ROBERT H. JENKINS JR. VETERANS' DOMICILIARY HOME OF FLORIDA APPLICATION PACKET

751 SE Sycamore Terrace
Lake City, Florida 32025
Phone: (386) 758-0600
Fax (386) 758-0549

WWW.FLORIDAVETS.ORG

ASSISTED LIVING FOR VETERANS
LICENSE #ALF7975

FDVA

FLORIDA DEPARTMENT OF VETERANS' AFFAIRS

Honoring those who served U.S.

ROBERT H. JENKINS JR VETERANS' DOMICILIARY HOME OF FLORIDA

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BASIC ADMISSION CRITERIA

- Be an honorably discharge veteran.
- Not in need of nursing home level of care.
- If you are dependent on a wheelchair for ambulation you must be able to transfer in/out of chair independently.
- Power scooters are **not allowed** inside the facility, they may be used outside the building and in the community. A sheltered area is provided outside the building for residents to store and charge scooters. We **do allow** power wheelchairs in the building. If your power wheelchair was not issued by VA you will need an order from your physician stating that you have need of a power wheelchair.
- At the time of admission, you must have photo identification, in the form of a driver's license, state ID card, VA card, or bank debit card with photo.
- We are unable to admit residents that are on kidney dialysis.
- We are unable to admit residents that have aspiration precautions or have need of thickened liquids.
- Due to county and city ordinances anyone who is on the sex offender registry cannot reside in this facility.
- Personal pets are not allowed into the home.

If you have any questions regarding admission criteria, please contact the admission coordinator at 386-758-0600 ext. 1005

APPLICATION PROCESS

- When an application is submitted it is reviewed for all needed documents. If any additional paperwork is required the admission coordinator will request the information from applicant or person that submitted application.
- When all needed documents are obtained application is routed to the admissions committee for review.
- The review committee consist of the following:

Director of Nursing is reviewing the medical information to assess level of care needs and appropriateness for ALF placement.

Licensed Clinical Social Worker reviewing for any psychiatric, substance abuse, or behavior issues.

Business Manager verifying that proof of income was provided.

When the admission committee has completed their review the file is forwarded to the administrator for final approval.

- When the administrator approves the application a letter is sent to the applicant asking them to call and make an appointment to come in for a face-to-face visit with the admissions committee.
- If an application is denied by the administrator a letter will be sent to the applicant with reason for denial and information about the appeal process.

If you have any questions regarding the review process, please contact the admission coordinator at 386-758-0600 ext. 1005

ROBERT H. JENKINS JR. VETERANS' DOMICILIARY HOME OF FLORIDA

WHAT WE PROVIDE FOR YOUR COST OF CARE

- Housing
- Utilities
- Transportation within the community and to local medical appointments
- Three hot meals and evening snack each day
- A nurse on duty everyday around the clock
- Housekeeping services provided weekly
- Furnished room
- Towels and linens provided
- TV and satellite
- Laundry facilities on site at no charge
- Numerous activities in and out of the home
- Assistance with activities of daily living as needed: bathing, dressing, grooming, medication management

EXCELLENT ASSISTED LIVING CARE FOR OUR VETERANS

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WHAT DOES IT COST MONTHLY TO LIVE IN THE HOME?

Robert H. Jenkins, Jr. Veterans' Domiciliary Home of Florida
(Effective January 1, 2020)

To calculate your cost of living in our Home, you will need to use your **NET MONTHLY INCOME.**

(For ALF Level of Care):
IF YOUR NET MONTHLY INCOME IS:

$1764.55 or more, your monthly cost of care is **$1619.55**

IF YOUR NET MONTHLY INCOME IS:

Less than **$1619.55** use the following formula:

FORMULA

	$	**(Your Net Monthly Income)**
Minus -	**$ 145.00**	**(Your Personal Use Funds)**
	$	**(Your Monthly Cost for DOUBLE OCCUPANCY ROOM)**

A limited number of private rooms are available the rate is **$1698.85** per month.

A veteran who receives an income from any source of more than **$145.00** per month shall contribute to his/her monthly cost to live in our Home.

Any veteran who receives **back pay from any source** will be responsible for a monthly co-payment from his/her **LATEST ADMISSION DATE TO THE CURRENT DATE.**

Our Home **EXTENDED CONGREGATE CARE (ECC)** unit monthly cost is higher. If your income is less than the full cost of care, these services will still be provided regardless of ability to pay. For information, please phone (386) 758-0600, extension 1005.

