposes.

Summary of Medicare Benefits – up to 100 Days

For days	Medicare pays for covered services	You pay for covered services
1–20	Full cost	Nothing
21–100	All but a daily coinsurance*	A daily coinsurance*
Beyond 100	Nothing	Full cost

* There is a Medicare Part A co-insurance daily rate due from the resident while under a Medicare Part A stay beginning with the 21st day of covered services, and this rate changes annually based on Medicare. Your supplemental insurance or Medicaid (if applicable) may pay this co-insurance. Please be sure to give the Admission Coordinator your supplemental insurance information at time of admission. If there are any changes to your primary or supplemental insurance policies after admission, the Business Office must be contacted within 10 calendar days of any change(s). Failure to do so may result in the resident incurring any and/or all incurred charges for services.

You must also remember that as resident progresses in their recovery, a determination will be made as to the level of care still required. At some point during recovery, skilled nursing or rehabilitative care may no longer be needed and Medicare payments will cease.

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
- FINANCIAL INFORMATION RELEASE – **MUST BE NOTARIZED**
- VETERAN’S CONTACT INFO, MORTUARY, AND PRIMARY CONTACT INFORMATION
- FAMILY QUESTIONNAIRE
- CUSTOMARY ROUTINES
- PERSONAL PROFILE
- INCOME TAX STATEMENT FORM - IF APPLICABLE
- REQUEST FOR COPY OF TAX STATEMENT – IF APPLICABLE
- AUTHORIZATION TO RELEASE MEDICAL RECORDS AND HEALTH INFORMATION
- AGENCY FOR HEALTH CARE ADMINISTRATION / DEPT OF ELDER AFFAIRS INFORMED CONSENT
- COPY OF CURRENT NOCA (IF APPLICABLE)

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

- “3008” - MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM
- MEDICAL VERIFICATION OF CAPACITY OR INCAPACITY

MEDICAL INFORMATION AND OTHER 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)
- COPY OF SERVICE CONNECTED AWARD LETTER (IF APPLICABLE)

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

- PROOF OF MILITARY HONORABLE DISCHARGE DOCUMENTS – **ONLY ONE FORM IS NECESSARY**
- DD214
 - VA ELECTRONIC RECORD (SHARE)
 - WD ADGO 53
 - 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)

FINANCIAL INFORMATION REQUIRED

Proof of all income is required to determine Cost of Care

TO DETERMINE COST OF CARE FOR ANY VETERAN WITH A SERVICE CONNECTED DISABILITY OF LESS THAN 70% PLEASE PROVIDE THE FOLLOWING:

- Yes No Does the veteran have a service connected disability less than 70%? If yes, please provide a copy of the veteran's current VA Summary of Benefits.
- Yes No Does the veteran currently receive Social Security benefits? If yes, please provide a copy of the veteran's most recent Social Security Benefit Letter (not the Social Security tax statement)
- Yes No Does the veteran currently receive Aid & Attendance? If yes, please provide a copy of the veteran's most recent Aid & Attendance Benefit Letter.
- Yes No Does the veteran receive a pension? If yes, please provide a copy of the veteran's most recent pension statement.
- Yes No Does the veteran have any investment accounts or received a Required Minimum Distribution? If yes, please provide copies of the most recent 3 months statements for each account. Please include ALL pages of each statement.
- Yes No Does the veteran receive any income from rental property? If yes, please provide a copy of the current rental agreement for each property.
- Yes No Does the veteran currently have a Medicare supplemental insurance? If yes, please provide a copy of the veteran's most recent statement from the supplemental insurance company that states the cost of the monthly premium for the Medicare supplemental insurance.
- Yes No Does the veteran have any bank accounts (savings, checking)? If yes, please provide copies of the most recent 3 months statements for each account. Please include ALL pages of each statement and make sure the veteran's name is printed on each statement. Some statements printed from a home computer do not have the veteran's name.
- Yes No Did the veteran file a tax return for the last year? If yes, please provide a copy of the tax return. If the veteran did not file or will not file for the most recent year, please complete the **INCOME TAX STATEMENT** form (page 23 of application packet). If the resident completed a tax return and needs to request a copy from the IRS, please complete the **REQUEST FOR COPY OF TAX RETURN**.



