

**STATE OF FLORIDA  
DEPARTMENT OF VETERANS'  
AFFAIRS**



FLORIDA DEPARTMENT OF VETERANS' AFFAIRS

*Honoring those who served U.S.*

**RESIDENT STANDARD  
APPLICATION PACKET**

**CLYDE E. LASSEN STATE VETERANS' NURSING HOME  
4650 STATE ROAD 16, ST. AUGUSTINE, FL 32092  
PHONE: 904-940-2193**

# **GENERAL INFORMATION**

**STATE OF FLORIDA  
DEPARTMENT OF VETERANS' AFFAIRS**

**APPLICATION FOR CONSIDERATION FOR ADMISSION  
GENERAL INFORMATION**

This facility is a 120-bed skilled nursing facility of which 60 beds are dedicated to the care of veterans with Alzheimer's. Additionally, we offer rehabilitation services such as: Physical, Occupational & Speech therapy and Restorative Programs, all under the direct supervision of trained qualified therapists. Hospice and Respite Services are also available.

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

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

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

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

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 \$208.86 for a semi-private room and \$212.04 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

### **ALZHEIMER / TRANSITIONAL / MEMORY UNIT**

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

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

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

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

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

### **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**

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

\* 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.

# 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](http://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](http://www.doh.state.fl.us) or [www.MyFlorida.com](http://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](http://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](http://www.fdhc.state.fl.us) (Click on "Site Index," then scroll down to "Organ Donors") or the federal government site [www.organdonor.gov](http://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](http://www.agingwithdignity.org)  
 (888) 594-7437

Other resources include:

American Association of Retired Persons (AARP)  
[www.aarp.org](http://www.aarp.org)  
 (Type "advance directives" in the website's search engine)  
 Partnership for Caring  
[www.partnershipforcaring.org](http://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](http://www.FloridaHealthStat.com) (Under Reports and Guides)  
 (888) 419-3456



## **FACILITY CHARACTERISTICS/LIMITATIONS**

*This is a 120-bed facility providing skilled nursing care and can accommodate 60 residents with dementia/Alzheimer's disease. (Applies to all Facilities except Emory L. Bennett)*

### ***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. (Applies to all facilities)*



**STEP 1**  
**COMPLETE ALL**  
**REQUIRED**  
**APPLICATION FORMS**

**\*\*\* PLEASE READ THE CHECKLIST FOR REQUIRED  
FORMS INCLUDED IN THE APPLICATION PACKET FOR  
ADDITIONAL INFORMATION AND INSTRUCTIONS \*\*\***

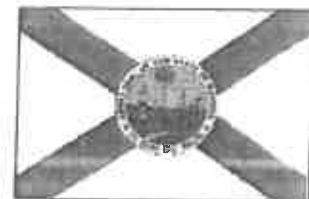
## **STEP 1**

### **CHECKLIST FOR REQUIRED FORMS INCLUDED IN APPLICATION PACKET**

- \_\_\_ **APPLICATION FOR ADMISSION / FDVA FORM 54.**  
**This is a 2-page form. MUST BE NOTARIZED**
- \_\_\_ **APPLICATION FOR HEALTH BENEFITS / VA FORM 10-10 EZ**  
**This is a 3-page form**
- \_\_\_ **APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE**  
**VA FORM 21-22**
- \_\_\_ **FINANCIAL INFORMATION RELEASE**  
**This is a 1-page form. MUST BE NOTARIZED**
- \_\_\_ **FDVA MEDICAL RECORDS AND HEALTH INFORMATION RELEASE**  
**This is a 2-page form. MUST BE SIGNED BY A WITNESS**
- \_\_\_ **VA REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION**  
**VA FORM 10-5345**  
**This is a 2-page form**
- \_\_\_ **CONTACT INFORMATION FOR VETERAN, MORTUARY, & EMERGENCY**  
**MORTUARY CONTACT INFORMATION IS REQUIRED**
- \_\_\_ **PHYSICIAN CONTACT INFORMATION**
- \_\_\_ **FAMILY QUESTIONNAIRE**  
**This is a 4-page form**
- \_\_\_ **CUSTOMARY ROUTINES**
- \_\_\_ **PERSONAL PROFILE / ASSISTIVE DEVICES**  
**This is a 2-page form**
- \_\_\_ **ACTIVITIES OF DAILY LIVING (ADL) INFORMATION**  
**This is a 4-page form**
- \_\_\_ **AGENCY FORM HEALTH CARE ADMINISTRATION (AHCA) / DEPARTMENT OF ELDER AFFAIRS (DOEA) INFORMED CONSENT FORM**