Please read and understand: ***"Cost of care for living in our Home is subject to change with a 30-day written notice."***

Robert H. Jenkins, Jr. Veterans' Domiciliary Home of Florida

DOCUMENTS NEEDED FOR APPLICATION TO OUR HOME

PLEASE READ THIS ENTIRE DOCUMENT IT CONTAINS VERY IMPORTANT INFORMATION CONCERNING THE APPLICATION PROCESS AND WHAT TO PROVIDE WITH YOUR APPLICATION PACKET.

- Completed and signed application (to be signed by applicant, power of attorney, or legal guardian) if guardian or POA is signing application please include this information with application. **10 pages**
- VA form 10-5345 (Medical Release Form for VA) (To be signed and dated by applicant) (attached) **2 pages**
- AHCA Form 1823 – resident health assessment for assisted living facilities (to be completed by Physician, DO, PA, or ARNP) (attached) **4 pages**
- VA form 1010SH – this form is to be completed by a VA physician (attached) **2 pages**
- Copy of current medication list
- Current medical diagnosis/problem list
- Medical progress notes from your last two visits with Primary Care Physician, if you are followed by psychiatry or psychology progress notes from last two visits. Discharge summary from your last hospital admission if you have been hospitalized in the last three months. (you may have the physician's office or hospital fax the notes to our facility, attention admissions coordinator, fax number (386)758-0549.
- PPD results less than 30 days old (this is a test for tuberculosis) or chest x-ray results less than one-year-old.
- Copy of most recent lab results.
- Copy of DD214 (MILITARY DISCHARGE) If you need information on applying for a DD214 please contact the admissions coordinator for assistance (386) 758-0600 ext. 1005

Please note that your application cannot be processed without valid proof of service.

- If you are on probation or parole, please send a copy of the conditions/terms of your probation/parole.

- If you have a power of attorney (for financial, health care, or both) health care surrogate, a legal guardian, advance directives (living will) please provide copies of these documents.

- Copy of a current bank statement that shows the direct deposit of your benefits. If your benefits are not direct deposited to your bank please provide documentation of your income/benefit. Considered income sources are retirement, Social Security, SSI, OSS, VA pension or compensation (service connected and non-service connected), interest income from stocks, bonds, cd's, etc.

- If you have any deductions from your income child support, alimony, IRS, arrears payment please provide this documentation.

Please note that your application cannot be processed without valid proof of income.

If you have any questions about needed documents, please contact the admissions coordinator for assistance. (386)758-0600 ext.1005

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Honoring those who served U.S

Robert H. Jenkins, Jr. Veterans' Domiciliary Home of Florida, 751 SE Sycamore Terrace
Lake City, Florida 32025

APPLICATION FOR CERTIFICATE OF ELIGIBILITY (C.O.E.)

NAME: _____
Last First Middle Suffix

Name you prefer to be called: _____

Date of Birth: ____/____/____ AGE: _____ Male ☐ Female ☐
Month Day Year

Social Security Number: _____

Phone Number: _____ Cell Phone Number: _____

Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

E-mail address: _____

Marital Status: Married☐, Divorced☐, Separated☐, Widowed☐, Single☐, Significant other☐

If married date of marriage: _____

If divorced/widowed date you were divorced/widowed: _____

Race (please check appropriate box below):
☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander
☐ Black, Not of Hispanic Origin ☐ Hispanic
☐ White, Not of Hispanic Origin

Have you previously resided in our Home? NO - ☐ YES - ☐

If YES: a) When did you leave? _____/_____

b) Please give the reason for leaving. _____

How did you hear about our home?

_____

What are your current living arrangements?

☐ Independently ☐ With a family member ☐ Assisted living

☐ Nursing home ☐ Shelter ☐ Homeless ☐ Hotel ☐ Other _____

Military Service Information

Date of Enlistment Month/ Day/ Year	Date of Discharge Month/ Day/ Year	Branch of Service	Military Service #

Type of discharge: Honorable☐, Under Honorable Conditions☐, General☐, Medical☐, Retired ☐

Wars/Conflicts (check those that apply):

☐ World War II ☐ Korean War ☐ Vietnam ☐ Vietnam Era
☐ Grenada ☐ Panama ☐ Persian Gulf War
☐ Somalia ☐ Bosnia ☐ Haiti
☐ Kosovo-Yugoslav ☐ War on Terrorism ☐ Operation Enduring Freedom
☐ Operation Iraqi Freedom ☐ _____ ☐ _____

Were you ever a POW? ☐ Yes ☐ No If YES, where? _____

Are you a Purple Heart Recipient? ☐ Yes

Are you a Pearl Harbor survivor? ☐ Yes

Theater of Operation(s) (i.e., Europe, Korea, China, Vietnam, Pacific, Atlantic):

1. _____ 3. _____
2. _____ 4. _____

Military Honors (awards/medals) (i.e., Good Conduct Medal, Medal of Honor, Purple Heart):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Veteran Service Organization(s) in which you have current membership (i.e., American Legion, Veterans of Foreign Wars (VFW), AMVETS, Disabled American Veterans (DAV).