**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 <input type="checkbox"/>	Hospital <input type="checkbox"/>	Nursing Home <input type="checkbox"/>
PHONE NUMBERS		Retirement Home <input type="checkbox"/>	Boarding Home <input type="checkbox"/>	Other <input type="checkbox"/> explain:
		Home:	Work:	Other:
Date of Birth		Birthplace		Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>				
Date of Marriage: _____			Date of Divorce: _____	
Have you been a patient or resident in a hospital or nursing home during the past year? YES <input type="checkbox"/> NO <input type="checkbox"/>				
Name of Facility: _____ Address of Facility: _____				
Have you been treated in a Federal VA facility before? YES <input type="checkbox"/> NO <input type="checkbox"/> If so, where? _____ Please give dates: _____				
Have you ever been convicted of a Felony? Yes <input type="checkbox"/> No <input type="checkbox"/> 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		SPOUSE	
	Gross	Net	Gross	Net
VA Pension/VA Compensation				
Social Security				
U.S. Civil Service				
U.S. Railroad Retirement				
Military Retirement				
Employment				
Other Retirement, or Income	ASSET VALUE/MONTHLY INCOME		ASSET VALUE/MONTHLY INCOME	
Source: _____	_____		_____	
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. If admitted, I understand that all of my income, regardless of source, may be contributed toward the cost of my care. I will be allowed to retain \$105.00 for my own personal use. If my income is above the calculated cost of care, I will be required to pay the full amount. 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 APPLY FOR ALL FINANCIAL ASSISTANCE AVAILABLE TO ME INCLUDING MEDICAID. 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 <i>(Last, First, Middle Name)</i>			1B. PREFERRED NAME		2. MOTHER'S MAIDEN NAME	
3A. BIRTH SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	3B. SELF-IDENTIFIED GENDER IDENTITY <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	4. ARE YOU SPANISH, HISPANIC, OR LATINO? <input type="checkbox"/> YES <input type="checkbox"/> NO	5. WHAT IS YOUR RACE? <i>(You may check more than one. Information is required for statistical purposes only.)</i> <input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER			6. SOCIAL SECURITY NO.
7. VA CLAIM NUMBER		8A. DATE OF BIRTH <i>(mm/dd/yyyy)</i>		8B. PLACE OF BIRTH <i>(City and State)</i>		9. RELIGION
10A. PERMANENT ADDRESS <i>(Street)</i>			10B. CITY	10C. STATE	10D. ZIP CODE	10E. COUNTY
10F. HOME TELEPHONE NO. <i>(Include area code)</i>		10G. MOBILE TELEPHONE NO. <i>(Include area code)</i>		10H. E-MAIL ADDRESS		
11A. RESIDENTIAL ADDRESS <i>(Street)</i>			11B. CITY	11C. STATE	11D. ZIP CODE	11E. COUNTY
12. TYPE OF BENEFIT(S) APPLYING FOR <i>(You may check more than one)</i> <input type="checkbox"/> ENROLLMENT/HEALTH SERVICES <input type="checkbox"/> DENTAL			13. CURRENT MARTIAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			
14A. NEXT OF KIN NAME		14B. NEXT OF KIN ADDRESS			14C. NEXT OF KIN RELATIONSHIP	
14D. NEXT OF KIN TELEPHONE NO. <i>(Include Area Code)</i>	14E. NEXT OF KIN WORK TELEPHONE NO. <i>(Include Area Code)</i>	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 <i>(Note: This does not constitute a will or transfer of title)</i>				
16. I AM ENROLLING TO OBTAIN MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT <input type="checkbox"/> YES <input type="checkbox"/> NO		17. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? <i>(for listing of facilities visit www.va.gov/directory)</i>			18. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	

SECTION II - MILITARY SERVICE INFORMATION

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

APPLICATION FOR HEALTH BENEFITS <i>Continued</i>	VETERAN'S NAME <i>(Last, First, Middle)</i>	SOCIAL SECURITY NUMBER
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SECTION III - INSURANCE INFORMATION (Use a separate sheet for additional information)