# 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

- Print or type and answer all items. **PAGE 2 MUST BE NOTARIZED**
- Individuals must meet the criteria required by the U.S. Department of Veterans Affairs for veteran status.
- Must be resident of Florida immediately preceding this application.
- 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"/> Retirement Home <input type="checkbox"/> Boarding Home <input type="checkbox"/> Other <input type="checkbox"/> explain: _____		
PHONE NUMBERS	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

O&B Approved No. 2990-0091  
Estimated Burden Avg. 30 min.



Department of Veterans Affairs

## APPLICATION FOR HEALTH BENEFITS

### SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

1A. VETERAN'S NAME (Last, First, Middle Name)		1B. PREFERRED NAME		2. MOTHER'S MAIDEN NAME	
3A. BIRTH SEX <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? (You may check more than one. Information is required for statistical purposes only.) <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 (mm/dd/yyyy)	8B. PLACE OF BIRTH (City and State)		9. RELIGION	
10A. PERMANENT ADDRESS (Street)		10B. CITY	10C. STATE	10D. ZIP CODE	10E. COUNTY
10F. HOME TELEPHONE NO. (Include area code)		10G. MOBILE TELEPHONE NO. (Include area code)		10H. E-MAIL ADDRESS	
11A. RESIDENTIAL ADDRESS (Street)		11B. CITY	11C. STATE	11D. ZIP CODE	11E. COUNTY
12. TYPE OF BENEFIT(S) APPLYING FOR (You may check more than one) <input type="checkbox"/> ENROLLMENT/HEALTH SERVICES <input type="checkbox"/> DENTAL		13. CURRENT MARITAL 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. (Include Area Code)		14E. NEXT OF KIN WORK TELEPHONE NO. (Include Area Code)		15. DESIGNEE - INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH (Note: This does not constitute a will or transfer of title)	
16. I AM ENROLLING TO OBTAIN MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT <input type="checkbox"/> YES <input type="checkbox"/> NO		17. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? (for listing of facilities visit <a href="http://www.va.gov/directory">www.va.gov/directory</a> )		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 (Check yes or no)				YES		NO	
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?				<input type="checkbox"/>	<input type="checkbox"/>		
B. ARE YOU A FORMER PRISONER OF WAR?				<input type="checkbox"/>	<input type="checkbox"/>		
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?				<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"/>		
E. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?				<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"/>		
G. DO YOU HAVE A VA SERVICE-CONNECTED RATING?				<input type="checkbox"/>			
IF "YES", WHAT IS YOUR RATED PERCENTAGE _____ %							
H. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975?				<input type="checkbox"/>	<input type="checkbox"/>		
I. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?				<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"/>		
K. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1957?				<input type="checkbox"/>	<input type="checkbox"/>		