1. _____ 3. _____
2. _____ 4. _____

Financial Information

Monthly Net Income:

Retirement: $_____._____

Social Security: $_____._____

SSI: $_____._____
Was this benefit granted due to a mental health diagnosis?
YES - ☐ NO - ☐

SSDI: $_____._____
Was this benefit granted due to a mental health diagnosis?
YES - ☐ NO - ☐

OSS: $_____._____

Pension (Including VA NSC Pension): $_____._____

Compensation (Including VA service connected): $_____._____

Interest/ Dividends: $_____._____

All other income: $_____._____

Do you have a Service Connected Disability Rating YES ☐ NO ☐ Percentage: _____%

What is your service connected disability? _____

Which of the following ways do you receive your benefit(s)/income:

Direct Deposit to your bank account☐, on a debit card☐, in the mail☐, representative payee ☐

Who handles your finances?
Fiduciary ☐ Guardian ☐ POA ☐ Family member/Friend handles my finances ☐ I handle my own finances ☐

Do you have any of the following? Financial Power of Attorney☐, Legal Guardian☐,

Health Care Power of Attorney☐, Health Care Surrogate☐, Living will☐, DNR☐

If you **DO NOT** currently have any type of income have you applied for benefits? YES☐ NO☐

If yes, what type of benefit?

☐ Social Security – what date did you apply _____/ _____.
☐ VA Service Connected Pension – what date did you apply _____/ _____.
☐ VA Non Service Connected Pension – what date did you apply _____/ _____.

Insurance Information

☐ Medicaid #: _____

☐ Medicare # _____ Part A ☐ Part B ☐ Part D ☐

☐ Medical Insurance Policy #: _____

☐ Medicare Supplement Policy #: _____

☐ Dental Insurance Policy #: _____

☐ Long-term Care Insurance Policy #: _____

☐ TRI-CARE: _____

Emergency Contact/Next of Kin Information

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Cell: _____
E-mail address: _____

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Cell: _____
E-mail address: _____

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Cell: _____
E-mail address: _____

Medical Information

Have you been treated by a VA or Private Physician, or been hospitalized in the past year? Yes☐ No☐
If YES, please complete information below:

Name of Physician	Reason for visit	Date	Location	VA or private

At what VA Medical Centers or VA Out-Patient Clinics have you received services in the past five years?

_____

Do you consume alcoholic beverages?
Yes☐ No☐ How often? _____

Are you currently being treated for alcohol or other substance abuse/dependence?
Yes☐ No☐ If yes, where are you receiving treatment: _____

In the past, have you ever been treated for substance abuse/dependence?
Yes☐ No☐ If yes, when and where were you treated: _____

Have you ever been referred to a substance abuse treatment program that you declined to attend or did not complete? Yes☐, No,☐ Declined to attend☐, Failed to complete☐ when and where and why was treatment declined or not completed: _____

Are you presently being seen by a mental health professional?
Yes☐ No☐ Psychiatrist☐, Psychologist☐, Social Worker☐, Other: _____

For what are you being treated? _____

Do you use tobacco products? Yes☐ No☐ cigarettes ☐ pipe ☐ cigars☐ chewing tobacco ☐ snuff ☐

Do you have your own teeth? ☐ Yes ☐ No.

If yes are your teeth in good condition? ☐ Yes ☐ No

If no, what type of issues are you having? _____

_____

Do you have dentures? ☐ Yes ☐ No, upper denture ☐ lower denture ☐ partial ☐

If yes, do you wear your dentures? ☐ Yes ☐ No. Do your dentures fit well? ☐ Yes ☐ No

Do you have any problems with chewing? ☐ Yes ☐ No

If so, please describe the issue: _____

Do you have any problems with swallowing? ☐ Yes ☐ No

If so, please describe the issue: _____

Have you had a swallow study completed related to your swallowing issues? ☐ Yes ☐ No
If yes, when and where was this completed? _____

Have you had a speech evaluation related to your swallowing issues ☐ Yes ☐ No
If yes, when and where was this completed? _____