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

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

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

SECTION V - EMPLOYMENT INFORMATION

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

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

SECTION VII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

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

APPLICATION FOR HEALTH BENEFITS <i>Continued</i>	VETERAN'S NAME <i>(Last, First, Middle)</i>	SOCIAL SECURITY NUMBER
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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.			
<input type="checkbox"/> 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:			
<input type="checkbox"/> DRUG ABUSE	<input type="checkbox"/> INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)		
<input type="checkbox"/> ALCOHOLISM OR ALCOHOL ABUSE	<input type="checkbox"/> 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.			
<input type="checkbox"/> 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 5, 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: <input type="checkbox"/> VR&E FILE <input type="checkbox"/> EDU FILE <input type="checkbox"/> LG FILE <input type="checkbox"/> 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 21-22
AUG 2015

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



State of Florida
DEPARTMENT OF VETERANS' AFFAIRS

Emory L. Bennett Veteran's Nursing Home

1920 Mason Ave.
Daytona Beach, FL 32117
Phone: (386) 274-3460 Fax: (386) 274-3487
www.floridavets.org

Rick Scott
Governor
Pam Bondi
Attorney General
Jimmy Patronis
Chief Financial Officer
Adam Putnam
Commissioner of Agriculture

Glenn W. Sutphin Jr.
Executive Director
Connie Tolley
Division Director
Gray Kilpatrick
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



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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
Discharge summary
History & physical
X-ray/Lab/EKG reports
MDS
Physician's progress notes
Nursing notes
Care plans
Medication list
Dietary notes
Activity 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
<input type="checkbox"/>	Wandering		
<input type="checkbox"/>	Continuous pacing		
<input type="checkbox"/>	Repetitive behaviors (words, actions)		
<input type="checkbox"/>	Withdrawn/depressed (long periods of time inactive)		
<input type="checkbox"/>	Appears anxious, worried		
<input type="checkbox"/>	Crying, tearful		
<input type="checkbox"/>	Comments about death of self or others		
<input type="checkbox"/>	Sleep disturbances (insomnia or frequent napping)		
<input type="checkbox"/>	Mood swings (sudden changes in mood)		
<input type="checkbox"/>	Over-eating		
<input type="checkbox"/>	Under-eating		
<input type="checkbox"/>	Clinging (to caregiver, can't leave sight)/needs reassurance		
<input type="checkbox"/>	Verbally abusive (curses, screams, threatens)		
<input type="checkbox"/>	Physically abusive (strikes out, grabs)		
<input type="checkbox"/>	Rummaging or hoarding (goes through garbage or hides things)		
<input type="checkbox"/>	Inappropriate toileting habits		
<input type="checkbox"/>	Inappropriate sexual behavior		
<input type="checkbox"/>	Sun-downing behavior (difficult behaviors or increased confusion occurs in late afternoon)		
<input type="checkbox"/>	Hallucinations (hears or sees things that are not there)		
<input type="checkbox"/>	Delusions (tells stories that are not fact based)		
<input type="checkbox"/>	Suspiciousness, paranoia		
<input type="checkbox"/>	Resistant to care, stiffening, rigidity, refusal		
<input type="checkbox"/>	Repetitive verbalizations or behaviors		
<input type="checkbox"/>	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:

- | | |
|---|--|
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Wheelchair |
| <input type="checkbox"/> Hearing Aids | <input type="checkbox"/> Motorized Conveyance |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Wheel chair cushion,
Who Provided? _____ |
| <input type="checkbox"/> Cane | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Artificial limbs | |
| <input type="checkbox"/> Crutches | |
| <input type="checkbox"/> Walker | |

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: _____



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INCOME TAX STATEMENT FORM

Name: _____

Date: _____

This is to certify that the above named Veteran and applicant for admission did not file Federal Taxes for the preceding year(s) of

Reason Federal Taxes not filed: _____

Signature: _____

Relationship to Veteran: _____

REQUEST FOR COPY OF TAX RETURN

Form **4506-T**
(July 2017)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

- ▶ Do not sign this form unless all applicable lines have been completed.
- ▶ Request may be rejected if the form is incomplete or illegible.
- ▶ For more information about Form 4506-T, visit www.irs.gov/form4506t.