VA Form 10-10 EZ  
APR 2017

PREVIOUS EDITIONS OF THIS FORM ARE NOT TO BE USED

Page 1

<b>APPLICATION FOR HEALTH BENEFITS</b> <i>Continued</i>		VETERAN'S NAME (Last, First, Middle)		SOCIAL SECURITY NUMBER	
<b>SECTION III - INSURANCE INFORMATION</b> (Use a separate sheet for additional information)					
1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER (Include coverage through spouse or other person)					
2. NAME OF POLICY HOLDER	3. POLICY NUMBER	4. GROUP CODE	5. ARE YOU ELIGIBLE FOR MEDICAID? <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 (mm/dd/yyyy)	
<b>SECTION IV - DEPENDENT INFORMATION</b> (Use a separate sheet for additional dependents)					
1. SPOUSE'S NAME (Last, First, Middle Name)			2. CHILD'S NAME (Last, First, Middle Name)		
1A. SPOUSE'S SOCIAL SECURITY NUMBER			2A. CHILD'S DATE OF BIRTH (mm/dd/yyyy)		2B. CHILD'S SOCIAL SECURITY NO.
1B. SPOUSE'S DATE OF BIRTH (mm/dd/yyyy)	1C. SPOUSE SELF-IDENTIFIED GENDER IDENTITY <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		2C. DATE CHILD BECAME YOUR DEPENDENT (mm/dd/yyyy)		
1D. DATE OF MARRIAGE (mm/dd/yyyy)			2D. CHILD'S RELATIONSHIP TO YOU (Check one) <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEPSON <input type="checkbox"/> STEPPAUGHTER		
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER (Street, City, State, ZIP if different from Veteran's)			2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? <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 (e.g., tuition, books, materials)		
<b>SECTION V - EMPLOYMENT INFORMATION</b>					
1A. VETERAN'S EMPLOYMENT STATUS (Check one). <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 (Complete if employed or retired)		1D. COMPANY ADDRESS (Complete if employed or retired - Street, City, State, ZIP)		1E. COMPANY PHONE NUMBER (Complete if employed or retired) (Include area code)	
<b>SECTION VI - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN</b> (Use a separate sheet for additional dependents)					
1. GROSS ANNUAL INCOME FROM EMPLOYMENT (wages, bonuses, tips, etc.) EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	VETERAN	SPOUSE	CHILD 1		
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS					
3. LIST OTHER INCOME AMOUNTS (e.g., Social Security, compensation, pension interest, dividends) EXCLUDING WELFARE.					
<b>SECTION VII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES</b>					
1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE (e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.			\$		
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD (Also enter spouse or child's information in Section VI.)			\$		
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES (e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.			\$		



**APPLICATION FOR HEALTH  
BENEFITS***Continued*

VETERAN'S NAME (Last, First, Middle)

SOCIAL SECURITY NUMBER

**SECTION VII - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS**

By submitting this application you are agreeing to pay the applicable VA copays for treatment or services of your NSC conditions as required by law. You also agree to receive communications from VA to your supplied email or mobile number.

**ASSIGNMENT OF BENEFITS**

I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

**SIGNATURE OF APPLICANT***(Sign in ink)***DATE**



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](http://www.va.gov/vaforms).**

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

1. LAST-FIRST-MIDDLE NAME OF VETERAN	2. VA FILE NUMBER (include prefix)
3A. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS (See list on reverse side before selecting organization)	
3B. NAME AND JOB TITLE OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 3A (This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)	
3C. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 3A	

## **INSTRUCTIONS - TYPE OR PRINT ALL ENTRIES**

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

**12. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C.**  
By checking the box below I authorize VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

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

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

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

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

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

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

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

15. SIGNATURE OF VETERAN OR CLAIMANT (Do Not Print)		16. DATE SIGNED	
17. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 3B (Do Not Print)		18. DATE SIGNED	
<b>VA USE ONLY</b>	COPY OF VA FORM 21-22 SENT TO:	DATE SENT	ACKNOWLEDGED (Date)
	<input type="checkbox"/> VR&E FILE <input type="checkbox"/> EDU FILE <input type="checkbox"/> LG FILE <input type="checkbox"/> INSURANCE FILE		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.



**Glenn W. Sutphin Jr.**  
Executive Director  
**Connie Tolley**  
Division Director  
**Margaret Kaplan**  
Administrator

State of Florida  
**DEPARTMENT OF VETERANS' AFFAIRS**  
**Clyde E Lassen State Veterans' Nursing Home**  
4650 State Road 16  
St. Augustine, FL 32092  
Phone: (904) 940-2193 Fax: (904) 940-9913  
[www.floridavets.org](http://www.floridavets.org)

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

## 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



**Glenn Sutphin**  
Executive Director  
**Connie Tolley**  
Homes Program Director  
**Margaret Kaplan**  
Administrator

State of Florida  
**CLYDE E. LASSEN**  
**STATE VETERANS' NURSING HOME**

4650 State Road 16  
St. Augustine, FL 32092  
Phone (904) 940-2193  
Fax (904) 940-9913

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

## **MEDICAL RECORDS AND HEALTH INFORMATION RELEASE**

**PATIENT NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

I authorize the use or disclosure of the above individual's health information as described below. The following individual or organization is authorized to make the disclosure:

\_\_\_\_\_  
**NAME OF HOSPITAL, PHYSICIAN, OR HEALTHCARE FACILITY**

This information may be disclosed to and used by the following individual or organization for the purposes of assisting with placement and providing medical care:

**CLYDE E. LASSEN STATE VETERANS' NURSING HOME**  
4650 State Road 16, St. Augustine, FL 32092

The purpose of the disclosure is to assist with placement and providing medical care and may be shared with other Florida State Veterans' Homes for placement.