Has your doctor advised a specific diet? ☐ Yes ☐ No

If yes, what type of diet? _____

Do you follow this diet? ☐ Yes ☐ No

If yes, do you follow the diet ☐ all of the time, ☐ most of the time, ☐ sometimes

What is your usual weight? _____

Have you lost or gained weight in the last six months? ☐ Yes ☐ No

If you lost weight was this a planned loss? ☐ Yes ☐ No How much weight did you lose? _____

If this was not a planned weight loss have you discussed with your doctor? ☐ Yes ☐ No

What is the usual time you go to bed? _____

What time do you usually awaken? _____

Do you prefer your sleeping environment to be: ☐ cool, ☐ very cool, ☐ warm, ☐ very warm.

Do you have difficulty sleeping? ☐ Yes ☐ No

DO YOU HAVE/USE ANY OF THE FOLLOWING EQUIPMENT/DEVICES?

☐ WALKER ☐ HEARING AIDS ☐ GLASSES ☐ SHOWER CHAIR ☐ CANE
☐ ROLLATOR WALKER
☐ MANUAL WHEELCHAIR ☐ POWER CHAIR ☐ SCOOTER ☐ TRAPEZE BAR
☐ C-PAP MACHINE ☐ OXYGEN ☐ OXYGEN CONCENTRATER

☐ PROSTETIC LIMBS: _____

Religious Preference: _____

Do you regularly attend religious services: _____

Where were you born? City: _____ State: _____ Country: _____

Former Occupation(s): _____

Job(s) you held in the military: _____

What was your military rank: _____

Schooling in Years: _____ years. Degree Earned ☐ Yes ☐ No If yes in what field of study.

_____

Fathers Name: _____ Living _____ Deceased _____

Mothers Name: _____ Living _____ Deceased _____

Mothers Maiden Name: _____

Children: _____

Brothers: _____

Sisters: _____

Are you in contact with your children? ☐ Yes ☐ No

Are you in contact with your siblings? ☐ Yes ☐ No

Hobbies (check those you like to participate in):

☐ Antiques	☐ Fishing	☐ Pottery	☐ Games
☐ Reading	☐ Card Games	☐ Gardening	☐ Sports
☐ Computers	☐ Golf	☐ Swimming	☐ Volunteering
☐ Continued Education	☐ Knitting/Crocheting	☐ Tennis	☐ jig saw puzzles
☐ Cooking	☐ Movies	☐ Theater	☐ Word puzzles
☐ Crafts	☐ Music	☐ Travel	
☐ Creative Writing	☐ Needlework	☐ Woodworking	
☐ Painting	☐ Exercise	☐ Photography	

☐ Other: _____

Do you own a vehicle? YES ☐ NO ☐
If yes, do you plan to bring your vehicle with you to the home? YES ☐ NO ☐
Please note that to keep a vehicle on premises you must have a valid driver's license, insurance and current tag.

LEGAL INFORMATION

Are you currently on Probation or Parole? YES ☐ NO ☐ Do you have any pending legal issues? YES ☐ NO ☐

If so, please explain: _____

_____

_____

Names of Probation/Parole Officer: _____ Phone _____

Have you ever been convicted of a felony? YES ☐ NO☐

Pled guilty, or no contest to a felony? YES ☐ NO ☐

If you have had a felony charge when was the charge? ____/____/____

What was the charge(s): _____

Where did this charge(s) occur: City: _____ County: _____ State: _____

SIGNATURE

The statements made in this application are true and correct to the best of my knowledge. I understand that if I have given false statements or information on this application, at the discretion of the Administrator, I may be discharged from the Robert H. Jenkins, Jr. Veterans' Domiciliary Home of Florida.

_____
Date

_____
Signature of Applicant, Legal guardian or Power of Attorney

Please return your completed application and documents to the admissions coordinator by mail, e-mail or fax. If you have any questions about the home or the application process, please call the admission coordinator for assistance at 386-758-0600 ext. 1005.

Please make sure to include proof of service, proof of income and medical information with your application. Your application cannot be processed without this information.