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946. If you need a copy of your return, use Form 4506, Request for Copy of Tax Return. There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)
2a If a joint return, enter spouse's name shown on tax return.	2b Second social security number or individual taxpayer identification number if joint tax return
3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)	
4 Previous address shown on the last return filed if different from line 3 (see instructions)	
5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.	

Caution: If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 Transcript requested. Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ _____

a Return Transcript, which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days

b Account Transcript, which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days

c Record of Account, which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days

7 Verification of Nonfiling, which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days

8 Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript. The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2011, filed in 2012, will likely not be available from the IRS until 2013. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 Year or period requested. Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

/ / / / / / / / / / /

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T. See instructions.

Phone number of taxpayer on line 1a or 2a _____

Sign Here	▶ Signature (see instructions)	Date
	▶ Title (if line 1a above is a corporation, partnership, estate, or trust)	
	▶ Spouse's signature	Date

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506-T and its Instructions, go to www.irs.gov/form4506t. Information about any recent developments affecting Form 4506-T (such as legislation enacted after we released it) will be posted on that page.

General Instructions

Caution: Do not sign this form unless all applicable lines have been completed.

Purpose of form. Use Form 4506-T to request tax return information. You can also designate (on line 5) a third party to receive the information. Taxpayers using a tax year beginning in one calendar year and ending in the following year (fiscal tax year) must file Form 4506-T to request a return transcript.

Note: If you are unsure of which type of transcript you need, request the Record of Account, as it provides the most detailed information.

Tip. Use Form 4506, Request for Copy of Tax Return, to request copies of tax returns.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946.

Where to file. Mail or fax Form 4506-T to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual transcripts (Form 1040 series and Form W-2) and one for all other transcripts.

If you are requesting more than one transcript or other product and the chart below shows two different addresses, send your request to the address based on the address of your most recent return.

Chart for individual transcripts (Form 1040 series and Form W-2 and Form 1099)

If you filed an individual return and lived in:	Mail or fax to:
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AJUSC Austin, TX 73301
Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	Internal Revenue Service RAIVS Team Stop 37106 Fresno, CA 93888
Connecticut, Delaware, District of Columbia, Florida, Georgia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia	Internal Revenue Service RAIVS Team Stop 6705 P-6 Kansas City, MO 64999

Chart for all other transcripts

If you lived in or your business was in:	Mail or fax to:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team P.O. Box 145500 Stop 2800 F Cincinnati, OH 45250

Line 1b. Enter your employer identification number (EIN) if your request relates to a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.


Line 3. Enter your current address. If you use a P.O. box, include it on this line.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note: If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address. For a business address, file Form 8822-B, Change of Address or Responsible Party — Business.

Line 6. Enter only one tax form number per request.

Signature and date. Form 4506-T must be signed and dated by the taxpayer listed on line 1a or 2a. The IRS must receive Form 4506-T within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines are completed before signing.

 You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked.

Individuals. Transcripts of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506-T exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506-T can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506-T but must provide documentation to support the requester's right to receive the information.

Partnerships. Generally, Form 4506-T can be signed by any person who was a member of the partnership during any part of the tax period requested on line 9.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Note: If you are heir at law, next of kin, or beneficiary you must be able to establish a material interest in the estate or trust.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506-T for a taxpayer only if the taxpayer has specifically delegated this authority to the representative on Form 2848, line 5. The representative must attach Form 2848 showing the delegation to Form 4506-T.

Privacy Act and Paperwork Reduction Act Notice.

We ask for the information on this form to establish your right to gain access to the requested tax information under the Internal Revenue Code. We need this information to properly identify the tax information and respond to your request. You are not required to request any transcript; if you do request a transcript, sections 6103 and 6109 and their regulations require you to provide this information, including your SSN or EIN. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506-T will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form, 10 min.;** **Preparing the form, 12 min.;** and **Copying, assembling, and sending the form to the IRS, 20 min.**

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506-T simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send the form to this address. Instead, see **Where to file** on this page.