**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, and History & Physical  
X-ray/Lab/EKG reports, MD's 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**

\_\_\_\_\_  
**Relationship of Legal Representative to Resident**

\_\_\_\_\_  
**Signature of Witness**

\_\_\_\_\_  
**Date**

**REQUEST FOR AND AUTHORIZATION TO  
RELEASE HEALTH INFORMATION**

**PRIVACY ACT INFORMATION:** 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. VHA 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" and in accordance with the VHA Notice of Privacy Practices. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

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

**VETERAN'S REQUEST**

I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

- ☐ DRUG ABUSE ☐ SICKLE CELL ANEMIA  
☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ HUMAN IMMUNODEFICIENCY VIRUS (HIV)

**DESCRIPTION OF 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  
☐ OTHER (Describe):

**PURPOSE(S) OR NEED**

Information is to be used by the individual for:

- ☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ OTHER (Specify below)

LAST NAME- FIRST NAME- MIDDLE INITIAL		LAST 4 SSN	DATE OF BIRTH
<b>AUTHORIZATION</b>			
<p>I certify that this request has been made freely, voluntarily and without coercion and that 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 disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.</p> <p>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.</p>			
<b>EXPIRATION</b>			
<p>Without my express revocation, the authorization will automatically expire.</p> <p><input type="checkbox"/> UPON SATISFACTION OF THE NEED FOR DISCLOSURE</p> <p><input type="checkbox"/> ON _____ (enter a future date other than date signed by patient)</p> <p><input type="checkbox"/> UNDER THE FOLLOWING CONDITION(S): _____</p>			
PATIENT SIGNATURE (Sign in ink)		DATE (mm/dd/yyyy)	
LEGAL REPRESENTATIVE SIGNATURE (if applicable) (Sign in ink)		DATE (mm/dd/yyyy)	
PRINT NAME OF LEGAL REPRESENTATIVE		RELATIONSHIP TO PATIENT	
<b>FOR VA USE ONLY</b>			
TYPE AND EXTENT OF MATERIAL RELEASED			
DATE RELEASED		RELEASED BY:	

## 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: \_\_\_\_\_



## PHYSICIAN CONTACT INFORMATION

**VETERAN'S NAME:** \_\_\_\_\_

PHYSICIAN TYPE	PHYSICIAN NAME	PHYSICIAN PHONE
PRIMARY CARE		
CARDIOLOGIST		
DERMATOLOGIST		
ENDOCRINOLOGIST		
GASTROENTEROLOGIST		
NEPHROLOGIST		
ONCOLOGIST		
OPHTHALMOLOGIST		
PSYCHOLOGIST		
PULMONOLOGIST		
UROLOGIST		
VA OUTPATIENT CLINIC		
VA SOCIAL WORKER		
HOSPICE		

# 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"/> Rumaging 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)

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

### Eating Patterns (Check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Distinct food preferences            | <input type="checkbox"/> Ignores dietary precautions                |
| <input type="checkbox"/> Eats between meals all or most days  | <input type="checkbox"/> Skips Meals                                |
| <input type="checkbox"/> Diet Restrictions                    | <input type="checkbox"/> Prefers sweets                             |
| <input type="checkbox"/> Eating disorders (bulimia, anorexia) | <input type="checkbox"/> Use of alcoholic beverages at least weekly |
| <input type="checkbox"/> Hoards food                          |   |

### ADL Patterns (Check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> In bed clothes much of the day       | <input type="checkbox"/> Practices good hygiene       |
| <input type="checkbox"/> Wakens to toilet all or most nights  | <input type="checkbox"/> Prefers grooming in AM       |
| <input type="checkbox"/> Has irregular bowel movement pattern | <input type="checkbox"/> Reluctant to change clothing |
| <input type="checkbox"/> Showers for bathing                  | <input type="checkbox"/> Fear of water                |
| <input type="checkbox"/> Baths in PM                          |   |