IMPORTANT INFORMATION ABOUT WHAT THINGS YOU MAY AND MAY NOT BRING INTO THE HOME

WHAT IS PROVIDED IN THE ROOM

- Bed
- Wardrobe cabinet with drawers (drawers and cabinets lock)
- Bed side table
- Chair
- Medicine cabinet
- Bed linens/towels/pillows
- Television (satellite service is provided)

WHAT ITEMS YOU MAY BRING INTO THE HOME

- Clothing
- Personal hygiene items
- Alarm clock
- Bed linens/towels/pillows (the home provides these items but you may bring your own if you wish.)
- Pictures (maintenance staff will hang/install)
- Radio/ cd player
- DVD player or VCR (upon request maintenance will install holder/rack for this equipment)
- Computer (lap top only)
- TV's are provided in the room, but you may bring your own TV if you wish to do so. TV must be less than 40 inches and you must have wireless head phones.
- Laptop computer

WHAT ITEMS **NOT** TO BRING WITH YOU TO THE HOME.

- Recliners, chairs, chairs with rollers, beds, desk, dressers or other furniture
- Exercise equipment
- Tools
- Candles
- Appliances (coffee pots, electric skillets, microwaves etc.)
- Throw rugs or any other type of carpeting

Contraband

- Weapons, guns, knives, etc., alcoholic beverages of any type and illegal drugs are not allowed in the home or on the grounds. Possession of these items could lead to discharge from the home.

Private rooms

- If you are paying for a private room you have more options of what you will be allowed to bring into the room (bed, dresser, desk, recliner etc.). Please contact the admissions office at (386) 758-0600 ext. 1005 to discuss these items.

Storage

- A limited amount of storage is available for each resident. As needed each resident will be provided with 4 boxes for storage the box size is 22" x 22" x 18". Four boxes are strictly the limit.

I am verifying by my signature below that I have read and understood what items are and are not allowed to be brought into the home. Please sign and return these two pages with your application.

_____
Printed name of applicant

_____
Signature of applicant

_____
Date

Department of Veterans Affairs	REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 "Patient Medical Record – VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS (Name and address of VA health care facility):

LAST NAME-FIRST NAME-MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

PURPOSE(S) OR NEED: Information is to be used by the organization or individual for

☐ Treatment ☐ Benefits ☐ Legal ☐ Employment ☐ Other – Please specify._____

_____

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

- ☐ Health Summary (prior 2 years)
- ☐ Inpatient Discharge Summary (dates): _____
- ☐ Progress Notes:
  - ☐ Specific clinics (name & date range): _____
  - ☐ Specific providers (name & date range): _____
  - ☐ Date range: _____
- ☐ Operative/Clinical Procedures (name &date): _____
- ☐ Lab results:
  - ☐ Specific tests (name & date): _____
  - ☐ Date range: _____
- ☐ Radiology Reports (name & date): _____
- ☐ List of Active Medications
- ☐ Flu Vaccination (dose, lot number, date & location)
- ☐ Other (describe below):

LAST NAME-FIRST NAME-MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize the Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization:

☐ Drug Abuse ☐ Alcoholism or Alcohol Abuse ☐ Sickle Cell Anemia
☐ Human Immunodeficiency Virus (HIV)

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion, or because a condition of VA employment mandates the signing of this authorization. The information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any information disclosed per this authorization may no longer be protected by Federal confidentiality laws or regulations and may be subject to re-disclosure by the recipient.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire

☐ After one-time disclosure, if all needs are satisfied
☐ On _____ (enter a future date other than date signed by patient)
☐ Under the following condition(s):_____

PATIENT SIGNATURE	DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE (if applicable)	**DATE (mm/dd/yyyy)**

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

Type and Extent of Material Released:

Date Released:	Released by:

Resident Health Assessment for Assisted Living Facilities

To Be Completed By Facility:

Resident Information	
Resident Name:	DOB:
Authorized Representative (if applicable):	

Facility Information		
Facility Name: Robert H. Jenkins Jr. Veterans Domiciliary Home of Florida		Telephone Number: (386)758-0600
Street Address: 751 SE Sycamore Terrace		Fax Number: (386)758-0549
City: Lake City	County: Columbia	Zip: 32025
Contact Person: Admissions Coordinator 386-758-0600 ext. 1005		

INSTRUCTIONS TO LICENSED HEALTH CARE PROVIDERS:
After completion of all items in Sections 1 and 2 (pages 1 – 4), return this form to the facility at the address indicated above.

SECTION 1. Health Assessment

NOTE: This section must be completed by a licensed health care provider and must include a face-to-face examination and interview with the resident.

Known Allergies:	**Height:**	**Weight:**
Medical History and Diagnoses:		
Physical or Sensory Limitations:		
Cognitive or Behavioral Status:		
Nursing/Treatment/Therapy Service Requirements:		
Special Precautions:	**Elopement Risk:** Yes: ☐ No: ☐	

To Be Completed By Facility:

Resident Name:	DOB:
Authorized Representative (if applicable):	

SECTION 1. Health Assessment (continued)

NOTE: This section must be completed by a licensed health care provider and must include a face-to-face examination and interview with the resident.