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: _____

<p>*A. PATIENT INFORMATION</p> <p>*Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female *Hispanic Ethnicity: <input type="checkbox"/> Yes <input type="checkbox"/> No *Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Other: _____ *Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____</p> <p>*B. SIGHT HEARING</p> <p><input type="checkbox"/> Normal <input type="checkbox"/> Impaired <input type="checkbox"/> Deaf <input type="checkbox"/> Normal <input type="checkbox"/> Impaired <input type="checkbox"/> Blind <input type="checkbox"/> Hearing Aid <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>C. DECISION MAKING CAPACITY (PATIENT)</p> <p><input type="checkbox"/> Capable to make healthcare decisions <input type="checkbox"/> Requires a surrogate</p> <p>*D. EMERGENCY CONTACT</p> <p>Name: _____ Name: _____ Phone: _____ Phone: _____</p> <p>*E. MEDICAL CONDITION</p> <p>*Primary diagnosis: _____ *Other diagnoses: _____</p> <p>If Hospitalized: Primary diagnosis at discharge: _____ Reason for transfer: _____ Surgical procedures performed: _____</p> <p>F. INFECTION CONTROL ISSUES</p> <p>PPD Status: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not known Screening date: _____ Associated Infections/resistant organisms: _____</p> <p><input type="checkbox"/> MRSA Site: _____ <input type="checkbox"/> VRE Site: _____ <input type="checkbox"/> ESBL Site: _____ <input type="checkbox"/> MDRO Site: _____ <input type="checkbox"/> C-Diff Site: _____ <input type="checkbox"/> Other: Site: _____</p> <p>Isolation Precautions: <input type="checkbox"/> None <input type="checkbox"/> Contact <input type="checkbox"/> Droplet <input type="checkbox"/> Airborne</p> <p>*G. PATIENT RISK ALERTS</p> <p><input type="checkbox"/> *None Known <input type="checkbox"/> *Harm to self <input type="checkbox"/> *Difficulty swallowing <input type="checkbox"/> *Elopement <input type="checkbox"/> *Harm to others <input type="checkbox"/> *Seizures <input type="checkbox"/> *Pressure Ulcers <input type="checkbox"/> *Falls <input type="checkbox"/> *Other: _____</p> <p>RESTRAINTS: <input type="checkbox"/> Yes <input type="checkbox"/> No Types: _____</p> <p>Reasons for use: _____</p> <p>ALLERGIES: <input type="checkbox"/> None Known <input type="checkbox"/> Yes, List below: _____</p> <p>Latex Allergy: <input type="checkbox"/> Yes <input type="checkbox"/> No Dye Allergy/Reaction: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>H. ADVANCE CARE PLANNING</p> <p>Please ATTACH any relevant documentation:</p> <p>Advance Directive <input type="checkbox"/> Yes <input type="checkbox"/> No Living Will <input type="checkbox"/> Yes <input type="checkbox"/> No DO NOT Resuscitate (DNR) <input type="checkbox"/> Yes <input type="checkbox"/> No DO NOT Intubate <input type="checkbox"/> Yes <input type="checkbox"/> No DO NOT Hospitalize <input type="checkbox"/> Yes <input type="checkbox"/> No No Artificial Feeding <input type="checkbox"/> Yes <input type="checkbox"/> No Hospice <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>I. TRANSFERRED FROM</p> <p>Facility Name: _____ Date: _____ Unit: _____ Phone: _____ Fax: _____ Discharge Nurse: _____ Phone: _____ Admit Date: _____ Discharge Date: _____ Admit Time: _____ AM <input type="checkbox"/> PM <input type="checkbox"/> Discharge Time: _____ AM <input type="checkbox"/> PM <input type="checkbox"/></p> <p>J. TRANSFERRED TO</p> <p>Facility Name: _____ Address 1: _____ Address 2: _____ Phone: _____ Fax: _____</p> <p>K. PHYSICIAN CONTACTS</p> <p>Primary Care Name: _____ Phone: _____ Hospitalist Name: _____ Phone: _____</p> <p>L. TIME SENSITIVE CONDITION SPECIFIC INFORMATION</p> <p>Medication due near time of transfer / list last time administered Script sent for controlled substances (attached): <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Anticoagulants Date: _____ Time: _____ AM <input type="checkbox"/> PM <input type="checkbox"/> <input type="checkbox"/> Antibiotics Date: _____ Time: _____ AM <input type="checkbox"/> PM <input type="checkbox"/> <input type="checkbox"/> Insulin Date: _____ Time: _____ AM <input type="checkbox"/> PM <input type="checkbox"/> <input type="checkbox"/> Other: Date: _____ Time: _____ AM <input type="checkbox"/> PM <input type="checkbox"/></p> <p>Has CHF diagnosis: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes; new/worsened CHF present on admission? <input type="checkbox"/> Yes <input type="checkbox"/> No Last echocardiogram: Date: _____ LVEF _____ %</p> <p>On a proton pump inhibitor? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was it for: <input type="checkbox"/> In-hospital prophylaxis and can be discontinued <input type="checkbox"/> Specific diagnosis: _____</p> <p>On one or more antibiotics? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify reason(s): _____</p> <p>Any critical lab or diagnostic test pending at the time of discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list: _____</p> <p>M. PAIN ASSESSMENT:</p> <p>Pain Level (between 0 - 10): _____ Last administered: Date: _____ Time: _____ AM <input type="checkbox"/> PM <input type="checkbox"/></p> <p>*N. FOLLOWING REPORTS ATTACHED</p> <p><input type="checkbox"/> Physicians Orders <input type="checkbox"/> Treatment Orders <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Includes Wound Care <input type="checkbox"/> Medication Reconciliation <input type="checkbox"/> Lab reports <input type="checkbox"/> Discharge Medication List <input type="checkbox"/> X-ray <input type="checkbox"/> EKG <input type="checkbox"/> PASRR Forms <input type="checkbox"/> CT Scan <input type="checkbox"/> MRI <input type="checkbox"/> Social and Behavioral History <input type="checkbox"/> History & Physical</p> <p>*ALL MEDICATIONS: (MUST ATTACH LIST)</p> <p>_____</p>
---	--