### Involvement Patterns (Check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Finds strength in faith         | <input type="checkbox"/> Many friends and companions                        |
| <input type="checkbox"/> Daily animal companion presence | <input type="checkbox"/> Visits per phone                                   |
| <input type="checkbox"/> Involved in group activities    | <input type="checkbox"/> Daily close contacts with relatives or friends     |
| <input type="checkbox"/> Loner, prefers seclusion        | <input type="checkbox"/> Usually attends church, temple, etc. (TV Services) |
| <input type="checkbox"/> Territorial, draws boundaries   |   |

### Bed Mobility and Transfer (Check only one)

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

### Eating (Check only one)

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

Does applicant use any adaptive equipment? ☐ No ☐ Yes If so, what is used? \_\_\_\_\_

Does resident have a history of dysphagia? ☐ No ☐ Yes If so, explain: \_\_\_\_\_

Is resident on a special diet involving variance in food and liquid consistency? ☐ No ☐ Yes If so, explain: \_\_\_\_\_

## PERSONAL PROFILE / RESIDENT INFORMATION

Veteran's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Birthplace: \_\_\_\_\_ Primary Language: \_\_\_\_\_

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

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

Parent's Occupations \_\_\_\_\_

Family Pets \_\_\_\_\_

Mental Health History \_\_\_\_\_

Number of Marriages, Children, Etc. \_\_\_\_\_

Things Loved and Hated \_\_\_\_\_

Former Lifetime Occupations \_\_\_\_\_

Places Traveled \_\_\_\_\_

Foods Liked and Disliked \_\_\_\_\_

Musical Tastes \_\_\_\_\_

Hobbies \_\_\_\_\_

Clubs and Organizations belonged to \_\_\_\_\_

Church Preferences and Holidays Celebrated \_\_\_\_\_

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

Highest Level of Education \_\_\_\_\_

Personality \_\_\_\_\_

Traumas and/or Tragedies in Life \_\_\_\_\_

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

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

- ☐ Glasses
- ☐ Hearing Aids
- ☐ Dentures
- ☐ Cane
- ☐ Artificial limbs
- ☐ Crutches
- ☐ Walker

- ☐ Wheelchair
- ☐ Motorized Conveyance
- ☐ Wheel chair cushion,  
Who Provided? \_\_\_\_\_
- ☐ Other: \_\_\_\_\_

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

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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: \_\_\_\_\_



# ACTIVITIES OF DAILY LIVING (ADL) INFORMATION

PAGE 1 OF 4

**VETERAN'S NAME:** \_\_\_\_\_

**Please check the most appropriate answer for each ADL box.**

<b>CHAIR / BED TRANSFERS</b>	<p><input type="checkbox"/> The patient is unable to participate in a transfer. Two attendants are required to transfer the patient with or without a mechanical device.</p> <p><input type="checkbox"/> The patient is able to participate but maximum assistance of one other person is required in ALL ASPECTS of the transfer.</p> <p><input type="checkbox"/> The transfer of the patient requires the assistance of one other person. Assistance may be required IN ANY aspect of the transfer.</p> <p><input type="checkbox"/> The presence of another person is required either as a confidence measure, or to provide supervision for safety.</p> <p><input type="checkbox"/> The patient can safely approach the bed walking or in a wheelchair, lock brakes, lift footrests, or position walking aid, move safely to bed, lie down, come to a sitting position on the side of the bed, change the position of the wheelchair, transfer back into it safely, and/or grasp aid and stand. The patient must be independent in all phases of this activity.</p>
<b>AMBULATION</b>	<p><input type="checkbox"/> Dependent in ambulation (CAN NOT AMBULATE)</p> <p><input type="checkbox"/> Constant presence of one or more assistant is required during ambulation.</p> <p><input type="checkbox"/> Assistance is required with reaching aids and/or their manipulation. One person is required to offer assistance.</p> <p><input type="checkbox"/> The patient is independent in ambulation but unable to walk 150 feet without help, or supervision is needed for confidence or safety in hazardous situations.</p> <p><input type="checkbox"/> The patient is able to use crutches, canes, or a walker, and walk 150 feet without help or supervision.</p>
<b>AMBULATION / WHEELCHAIR</b> *If unable to walk. Only use this item if the patient is unable to ambulate.	<p><input type="checkbox"/> Dependent in wheelchair ambulation.</p> <p><input type="checkbox"/> Patient can propel self for short distances on flat surface, but assistance is required for all other steps of wheelchair management.</p> <p><input type="checkbox"/> Presence of one person is necessary and constant assistance is required to manipulate chair to table, bed, etc.</p> <p><input type="checkbox"/> The patient can propel self for a reasonable duration over regularly encountered terrain. Minimal assistance may still be required in "tight corners" or to negotiate a curb 4" high.</p> <p><input type="checkbox"/> To propel wheelchair independently, the patient must be able to go around corners, turn around, maneuver the chair to a table, bed, toilet, etc. The patient must be able to push a chair at least 150 feet and negotiate a curb.</p>