A. To what extent does the individual need supervision or assistance with the following?

Key	I = Independent	S = Needs Supervision	A = Needs Assistance	T = Total Care

Indicate by a checkmark (✓) in the appropriate column below, the extent to which the individual is able to perform each of the activities of daily living. If "Needs Supervision" or "Needs Assistance" is indicated, explain the extent and type of supervision or assistance needed in the comments column.

ACTIVITIES OF DAILY LIVING	I	S	A	T	COMMENTS
Ambulation					
Bathing					
Dressing					
Eating					
Self Care (grooming)					
Toileting					
Transferring					

B. Special Diet Instructions:

Regular ☐ Calorie Controlled ☐ No Added Salt ☐ Low Fat/Low Cholesterol ☐

Other (specify, including consistency changes such as puree): _____

C. Does the individual have any of the following conditions/requirements? If yes, please include an explanation in the comments column.

STATUS	Yes/No	COMMENTS
A communicable disease, which could be transmitted to other residents or staff?		
Bedridden?		
Any stage 2, 3 or 4 pressure sores?		
Pose a danger to self or others? (Consider any significant history of physically or sexually aggressive behavior.)		
Require 24-hour nursing or psychiatric care?		

D. In your professional opinion, can this individual's needs be met in an assisted living facility, which is not a medical, nursing or psychiatric facility? Yes ☐ No ☐

Comments (use additional paper if necessary): _____

To Be Completed By Facility:

Resident Name:	DOB:
Authorized Representative (if applicable):	

SECTION 2-A. Self-Care and General Oversight Assessment

NOTE: This section must be completed by a licensed health care provider and must include a face-to-face examination and interview with the resident.

A. Ability to Perform Self-Care Tasks:

Key	I = Independent	S = Needs Supervision	A = Needs Assistance

Indicate by a checkmark (✓) in the appropriate column below, the extent to which the individual is able to perform each of the listed self-care tasks. If "Needs Supervision" or "Needs Assistance" is indicated, explain the extent and type of supervision or assistance necessary in the comments column.

TASKS	I	S	A	COMMENTS
Preparing Meals				
Shopping				
Making Phone Calls				
Handling Personal Affairs				
Handling Financial Affairs				
Other				

B. General Oversight:

Key	I = Independent	W = Weekly	D = Daily	O = Other

Indicate by a checkmark (✓) in the appropriate column below, the extent to which the individual needs general oversight. If other, explain in the comments column.

TASKS	I	W	D	O	COMMENTS
Observing Wellbeing					
Observing Whereabouts					
Reminders for Important Tasks					
Other					
Other					
Other					
Other					

C. Additional Comments/Observations (use additional paper if necessary):

To Be Completed By Facility:

Resident Name:	DOB:
Authorized Representative (if applicable):	

SECTION 2-B. Self-Care and General Oversight Assessment – Medications

NOTE: This section must be completed by a licensed health care provider and must include a face-to-face examination and interview with the resident.

A. List all current medications prescribed below (attach additional pages if necessary):

	MEDICATION	DOSAGE	DIRECTIONS FOR USE	ROUTE
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

B. Does the individual need help with taking his or her medications (meds)? Yes ☐ No ☐ If yes, place a checkmark (✓) in front of the appropriate box below:

☐ **Needs Assistance With Self Administration**
- ❖ This allows unlicensed staff to assist with oral and topical medication

☐ **Needs Medication Administration**
- ❖ Not all assisted living facilities have licensed staff to perform this service

☐ **Able To Administer Without Assistance**

C. Additional Comments/Observations (use additional pages if necessary):

NOTE: MEDICAL CERTIFICATION IS INCOMPLETE WITHOUT THE FOLLOWING INFORMATION

Name of Examiner (please print):	
Medical License #:	
Telephone Number:	
Title of Examiner (check box) ☐ **MD** ☐ **DO** ☐ **ARNP** ☐ **PA**	
Address of Examiner:	
Signature of Examiner:	**Date of Examination:**