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: _____ SpO2: _____

***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**

<p>*Ambulation: <input type="checkbox"/> Not ambulatory <input type="checkbox"/> Ambulates independently <input type="checkbox"/> Ambulates with assistance <input type="checkbox"/> Ambulates with assistive device</p>	<p>*Transfer: <input type="checkbox"/> Self <input type="checkbox"/> Assistance <input type="checkbox"/> 1 Assistant <input type="checkbox"/> 2 Assistants</p>
<p>Devices: <input type="checkbox"/> Wheelchair (type): _____ <input type="checkbox"/> Appliances: <input type="checkbox"/> Prosthesis: <input type="checkbox"/> Lifting Device:</p>	<p>Weight-bearing: Left: <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> None Right: <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> None</p>

***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

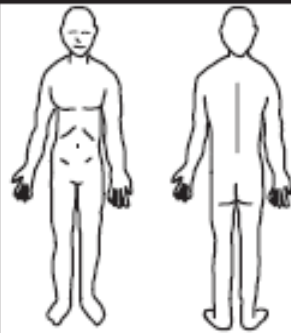
*Effective date of medical condition: _____ *Physician/ARNP/PA License #: _____
 *Physician/ARNP/PA Signature: _____ *Date: _____
 *Printed Physician/ARNP/PA Name & Title: _____ *Phone Number: _____

Z. PERSON COMPLETING FORM

Name: _____ Phone Number: _____ Date: _____

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: _____



State of Florida
DEPARTMENT OF VETERANS' AFFAIRS
Emory L. Bennett Veteran's Nursing Home
 1920 Mason Ave.
 Daytona Beach, FL 32117
 Phone: (386) 274-3460 Fax: (386) 274-3487
 www.floridavets.org

Rick Scott
 Governor
Pam Bondi
 Attorney General
Jimmy Patronis
 Chief Financial Officer
Adam Putnam
 Commissioner of Agriculture

Glenn W. Sutphin Jr.
 Executive Director
Connie Tolley
 Division Director
Gray Kilpatrick
 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
 (Patient name)

Facility Name 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

Important!
In order to be legally valid this form **MUST** be printed on yellow paper prior to being completed. EMS and medical personnel are only required to honor the form if it is printed on yellow paper.

This box will not show up when the form is printed.



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
- Proxy (both as defined in Chapter 765, F.S.)
- Court appointed guardian
- 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)

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 facility has no special characteristics.

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.