# ADL INFORMATION

## PAGE 2 OF 4

<b>STAIR CLIMBING</b>	<p><input type="checkbox"/> The patient is unable to climb stairs.</p> <p><input type="checkbox"/> Assistance is required in all aspects of stair climbing, including assistance with walking aids.</p> <p><input type="checkbox"/> The patient is able to ascend / descend but is unable to carry walking aids and needs supervision and assistance.</p> <p><input type="checkbox"/> Generally no assistance is required. At times supervision is required for safety due to morning stiffness, shortness of breath, etc.</p> <p><input type="checkbox"/> The patient is able to go up and down a flight of stairs safely without help or supervision. The patient is able to use handrails, cane, or crutches when needed and is able to carry these devices as he / she ascends or descends.</p>
<b>TOILET TRANSFERS</b>	<p><input type="checkbox"/> Fully dependent in toileting.</p> <p><input type="checkbox"/> Assistance required in all aspects of toileting.</p> <p><input type="checkbox"/> Assistance may be required with management of clothing, transferring, or washing hands.</p> <p><input type="checkbox"/> Supervision may be required for safety with normal toilet. A commode may be used at night but assistance is required for emptying and cleaning.</p> <p><input type="checkbox"/> The patient is able to get on / off the toilet, fasten clothing, and use toilet paper without help. If necessary, the patient may use a bedpan, commode, or urinal at night, but must be able to empty it and clean it.</p>
<b>BOWEL CONTROL</b>	<p><input type="checkbox"/> The patient is bowel incontinent.</p> <p><input type="checkbox"/> The patient needs help to assume appropriate position, and with bowel movement facilitatory techniques.</p> <p><input type="checkbox"/> The patient can assume appropriate position, but cannot use facilitatory techniques or clean self without assistance and has frequent accidents. Assistance is required with incontinence aids such as pad, etc.</p> <p><input type="checkbox"/> The patient may require supervision with the use of suppository or enema and has occasional accidents.</p> <p><input type="checkbox"/> The patient can control bowels and has no accidents, can use suppository, or take an enema when necessary.</p>
<b>BLADDER CONTROL</b>	<p><input type="checkbox"/> The patient is dependent in bladder management, is incontinent, or has indwelling catheter.</p> <p><input type="checkbox"/> The patient is incontinent, but able to assist with the application of an internal or external device.</p> <p><input type="checkbox"/> The patient is generally dry by day, but not at night and needs some assistance with the devices.</p> <p><input type="checkbox"/> The patient is generally dry by day and night, but may have an occasional accident or need minimal assistance with internal or external devices.</p> <p><input type="checkbox"/> The patient is able to control bladder day and night, and / or is independent with internal or external devices.</p>