OMB Approval No. 2900-0160
Estimated Burden: Avg. 20 min.
EXP: Feb 28, 2019

Department of Veterans Affairs

VA FORM 10-10SH
STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

PART I - ADMINISTRATIVE

1. STATE HOME FACILITY	2. DATE ADMITTED

3. STATE HOME FACILITY ADDRESS (Street, City, State and Zip Code)

4. RESIDENT'S NAME (Last, First, Middle) (Mandatory field)

5. SOCIAL SECURITY NUMBER (Mandatory field)	6. GENDER ☐ M ☐ F	7. AGE	8. DATE OF BIRTH (MM/DD/YYYY)	9. ADVANCED MEDICAL DIRECTIVE ☐ NO ☐ YES

10. HAS THE VETERAN PROVIDED FINANCIAL DISCLOSURE FOR PURPOSES OF DETERMINING ELIGIBILITY FOR DOMICILIARY PER DIEM PAYMENTS?
☐ YES ☐ NO ☐ N/A **10-10EZ or 10-10EZR IS REQUIRED TO BE SUBMITTED EITHER IN PAPER FORM OR ELECTRONICALLY WITH THE 10-10SH**

PART II - HISTORY AND PHYSICAL (Use separate sheet if necessary)

11. HISTORY

12. HEIGHT	13. WEIGHT	14. TEMP	15. PULSE	16. BP	17. HEAD/EYES/EAR/NOSE AND THROAT

18. NECK	19. CARDIOPULMONARY
29. ABDOMEN	21. GENITOURINARY
22. RECTAL	23. EXTREMITIES
24. NEUROLOGICAL	25. ALLERGY/DRUG SENSITIVITY

26. X-RAY/ LAB						
	CHEST X-RAY	DATE (MM/DD/YYYY)	RESULT	CBC	DATE (MM/DD/YYYY)	RESULT
	SEROLOGY					
	URINALYSIS	DATE (MM/DD/YYYY)	ALBUMIN	ACETONE		SUGAR

CHECK ALL BOXES THAT APPLY OR CHECK N/A

27. IS DEMENTIA THE PRIMARY DIAGNOSIS ☐ YES ☐ NO ☐ N/A	28. IS THERE A DIAGNOSIS OF MENTAL ILLNESS ☐ YES ☐ NO ☐ N/A	29. HAS RESIDENT RECEIVED MENTAL HEALTH SERVICES WITHIN THE PAST 2 YEARS ☐ YES ☐ NO ☐ N/A	30. IS CLIENT A DANGER TO SELF OR OTHERS ☐ YES ☐ NO ☐ N/A

31. IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:
☐ SCHIZOPHRENIA ☐ PARANOIA ☐ OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY ☐ N/A
☐ MOOD SWINGS ☐ SOMATOFORM DISORDER ☐ PANIC OR SEVERE ANXIETY DISORDER ☐ PERSONALITY DISORDER

32. OXYGEN	33. FEEDING	34. WOUND	35. FOLEY CATHETER
☐ MASK ☐ PRN ☐ N/A ☐ NASAL CANNULA ☐ CONTINUOUS	☐ TUBE FEEDING ☐ N/A ☐ OSTOMY ☐ TRACHEOSTOMY	☐ DECUBITUS ULCERS ☐ N/A ☐ DRAINING WOUND ☐ WOUND CULTURED	☐ TEMPORARY ☐ N/A ☐ PERMANENT

36. REFERRING PHYSICIAN	37. PRIMARY DIAGNOSIS
38. SECONDARY DIAGNOSIS	39. TERTIARY DIAGNOSIS

40. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? ☐ YES ☐ NO ☐ UNKNOWN

41. TYPE OF CARE RECOMMENDED: ☐ SKILLED NURSING HOME CARE ☐ DOMICILIARY CARE ☐ ADULT DAY HEALTH CARE

42. MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY

43. PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN ASSIGNED	44. SIGNATURE OF PRIMARY PHYSICIAN ASSIGNED

OMB Approval No. 2900-0160
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Department of Veterans Affairs

VA FORM 10-10SH
STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

PART III - EVALUATION (Select an appropriate number in each category)