# ADL INFORMATION

## PAGE 3 OF 4

<b>BATHING</b>	<p><input type="checkbox"/> Total dependence in bathing self.</p> <p><input type="checkbox"/> Assistance is required in all aspects of bathing, but patient is able to make some contribution.</p> <p><input type="checkbox"/> Assistance is required with either transfer to shower / bath or with washing or drying; including inability to complete a task because of condition or disease, etc.</p> <p><input type="checkbox"/> Supervision is required for safety in adjusting the water temperature, or in the transfer.</p> <p><input type="checkbox"/> The patient may use a bathtub, a shower, or take a complete sponge bath. The patient must be able to do all the steps of whichever method is employed without another person being present.</p>
<b>DRESSING</b>	<p><input type="checkbox"/> The patient is dependent in all aspects of dressing and is unable to participate in the activity.</p> <p><input type="checkbox"/> The patient is able to participate to some degree, but is dependent in all aspects of dressing.</p> <p><input type="checkbox"/> Assistance is needed in putting on, and / or removing any clothing.</p> <p><input type="checkbox"/> Only minimal assistance is required with fastening clothing such as buttons, zippers, bra, shoes, etc.</p> <p><input type="checkbox"/> The patient is able to put on, remove, corset, braces, as prescribed.</p>
<b>PERSONAL HYGIENE</b>	<p><input type="checkbox"/> The patient is unable to attend to personal hygiene and is dependent in all aspects.</p> <p><input type="checkbox"/> Assistance is required in all steps of personal hygiene, but patient able to make some contributions.</p> <p><input type="checkbox"/> Some assistance is required in one or more steps of personal hygiene.</p> <p><input type="checkbox"/> Patient is able to conduct his / her own personal hygiene but requires minimal assistance before and / or the operation.</p> <p><input type="checkbox"/> The patient can wash his/her hands and face, comb hair, clean teeth, and shave. A male patient may use any kind of razor, but must insert the blade, or plug in the razor without any help, as well as retrieve it from the drawer or cabinet. A female patient must apply her own make-up, if used, but need not braid or style her hair.</p>
<b>FEEDING</b>	<p><input type="checkbox"/> Dependent in all aspects and needs to be fed, nasogastric needs to be administered.</p> <p><input type="checkbox"/> Can manipulate an eating device, usually a spoon, but someone must provide active assistance during the meal.</p> <p><input type="checkbox"/> Able to feed self with supervision. Assistance is required with associated tasks such as putting milk / sugar into tea, salt, pepper, spreading butter, turning a plate or other "set up" activities.</p> <p><input type="checkbox"/> Independence in feeding with prepared tray, except may need meat cut, milk carton opened, or jar lid, etc. The presence of another person is not required.</p> <p><input type="checkbox"/> The patient can feed self from a tray or table when someone puts the food within reach. The patient must put on an assistive device if needed, cut food, and if desired, use salt and pepper, spread butter, etc.</p>

**ADL INFORMATION**  
**PAGE 4 OF 4**

<b>MEMORY CARE</b>	<p><b>PLEASE CHECK ALL THAT APPLY</b></p> <p><input type="checkbox"/> The patient has a current diagnosis of dementia or Alzheimer's disease.</p> <p><input type="checkbox"/> The patient currently is able to walk independently (without physical assist from another person) OR is able to propel self in a wheelchair.</p> <p><input type="checkbox"/> The patient is currently OR has a history of wandering, exit seeking, or elopement.</p>
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Signature of individual completing this form: \_\_\_\_\_

Relationship to Veteran: \_\_\_\_\_ Date: \_\_\_\_\_



**STATE OF FLORIDA**

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

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**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**



## **STEP 2**

# **PROVIDE VETERAN'S INFORMATION AND DOCUMENTS REQUIRED**

**\*\*\* PLEASE READ THE CHECKLISTS FOR ADDITIONAL  
INFORMATION AND DOCUMENTS REQUIRED\*\*\***

## **STEP 3**

### **CHECKLIST FOR FINANCIAL INFORMATION AND DOCUMENTS REQUIRED**

**Monthly Cost of Care is determined by the VETERAN'S NET MONTHLY INCOME. The Veteran will be required to apply for Institutional Care Program (ICP) Medicaid benefits upon admission. If the Veteran is eligible for ICP Medicaid benefits, Medicaid will determine the Veteran's monthly Cost of Care. If the Veteran is NOT eligible for ICP Medicaid benefits, the monthly Cost of Care amount will continue to be based on the Veteran's NET MONTHLY INCOME. Proof of income is required to determine monthly Cost of Care.**

**Please read the table below to determine financial information required to calculate Cost of Care. Read the column "DOES THE VETERAN RECEIVE OR HAVE" to determine the financial documents to provide that are listed in column "IF YES, PROVIDE A COPY OF THE FOLLOWING".**

	<b>DOES THE VETERAN RECEIVE OR HAVE?</b>	<b>IF "YES", PROVIDE A COPY OF THE FOLLOWING:</b>
	<b>SERVICE CONNECTED DISABILITY</b>	<b>CURRENT VA SUMMARY OF BENEFITS</b>
<b>*** STOP HERE IF THE VETERAN IS SERVICE CONNECTED DISABLED 70% - 100%</b>		
	<b>SOCIAL SECURITY BENEFITS</b>	<b>CURRENT SOCIAL SECURITY BENEFIT LETTER</b>
	<b>AID &amp; ATTENDANCE / VA PENSION</b>	<b>CURRENT BENEFIT LETTER OR BREAKDOWN LETTER</b>
	<b>PENSION</b>	<b>CURRENT PENSION BENEFIT LETTER OR STATEMENT</b>
	<b>REQUIRED MINIMUM DISTRIBUTION OR OTHER INCOME PRODUCING INVESTMENTS</b>	<b>MOST RECENT 3 MONTHS STATEMENT FOR EACH ACCOUNT. INCLUDE ALL PAGES OF EACH STATEMENT, EVEN IF PAGES ARE BLANK.</b>
	<b>BANK ACCOUNTS (CHECKING OR SAVINGS)</b>	<b>MOST RECENT 3 MONTHS STATEMENTS FOR EACH ACCOUNT. INCLUDE ALL PAGES OF EACH STATEMENT, EVEN IF PAGES ARE BLANK.</b>
	<b>INCOME FROM RENTAL PROPERTY</b>	<b>CURRENT RENTAL AGREEMENT</b>
	<b>MEDICARE SUPPLEMENTAL INSURANCE</b>	<b>MOST RECENT PREMIUM STATEMENT</b>
	<b>TAX RETURN FOR THE PREVIOUS YEAR</b>	<b>MOST RECENT TAX RETURN</b>
	<b>NO TAX RETURN FOR THE PREVIOUS YEAR</b>	<b>COMPLETE THE "INCOME TAX STATEMENT" FORM INCLUDED IN THE APPLICATION</b>
	<b>ICP MEDICAID / NOTICE OF CASE ACTION</b>	<b>NOCA IS VETERAN IS CURRENTLY RECEIVING ICP MEDICAID BENEFITS</b>
	<b>QUALIFIED INCOME TRUST</b>	<b>COPY OF QUALIFIED INCOME TRUST</b>





**Glenn W. Sutphin Jr.**  
Executive Director  
**Connie Tolley**  
Division Director  
**Margaret Kaplan**  
Administrator

State of Florida  
**DEPARTMENT OF VETERANS' AFFAIRS**  
**Clyde E Lassen State Veterans' Nursing Home**  
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**Rick Scott**  
Governor  
**Pam Bondi**  
Attorney General  
**Jimmy Patronis**  
Chief Financial Officer  
**Adam Putnam**  
Commissioner of Agriculture

## 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: \_\_\_\_\_

**FYI**

**MEDICAL RECORDS AND HEALTH INFORMATION REQUIRED**

**The following medical records and health information will be requested by the Admissions Coordinator from the physicians listed on the "PHYSICIAN CONTACT INFORMATION" form.**

**"3008" MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM**

**VERIFICATION OF CAPACITY**

**HISTORY & PHYSICAL REPROTS WITHIN THE LAST 12 MONTHS**

**PHYSICIAN / NURSING PROGRESS NOTES WITHIN THE LAST 12 MONTHS**

**CURRENT MEDICATION LIST**

**MOST RECENT LAB REPORT**

**CHEST X-RAY REPORT OR PPD SKIN TEST REPORT WITHIN THE LAST 12 MONTHS**

**IMMUNIZATION RECORDS**

**FACE SHEET (IF APPLICABLE)**

**CARE PLAN OR MDS (IF APPLICABLE)**

**LIST OF SERVICE CONNECTED DISABILITY DIAGNOSES (IF APPLICABLE)**