45. RESIDENT'S NAME *(Last, First, Middle) (This is a mandatory field)*	46. SOCIAL SECURITY NUMBER *(Mandatory field)*

COMMUNICATION	☐ 1. Transmits messages/receives information ☐ 2. Limited ability ☐ 3. Nearly or totally unable	**SPEECH**	☐ 1. Speaks clearly with others of same language ☐ 2. Limited ability ☐ 3. Unable to speak clearly or not at all
HEARING	☐ 1. Good ☐ 2. Hearing slightly impaired ☐ 3. Nearly or totally unable ☐ 4. Virtually/completely deaf	**SIGHT**	☐ 1. Good ☐ 2. Vision adequate - Unable to read/see details ☐ 3. Vision limited - Gross object differentiation ☐ 4. Blind
TRANSFER	☐ 1. No assistance ☐ 2. Equipment only ☐ 3. Supervision only ☐ 4. Requires human transfer w/wo equipment ☐ 5. Bedfast	**AMBULATION**	☐ 1. Independence w/wo assistive device ☐ 2. Walks with supervision ☐ 3. Walks with continuous human support ☐ 4. Bed to chair (total help) ☐ 5. Bedfast
ENDURANCE	☐ 1. Tolerates distances (250 feet sustained activity) ☐ 2. Needs intermittent rest ☐ 3. Rarely tolerates short activities ☐ 4. No tolerance	**MENTAL AND BEHAVIOR STATUS**	☐ 1. Alert ☐ 2. Confused ☐ 3. Disoriented ☐ 4. Comatose ☐ 5. Agreeable ☐ 6. Disruptive ☐ 7. Apathetic ☐ 8. Well motivated
TOILETING	☐ 1. No assistance ☐ 2. Assistance to and from transfer ☐ 3. Total assistance including personal hygiene, help with clothes ☐ A. Bathroom ☐ B. Bedside commode ☐ C. Bedpan	**BATHING**	☐ 1. No assistance ☐ 2. Supervision Only ☐ 3. Assistance ☐ 4. Is bathed ☐ A. Tub ☐ B. Shower ☐ C. Sponge bath
DRESSING	☐ 1. Dresses self ☐ 2. Minor assistance ☐ 3. Needs help to complete dressing ☐ 4. Has to be dressed	**FEEDING**	☐ 1. No assistance ☐ 2. Minor assistance, needs tray set up only ☐ 3. Help feeding/encouraging ☐ 4. Is fed
BLADDER CONTROL	☐ 1. Continent ☐ 2. Rarely incontinent ☐ 3. Occasional - once/week or less ☐ 4. Frequent - up to once a day ☐ 5. Total incontinence ☐ 6. Catheter, indwelling	**BOWEL CONTROL**	☐ 1. Continent ☐ 2. Rarely incontinent ☐ 3. Occasional - once/week or less ☐ 4. Frequent - up to once a day ☐ 5. Total incontinence ☐ 6. Ostomy
SKIN CONDITION	☐ 1. Intact ☐ 2. Dry/Fragile ☐ 3. Irritations (Rash) ☐ 4. Open wound ☐ 5. Decubitus Number _____ Stage _____	**WHEEL CHAIR USE**	☐ 1. Independence ☐ 2. Assistance in difficult maneuvering ☐ 3. Wheels a few feet ☐ 4. Unable to use ☐ N/A

47. SIGNATURE OF REGISTERED NURSE OR REFERRING PHYSICIAN	48. DATE

PHYSICAL THERAPY *(To be completed by Physical Therapist or Referring Physician)* 49. Check if ☐ NEW REFERRAL ☐ CONTINUATION OF THERAPY

50. SENSATION IMPAIRED	51. RESTRICT ACTIVITY	52. PRECAUTIONS	53. FREQUENCY OF TREATMENT
☐ YES ☐ NO	☐ YES ☐ NO	☐ CARDIAC ☐ OTHER (Type other, specify)	

54. TREATMENT GOALS:				
☐ STRETCHING	☐ ACTIVE	☐ COORDINATING ACTIVITIES	☐ FULL WEIGHT BEARING	☐ WHEELCHAIR INDEPENDENT
☐ PASSIVE ROM	☐ ACTIVE ASSISTIVE	☐ NON-WEIGHT BEARING	☐ PROGRESS BED TO WHEELCHAIR	☐ COMPLETE AMBULATION
	☐ PROGRESSIVE RESISTIVE	☐ PARTIAL WEIGHT BEARING	☐ RECOVERY TO FULL FUNCTION	

55. ADDITIONAL THERAPIES	56. SIGNATURE OF AND TITLE OF THERAPIST OR PHYSICIAN	57. DATE
☐ O.T. ☐ SPEECH ☐ DIETARY		

PART IV - SOCIAL WORK ASSESSMENT *(To be completed by Social Worker)*

58. PRIOR LIVING ARRANGEMENTS	59. LONG RANGE PLAN		
60. ADJUSTMENT TO ILLNESS OR DISABILITY	61. PRINT NAME OF SOCIAL WORKER	62. SIGNATURE OF SOCIAL WORKER	63. DATE
64. REMARKS			